

AFRICAN MIGRANTS IN OREGON: HEALTHCARE PREFERENCES
AND THE IMPORTANCE OF WORLDVIEWS

by

FRIEDA BIKELE

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THESIS APPROVAL PAGE

Student: Frieda Bikele

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This thesis has been accepted and approved in partial fulfillment of the requirements for the Master of Arts degree in the Department of International Studies by:

Dennis Galvan	Chairperson
Valerie Palmer	Member
Kristin Yarris	Member

and

Scott L. Pratt	Dean of the Graduate School
----------------	-----------------------------

Original approval signatures are on file with the University of Oregon Graduate School.

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THESIS ABSTRACT

Frieda Bikele

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Department of International Studies

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Title: African Migrants in Oregon: Healthcare Preferences and the Importance of Worldviews.

Oregon, especially the Portland metro area, has become an important relocation destination for migrants, including many from Africa (Curry, and Al 2010). According to data from the Immigrants and Refugees Community (2011) in Portland, there are more than 15,000 African migrants, and they are the fourth largest immigrant community in Oregon, which includes representations from over 28 African countries. This study is about migrant' worldviews and healthcare preferences in Oregon. My study centers on African migrant's health experiences within a broader context of how sending countries worldviews and health care system informs attitudes and healthcare preferences in Oregon. Focus groups, life histories and survey data were collected over a period of 18 months from participants of 12 countries living in Eugene and Portland, Oregon. The findings indicate that migrants worldviews results from prior socialization processes that shapes Africans and guides their interactions and healthcare preferences in the US healthcare system.

CURRICULUM VITAE

NAME OF AUTHOR: Frieda Bikele

GRADUATE AND UNDERGRADUATE SCHOOLS ATTENDED:

University of Oregon, Eugene
University of Douala, Cameroon

DEGREES AWARDED:

Master of Arts, 2017, University of Oregon
Master of Arts and Social Science, 2005, University of Douala
Bachelor of Arts and Social Science, 1998, University of Douala

AREAS OF SPECIAL INTEREST:

Minorities Health
Culture and Health
Women's Health
Healthcare Policies

PROFESSIONAL EXPERIENCE:

Corporate Taxes Specialist, Department of Taxation, Douala, Cameroon, 1999-2006
Financial Counselor Assistant, Cameroon Embassy, Washington D.C, 2006
C.N.A Concentric Health Care Solutions, Phoenix, AZ, 2007
C.N.A Life Care Center of Paradise Valley, Phoenix, AZ, 2007- 2008
Domestic Violence Advocate, Women's Space Shelter, Eugene, OR, 2012-2013
Graduate Teaching Fellowship, University of Oregon, Eugene, OR, 2013- 2016

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CHAPTER I

INTRODUCTION

The 21st century is on track to being remembered as predominately affected by unprecedented human migrations happening in many regions of the world. These large scales migrations affect not only Africa, but Europe, the Middle-East, as well as the Americas. If in some parts of the world, uncertain political climate and ethno religious conflicts are to blame, in other areas failed economies, climate change, and the pursuit of educational goals or better opportunities remains the driving force behind migrant's decision to venture into foreign lands.

Sub-Sahara African migrants are among displaced populations who have either forcibly or voluntarily crossed the borders of their countries of origin and entered either in a new country or a new continent. The South-South and South-North migration movements are in part due to push factors such as civil and ethnic conflicts, religious strife, and frequent to prolonged droughts. Pull factors such as educational opportunities or simply the hope to reunite with family members who have already relocated to the area are among other reasons to relocate. In some cases, migration tends to be justified by the pursuit of jobs opportunities. The United States is one of the many countries that has been receiving African migrants. Oregon, especially the Portland metro area, has become an important relocation destination for migrants, including many from Africa (Curry et al., 2010).

This study is about migrants' worldviews and healthcare preferences in Oregon. Sending-country (i.e., country of origin) factors may influence immigrant health before and after immigration, along the life course, alone or in combination with receiving-country (i.e., country of destination) factors. (Acevedo-Garcia et al., 2012).

I will firstly examine how this population's worldviews, medical practices, and healthcare system structure influences African migrant's healthcare preferences in their respective receiving countries, and secondly how it can not only create a disconnect, but also constitutes a root cause to many challenges affecting this populations' ability to fully utilize healthcare services available to them as well navigate the health care system in the US. This study seeks to reveal the importance of culturally derived worldviews and belief systems regarding health, contextually developed healthcare seeking behaviors, and healthcare preferences of migrants. I argue that perceptions, attitudes, and healing practices acquired during the socialization process in their home countries as well as the structure of the receiving countries shapes African migrant choices that in return guides their interactions with the US healthcare system. The complexity of this population in terms of languages, cultures, beliefs and practices not only within the same ethnic and social group but across regions needs an inter professional approach in other to understand how these factors affect their behaviors in the healthcare system in Oregon. I will expand more on this aspect later in the background section.

These perceptions, practices and attitudes create the least recognized and most salient barriers between migrants and the healthcare system in Oregon. Recognizing these "invisible" barriers could be informative and most helpful for local public health agencies in the development of strategic interventions to meet the needs of this population and make healthcare more accessible. In fact, miscommunication, limited knowledge of cultural and religious information during clinical encounters between providers, who are mostly from the dominant culture, and patients from diverse backgrounds, may be one of the various manifestations related to these invisible barriers.

To further my analysis on this subject, information from focus groups, life histories and survey data were collected over a period of 18 months. The results presented here are representative of my observations, information, opinions and the stories gathered from participants from 12 different countries (Gabon, Congo, Togo, Central African Republic, Chad, Burkina Faso, Senegal, Mali, Cameroon, Ethiopia, Nigeria, Liberia) living Eugene and Portland, Oregon as well as community leaders and service providers. This study is built on existing work done by Curry et al, (2010) and Boise et al (2004) but with a slightly different orientation. Previous research on Sub Sahara migrant's health in Oregon have focused on identifying the healthcare needs and structural barriers to accessing healthcare in Oregon. My study centers on African migrant's healthcare experiences within a broader context of how sending countries worldviews and health care system inform attitudes and healthcare preferences in Oregon.

This study is organized as follows: Chapter Two offers an overview of the literature on migrants' healthcare systems and norms that informs attitudes of health, illness, and treatments and ends with a discussion of the research designed to evaluate the hypothesis that migrants' prior socialization matters. Chapter Three deals with the methodology used in the study. Chapter Four, Five, Six and Seven presents the research findings. I conclude in Chapter Eight by discussing the policy implications of the study and formulating suggestions.

1.1. Background

According to data from the Immigrants and Refugees Community (2011) in Portland, there are more than 15,000 African migrants in Oregon, and they are the fourth largest immigrant community in the area, which includes representations from over 28

African countries. Newly arrived migrant groups face challenges such as adaptation to the new environment, learning a new language and cultures or accessing services such as healthcare, welfare and social benefits. These challenges are due in part to socio-cultural and /or linguistic differences between their country of origin and host communities. Structural barriers impose additional obstacles for a traumatized population whose very status as immigrant mandates they're dealing with the formal structures of the state—an entity they may not always have had positive dealing with in their countries of origin.

A brief review of migrant's healthcare system indicates there are some similarities and some differences between migrant's sending countries healthcare system and their US counterpart. The noticeable similarities are mostly in terms of how Western style clinics are structured and how they operate in mostly urban settings in migrant's sending countries. The differences between this population's sending countries healthcare system and Oregon's healthcare system are in part deeply rooted in migrant's worldviews and resulting healing practices and healthcare systems they have been engaging with before migrating to the US.

In rural settings for example, there is limited state public health presence, doctors and midwives purchase medication and supplies from individuals who are in the business of importing pharmaceutical products. Typically, there is a middle-man involved in these transactions and no local or state regulatory body to check the origin or quality of the medication distributed and sold in these unregulated markets. In some instances, treatment is acquired without prior medical diagnosis but based on self-diagnosis and/or a discussion of the person selling the medications. Most of the medications acquired through these networks are administered without proper medical prescription. What dose should be

administered and the duration of the treatment are left to the discretion of the patients' family. Medication conservation and disposal does not obey any rules or regulations. Payment is informal and can be done in goods and non-monetary forms (Blaise et al, 2004)

In urban settings, things are a little more structured. There is the co-existence of government owned hospitals and clinics alongside private sector clinics; Patients are seen on a walk-in basis or by appointments depending on the medical institution. The healthcare system is under the authority of the State Health Department, which not only oversees medical facilities mode of operation from both public and privates sector, but also regulates the pharmaceutical distributions while fighting counterfeit pharmaceutical plaguing the healthcare systems. Over the time, these sources of care (which includes Western, faith based and nonprofits institutions) are in some areas overburdened, deteriorated and even unavailable in many rural communities in Africa. These private and non-profit medical institutions are themselves constrained by the same challenges faced by state institutions they were seeking to supplement in the first place.

For Kleczkowski (1984), developing countries are still facing constraints imposed by limited financial and labor resources, harsh climates, insufficient or unreliable utilities, and specific social and cultural traits. He states that: "Health care facilities are essentially only shelters in which healthcare functions are defined. With many African economies collapsing after the neoliberal policies failed to generate revenues necessary to sustain many healthcare facilities, most African countries healthcare system are still far from meeting basic healthcare facilities standards when compared to Western countries. This leads to people travelling miles away to get care for non-life threatening medical issues or only seeking care when their condition worsens".

An important feature of this healthcare landscape is the socio-cultural context in which life, health, disease and death are imagined, experienced, understood and talked about. While the majority of Africans believe in, and use modern medical practices, a latent polytheistic view of life undergirds many health related decisions. Ill health, for example, is as much the product of insanitary practices such as not washing one's hands or a malarial attack from mosquitoes breed in open gutters as it is about a person getting bewitched or jinxed. According to Flint (2008) treatment of disease often varied among different social and racial communities. This is because concepts of health, wellness, and the body, like tradition, are informed by our own experiences and the culture and era in which we live. She continues by claiming that: "different communities often have various ways of understanding the body and illness and consequently diverse approaches to health and healing".

In migrant's healthcare system, people have more or less turned to spiritual healers, faith based and non-Western healing practices. According to Kofi Appiah (1981), faith healing in this context is part of the healthcare system led by indigenous African Christian churches in Ghana. Church related institutions in Ghana meet the needs of the rural poor that are not met by governmental health services (Ibid 1981). The social-cultural context and healthcare system from which most African migrant's originated from have an effect on their interactions with the healthcare system in receiving countries. Migrant's prior healing practices, beliefs in traditional and faith based healing condition their healthcare preferences in their host countries.

1.2. Statement of the Problem

This is a study about migrants' healing and medical preferences. I focus on migrants from twelve African countries in the Portland and Eugene, Oregon area. I argue that migrants' prior culturally derived worldviews, attitudes and norms shape their healthcare seeking behavior, which in turn influences how they interact with Oregon's healthcare delivery system which structurally differ from the one they originated from. While not unique to African migrants, these attitudes have important implications for healthcare delivery. I argue that to more effectively serve these communities, healthcare providers need to understand the impact of contextually developed perceptions of health and healthcare seeking behaviors migrants carry with them to their new communities. For example, migrants' prior experience with the healthcare system in their countries of origin could potentially make them less trusting or willing to interact with the US healthcare system. Additional factors such as limited access to adequate translations services, immigration status and difficulties in assimilating have a compounding effect on existing obstacles for migrants trying to access healthcare services. Even though access to preventive care is generally limited due high healthcare costs in the US, it is not uncommon for migrants to not use what little services they qualify for.

The net effect of this tendency is that people normally seek care when their condition worsens or when their conditions become chronic. Appropriately identifying the healthcare needs of African migrants and addressing their healthcare preferences by local public agencies can lead to better health outcomes, prevent the spread of communicable diseases, and allow better investment of already scarce government resources. African

migrants' attitudes and preferences towards the healthcare system in general, and their health access challenges in the healthcare systems in Oregon is at the core of this research.

The information gathered as well as the data collected during the research on African migrant's worldview and healthcare preferences in Oregon are derived from life histories, focus groups and surveys conducted over a period of 18 months in both Eugene and Portland Oregon. Valuable insights knowledge on migrant's current issues were provided by experienced community leaders, services providers and also by direct observations during a number of meetings and organized community gatherings held in Portland and Eugene. The result of this study encompasses data presented in a manner that showcases personal accounts and hard evidences in support of the central argument.

1.3. The Relevance of the Study

Oregon, especially the Portland metro area, has become an important relocation destination for migrants, including many from Africa (Curry et al., 2010). In 2012, census bureau data showed an increase of the total population of immigrants claiming an African ancestry from 15,000 to 18,000 in Portland (Census Bureau, 2012). This trend can be explained as we said earlier by a variety of push factors such as civil and ethnic conflict, religious strife and increasingly, climate change-induced factors such as frequent and prolonged droughts and famine. Pull factors such as educational opportunities or simply the hope to reunite with family members who have already relocated to the area also drives migrants.

Newly arrived African migrants, like other migrant groups, often face many challenges due to cultural and health care systems differences between migrants and their host communities. Language barriers impose additional obstacles. As mentioned in Curry

et al. (2010) study, African migrants face many obstacles including accessing social services, and in some cases benefits available to them during and after the relocation process in Oregon. Yet, Oregon's African immigrant's health needs and healthcare access have not been at the center of much research. As in other communities in the United States, information is lacking about the health needs of Africans refugees and immigrants living in Portland, Oregon (Boise et al., 2013).

This research considers African migrant's socially derived healthcare attitudes, norms, practices as well as the structure of the US healthcare system and their effects on this population's healthcare preference in Oregon. In general, these attitudes, norms and cultural competencies do not adapt readily to the biomedical conception of health and medicine predominately used in Western countries.

This study is also an opportunity to succinctly point out the implication of misleading ethnic and racial assumptions and classification of Africans as African American (Copeland, 2004). Africans' ancestry data is not typically captured by state and local governmental agencies or the US Census Bureau; thus it is hard to identify trends in the African migrants' population in Oregon (Boise, et al. 2013). By lumping them with African-Americans, the needs and challenges of African migrants in terms of health care access and social services utilization cannot be appropriately and accurately assessed, identified, and resolved during or after the relocation process. Lumping African migrants with the African-American racial and ethnic group makes these group invisible in terms identifying them as of distinct socio-cultural and racial ethnic groups in Oregon's demographical landscape. In addition, challenges confronted by African migrant's populations in accessing services, socio-cultural factors, and language barriers are

overlooked or ignored which in turn can undermine the allocation of much needed resources and compromise these communities wellbeing in Oregon.

As I would argue throughout this study, migrants' worldviews, in association with socio-cultural and structural factors of both their place of origin and host community affect their attitudes towards the healthcare system and shapes their healthcare preferences. In Oregon migrants, as products of their societies, often export their worldviews with them when they migrated. This tendency is far from being the result of their attachment to traditionalism but rather a coping mechanism driven by structural barriers existing within the healthcare system in Oregon.

To support this argument, data was gathered in Eugene and Portland by means of focus groups, interviews and life histories. A data analysis phase ensued, followed by a presentation of not only people's personal account of their lived experiences in the healthcare system in Oregon, but also hard evidences drawn from surveys suggesting a strong correlation between migrant's prior socialization and experiences, structural factors and their healthcare preferences in the healthcare system in Oregon. The research findings suggest that factors such migrant's healthcare needs and health condition, language, socio-economic status, level of education, immigration status and gender does not have an impact on migrant's healthcare preferences as significant as I would have predicted but their worldviews have a greater effect on their healthcare preferences.

1.4. Conclusion

The quest for understanding the interplay between migrant's worldview and their healthcare preferences in Oregon and how the structural barriers of the healthcare has a compounding effect on their healthcare preferences is the central theme of this study. This

objective could be attained through the agency of mixed research methods that captured migrant's attitudes and norms and how they affect their behaviors in the healthcare system. The incessant flow of migrants from war torn countries to the US can make it challenging for the healthcare system of receiving countries to understand the population they are dealing with and to provide appropriate and adequate healthcare services without any knowledge of these population's background.

CHAPTER II

LITERATURE REVIEW

Overview of African Migrants in Oregon

The United States has become an important relocation destination for migrants, including many from Sub-Saharan Africa. With many migrants relocating to the Pacific Northwest in recent years, it is appropriate (in the case of this study) to build a framework based on available data about African migrants. This chapter will explore literature that will guide us in our understanding of the history of African migrants in Oregon. Ample information on migrant's demographic, healthcare needs and migrant's health and healing practices will be the focus of the second section of the literature review. I will draw on existing research on African culture and health, African immigrant beliefs systems around health, and the very limited existing literature on African migrant's health in Oregon.

2.1. Background on African Migrants in the Metro Portland Oregon area

According to data from the Immigrant and Refugees Community Organization (IRCO), a large number of African migrants, refugees and secondary migrants have been relocated to the Portland Metro area since 1975 (Curry et al., 2013).¹ African migrants are now the fourth largest immigrant community in the metro area. Over 28 African countries are represented in this population, with as many as 45% from East Africa. The data from IRCO indicates that a quarter of migrants and refugees from Africa have a graduate or professional degree earned in their home countries. Often times these educational or professional credentials are not recognized in the United States.

¹ In 2011, more than 15,000 were resettled in Portland and 22,483 in Oregon. In 2012, the census bureau data showed an increase in the total population of immigrants claiming an African ancestry from 15,000 to 18,000 in Portland (Census Bureau 2012).

Many of the refugees have fled civil strife and conflicts (Agier 2008). They are now supported by federally funded resettlement programs and private organizations; the vast majority of migrants, however, are economic migrants who involuntarily left their countries of origin for greener pastures in Oregon (Arthur 2009, Agier 2008). The African migrant community is one of the most diverse groups in the Portland metro area.² The graph (figure 1) below not only reflects sending countries in terms of percentages and flow of migrants from Africa, but it also provides insight into the geopolitical situation that created these migration flows to the U.S. and particularly Oregon in the first place. For example, the flow of migrants from Congo to Oregon in late 1990, was the aftermath of the war between the government forces and the Rwanda back Congolese rebels fighting to control the mineral rich Eastern region of Congo.

African Ancestry Profile, Multnomah County, 1990

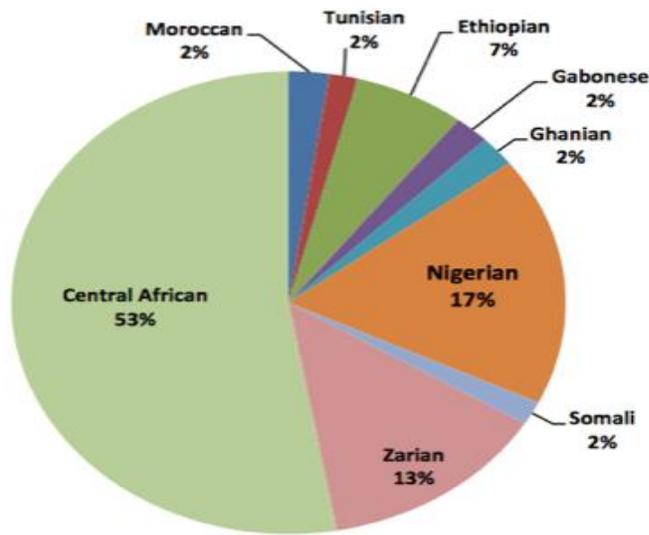


Figure 1. African Immigrants in Multnomah County.

Source: Census 2000 & American Community Survey, 2007, drawing from customized data extractions by Joseph Smith-Buani.

While the majority of the migrants and refugees come from Sub-Saharan Africa, they are far from being a homogenous group in terms of demography, language and religion (Falola and Heaton, 2006). In many African communities, it is not uncommon to find people who share the same tribal or ethnic affiliation, but not speaking the same dialect nor practicing the same religion. For instance, the “Sawa” ethnic group in Cameroon is believed to share an ancestor who is celebrated once a year. While customs, rituals and traditional dances remain fairly similar across the four main tribes, languages have evolved due in part to annexations, hetero-tribal marriages and colonization; the Southern part of the river was placed under British protectorate while the Northern part of the river ended up with French colonists. Many sub-languages with slight to major variances are now spoken from one end of the river to another making it impossible to communicate during the grandiose yearly festivity. English or French are the “Sawa” tribal group default languages during festivities. In general, there are 250 native languages spoken besides French and English, and approximately 289 ethnic groups in Cameroon. Animists believers, Christians and Muslims are part of the Cameroonian demographics (our-africa.org, Sama 2007).

This lack of homogeneity both in terms of languages spoken, culture and religion is among the most distinctive characteristics of African migrants in Oregon. Having three generations living in the same compound and speaking two or more languages besides English remains the norm for many African migrants in Oregon (Arthur, 2000).

With such a diverse group of migrants relocating to Oregon, it is expected that they will inevitably face a number of assimilation and structural challenges ranging from adapting

and integrating in the new environment to navigating a complex and unfamiliar healthcare system as well as dealing with the lack of family and community based support system they so desperately relied on in their home countries.

In recent years, two researches have been crucial in shedding light on these experiences, challenges, healthcare needs and access to care of African migrants as a distinct ethnic sub-group from the African-American ethnic and racial group in Oregon. In *Community of Colors in Multnomah County: An Unsettling Profile*, (Curry et al., 2010) report centers the experiences of communities of color in Multnomah County and the disparities that exist between this community and other communities in the metro area. Boise et al. (2012) *Community –Based House Meeting Project on African Migrants Health Needs Report* on the other hand focuses on underlining factors undermining this population's health needs and healthcare access in Oregon. According to the authors of the latter report, information is lacking about the health needs of Africans refugees and immigrants living in Portland, Oregon.

A review of literature on research conducted both by African and Western researchers will provide information of who the migrants are, their country of origin, their healthcare needs, the healthcare ecosystem they originated from and their beliefs system before the relocation process.

2.2. Who are Immigrants?

In a more general sense immigrants are referred to as individuals who leave their home country and venture to a different location because of safety concerns, better opportunities, or the pursuit of a better life, education or family reunification. This displacement can happen within the person's home country's boundaries (in the case of

internally displaced populations) or across national boundaries (Bookman 2002, Agier 2008, Arthur 2009).

In Oregon like in other US states, immigrants are divided into two categories: migrant and refugee. Each category adheres to very rigid social and legal implications that are different for each group. Immigrants are required to disclose their immigration status as proof of their legal presence in the state in order to qualify for social benefits in receiving countries(dhs.gov,acf.hhs.gov). Migrants' legal status weighs heavily on their ability to obtain health coverage and social services benefits. The health insurance coverage for refugees who qualify for the government sponsored health coverage is typically revoked after a grace period of nine months whether or not they are financially capable to fend for themselves (Borjas 2003, acf.hhs.gov, PRWORA)³ For refugees arriving with minor children, health coverage, cash allowance, food, and housing assistance is approved for up to five years if they are not financially capable to care for their family's needs.

Refugees are individuals who leave their home countries involuntarily; in most cases this is due to external forces beyond their control forcing them into displacement. These pushing factors can be, but are not limited to, persecution based on race, religion, nationality, group membership, sexual orientations, or political affiliations or civil unrest. In many instances, sending countries governments have failed to provide protection. The defining factor is crossing their home country boundaries, entering a new country. They are granted the status of refugee by local officials under the guidelines of the United Nations High Commissioner for Refugees (Bookman, 2002).

³1996 welfare reform act, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), have made most legal immigrants ineligible for publicly funded services such as Medicaid for the first five years of residence

Article 101(a) (42) of the U.S. Immigration and Nationality Act (INA) stipulates that a “Refugee” is a person who is unable or unwilling to return to his or her country of nationality for the same reasons mentioned above and is outside of the United States. The lack of border crossing is usually the main factor used by policymaker to compared refugees and internally displaced populations. The presence or the lack of borders during any migratory movement is perceived as being the determinant element and set as a condition in their eligibility for international protection and aid. The international resolution aiming at protecting this group was materialized through the United Nations High Commissioner for Refugees 1951 convention and its 1967 protocol.⁴ Twenty-six countries including the United States signed the 1951 convention and its 1967 protocol providing a legal framework defining and protecting refugees. Governmental agencies have set eligibility criteria for both migrants applying for the refugee status and for refugees relocating in the U.S. seeking social services benefits mainly health insurance, housing assistance, and cash assistance.

Agier (2008), refers to this population in these terms: “exodus from war is not a simple migration from one place to another, it is best to make it clear right away that refugees are not migrants. Not only have they not chosen to be on the move, but also their exile actually prolongs the violence, massacre and fear that provoked it in the first place and redefined their most intimate personal identity, which is attacked, injured and bruised”

⁴ According to the United Nation High Commissioner’s web archives, the 1951 treaty was grounded in the article 14 of the Universal Declaration of human rights 1948, which recognizes the right of persons to seek asylum from persecution in other countries, the United Nations Convention relating to the Status of Refugees, adopted in 1951, is the center piece of international refugee protection today. The Convention entered into force on 22 April 1954, and it has been subject to only one amendment in the form of a 1967 Protocol, which removed the geographic and temporal limits of the 1951 Convention. For the United Nations High Commissioner on Refugees: “the 1951 Convention, as a post-Second World War instrument, was originally limited in scope to persons fleeing events occurring before 1 January 1951 and within Europe. The 1967 Protocol removed these limitations and thus gave the Convention universal coverage. It has since been supplemented by refugee and subsidiary protection regimes in several regions, as well as via the progressive development of international human rights law.

(Ibid. 2008). International organizations operating within host and transitional countries who ratified the UNHCR treaty have the duty to ensure that refugees get services to which they are entitled (Bookman, 2002)/

2.3. Illness Experiences and Care-Taking Narratives of Migrants

To understand how migrants approach health care in their countries of origin, I turn to a model developed by Arthur Kleinman, a medical anthropologist, in which medical systems can be viewed as cultural and social systems. The health care system (HCS) model is composed of three distinct, yet overlapping social arenas: the popular, professional, and folk arenas (Kleinman, 1978). In the popular arena, care is primarily provided within the family, as well social and community networks. Somewhere between 70 and 90 percent of sickness is managed in the popular domain across all societies (Kleinman, Eisenberg, & Good, 1978). The popular arena is where the majority of health care decisions are made, which includes: when to seek care in other arenas, whom to consult, and whether to follow recommended treatment. The folk sector consists of non-professional healing specialists, whether these are sacred or secular. The professional arena primarily consists of biomedicine, or professional scientific medicine, and professionalized traditional healing traditions, such as Chinese medicine, acupuncture, and chiropractic medicine.

Migrants in this study originated from countries where rudimentary healthcare facilities and unreliable healthcare systems are predominant and these countries are plagued with high mortality rates. Despite the high technological state of Western-Style cosmopolitan medicine and the allocation of substantial funds to health services, the majority of nations in the Sub Sahara Africa, in the eighties, are facing an expanding volume of unmet needs, where 70 to 80 percent of the population have little to no access

to primary health care (Slikkerveer, 1990). Beliefs in superstition and non-western medical practices are part of the healthcare system as presented in the folk arena of care. The popular arena is an informal and well organized support system that allows these communities to care for the children in the family and the neighborhood, the sick, the mentally ill and elderly members of the family and in some cases, to care for elderly members of the community. In the absence of a welfare system, care taking norms, which are socially constructed, are deployed when an illness or any other situation deemed urgent occurs within the family. We need to understand social, language and cultural factors affecting illness and health in order to better contribute to addressing health problems and health seeking behaviors of this specific population (Ibid 1990).

The use of these popular arenas of the HCS is strong as these networks of support systems are an integral part of these communities and often times go beyond the boundaries of a locality to create an international web linking members by kinship. It is not unusual to see migrants sending funds to cover medical expenses on a regular basis to extended family members left behind. In this specific context, illness experiences are not a personal affair, but is a social one in the sense that people rely on each other for survival (Young 2002, Slobin 1998). When someone becomes ill, it triggers courses of action that range from taking them to the hospital, to remaining with them throughout a clinic visit. Hospital stays are rare but when they do occur, it signifies that the condition is serious. The care-taking mechanism, which in this context is part of the social structure, is systematically put into place. This structure changes depending on the gender of the sick person, the family power, hierarchy, the nature of the illness.

In some cases, age and marital status matter. For instance, if a middle-aged person is sick or suffering from malaria, the spouse or someone from the household will contact the neighbor or relative to seek help transporting the person to the clinic or to a treatment facility. This option is usually sought after a home remedy has been tried without success. If the family has a pressing matter such as to gather the cattle at dawn or sundown, or to care for grandchildren left at home, the neighbor(s), regardless of their personal or family duties, will tend to these tasks without expecting any financial compensation. It is not unheard of to have neighbor take care of a community member farm or crops when they are ill and unable to harvest their crops. The caretaker(s) and the sick person will have unlimited and unregulated visits from family members; some will provide financial support while other will take care of basic daily life activities. In most cases, women and children are in charges of attending to the needs of the sick while in the hospital and will continue to do so when they leave the hospital setting. The sick person is bathed, fed and not left alone throughout the illness; this implies that family members and friends will be by the sick person's side day in and out regardless of the duration of the illness. These forms of family and community supports are features of social organization, such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit (Putnam, 1995).

If the illness persists or becomes chronic, the care taking setting moves from the hospital to the family compound. Sometimes, the sick person is transferred to a relative's house if it is deemed appropriate by family members. For caretakers, it is a burden and more of a moral obligation to maintain the group cohesion by supporting each other during hardship. According to E. Rosny (1981), in Sub Sahara Africa illness and healing system,

the sickness is a social affair; we can understand the rites having a therapeutic aim. They make it possible to mobilize the group concerned through a language that everyone understands without saying a word.

Pregnant women are also provided similar supportive care by family members especially before and after birth. In some cases, there are people who will move in the house with the soon-to-be mother in order to support her during and after childbirth. Caretakers in this case are in charge of bathing and massage both the baby and the mother for up to 40 days while other family members as well as neighbor provides meals on a regular basis. The caretaking narratives in the African context is a reflection of pride, dedication, commitment, and support to the family and the community. This support mechanism is part of the belief system and the social structure in the majority of African communities. Its helps maintain the cohesion of community and response to a social need in times of distress and in the absence of a welfare system, provides support to the populations.

The network of support system these communities have created and maintained throughout generations in their home countries are shattered after the relocation process, leaving migrants with no alternative support system options. In their home countries, they were used to calling neighbors for help, having their kids feed, looked after and even disciplined by caring neighbors. In the highly formal context and the cultural norms that exists in the United States, migrants have difficulty interacting with their neighbors because of language barriers, social and cultural norms, and unfamiliarity with the environment.

2.4. What Are Migrants Health Needs?

Unlike other migrant groups, the African migrant population in Oregon has rarely been the focus of researchers. According to Curry et al. (2013), “very little research has been conducted on the experiences and challenges facing the African immigrant and refugee community in Multnomah County”. She goes on by saying that, “many African countries have been infused with conditions that have been violent and persecutory for many of our people. And many of our people have been forced to flee their homes and, ultimately, have had all paths towards the future curtailed by forces beyond our control. Forced into refugee camps and surviving much trauma, many among us have sought to find shelter and a new life in foreign countries, including the USA and approximately half of Africans in this region are believed to be refugees or former refugees” (Curry et al., 2013).

While this study is among the few studies conducted on migrants in Oregon that includes both men and women's migrations and relocation experiences in Oregon, there are a number of studies with special focus on key sub-populations, such as women and youth living in other US states⁵. Immigrants population in the US face post relocation challenges such as language, adaptation to the new environment and healthcare access challenges migrants are often identified as a “vulnerable population”—that is, a group at increased risk for poor physical, psychological, and social health outcomes and inadequate health care (Aday 2001, Derose et al. 2007, Kreps et al.2008).

Within the migrant population, a considerable number of individuals have been dealing with issues ranging from pre-migration and post migration related trauma to exposure to communicable diseases. For instance, a study by Lipson (2000), focused on

⁵ 1) African Refugee and Immigrant Health Needs: Report from a Community-Based House Meeting Project (Boise et al., 2013). 2) African, Russian, and Ukrainian refugee resettlement in Portland, Oregon (Hume and Hardwick, 2005

health issues related to refugees' experiences. According to her, refugees may have experienced violent flight and torture. They may have seen loved ones killed. They may have been starved, beaten, or exposed to a variety of infectious diseases. Women may have been raped and everyone has been at risk for malnourishment. Depending on circumstances, country of origin, age, gender, and pattern of flight, refugees may have specific physical and psychological health needs that should be addressed when they reach the safety of the United States (Ibid 2000). Agier (2008) paints the image of the refugee experience in refugee's camps in these terms: "there is always a widespread threat of malaria, tuberculosis, severe malnutrition, rape and abuses of power in this environment. Another defining factor raised by his research and affecting refugee's identity and sense of belonging is what he calls "being undesirable and placeless". The exposure to infection diseases in camps and the trauma they have experienced are among many health issues that may require medical attention in receiving US states.

While there is limited research, data, and a lack of literature on African migrant's living in Oregon, we might infer that they have experienced, in a more or lesser degree, the same trauma as studied by researchers on immigrants and mostly refugees. Migrants, will bear the responsibility and face a number of hurdles associated with migration whether they chose to relocate or not. These barriers include: familiarizing with the social and cultural context of the new environment, learning an unfamiliar language, and adjusting to a very formal and professionalized system of health care. To understand how to navigate the healthcare system in order to access the health services they so desperately need in their host countries begins by admitting the fact that migrants now face a healthcare system that

has formal structures and lack the support system they used to rely on in other to function in their country of origin.

2.5. Migrants beliefs, health practices and preferences

Assisting African migrants in their transition to the western medical system is critical. This is particularly true as their views and those of western trained providers are entrenched and dictated by their respective attitudes and beliefs in regards to healthcare. As a reflection of a society's health beliefs and practices, medical systems offer a particularly valuable perspective with respect to a society's collective worldviews. Health beliefs and practices reflect a fundamental understanding of how societies view an individual and community's relation to the natural, supernatural and social worlds (Baranov, 2010).

Many researchers have been making the case that health care systems are embedded and dictated by patients' cultural systems (Kleinman.1978; Dutta. 2007). According to Kleinman in *Writing at the Margin: Discourse Between Anthropology and Medicine*, health, illness and health-care-related aspects of societies are articulated as cultural systems. Such cultural systems which he calls health care systems, are like other cultural systems (kinship and religious systems), symbolic systems built out of meanings, values, behavioral norms and the like. He goes on by saying that because the healthcare systems are part of cultural system, health, illness and health care need to be understood in relation to each other. Health beliefs and behavior, illness beliefs and behavior, and health care activities are governed by the same set of socially sanctioned rules (Ibid.1997)

A. Fadiman (1997) explains in her study that Hmong, like many refugees, had limited contact with Western medicine during their stay in refugees' camps. Hmong

refugees were not confident going hospitals and clinics due the facts that the practices and approaches of Western medicine were different from the one a for the simple reason *Txiv neeb*s also known as *Sharman* or traditional healer uses. For the Hmong, Western doctors ask too many uncomfortable questions which at times refers to sexual activities, they spent less time with patients (20 minutes), demand samples of bloods, urine, feces, and request that patients to be undressed clinic visits. In the contrary, the *Txiv neeb*s, see patients in their own environment, often spend up to eight hours during visits and doesn't undress patients or ask many questions. Treating the body without treating the soul in the Hmong culture was pure folly and they noticed that doctors in the west never mentioned the soul.

As complex as beliefs systems are, they operate within specific social context and adapt to the lived realities of these communities (Falola et al. 2006, Airhihenbuwa 1995). They are not static and frozen in time but they are governed by the needs of their community and are adjusted accordingly. Healthcare attitudes emanate from these beliefs and are a coping mechanism built to respond to structural and social needs within the healthcare system of the community. Migrants' unreliable and rudimentary formal healthcare systems presents many structural gaps to be filled by communities. For instance, in response to the absence of nursing homes and home health aides to care for the chronically ill and the elderly, communities rely on each other to support and provide needed care for their love ones in their family compounds not only because of their strong family values, but also because there is no other alternative to the problem. According to Sunderland (1993) kinship groups, tribal and familial groups play an important part in therapy management and in the doctor-patient relationship within the African social

context. This unique feature of migrant's healthcare system relies on informal social structures to meet the community needs.

Many researchers have been conducting ethnographic studies and providing first-hand accounts of African's healthcare beliefs and the healthcare system apparatus under which they operate (Copco et al. 1992, Airhihenbuwa 1995, Brodwin 1996, Falola et al. 2006, Flint 2008). As a reflection of a society's health beliefs and practices, medical systems offer a particularly valuable perspective with respect to a society's collective worldviews. Health beliefs and practices reflect a fundamental understanding of how societies view an individual's and community's relation to the natural, supernatural and social worlds (Baranov, 2008. P.18). As stated by Appiah-Kubi (1981), healing implies restoring the equilibrium in the otherwise strained relationship between [sic] man, his fellowmen, environment, ecology and God. This includes physical, emotional, social and spiritual dimensions.

Many African national healthcare systems are complex (Sunderland 1993, Slikkerveer 1990). African pluralistic – medical system does not imply a medical system that is somehow frozen in time, embracing an ancient and primordial set of health beliefs and practices. Rather, African pluralistic medical systems are dynamic, evolving medical systems that combine a wide variety of traditions, values and cultural influences. In this sense, it can be argued that, even in the absence of biomedicine, African pluralistic – medical systems are themselves syncretic insofar as they comprise a mix of medical systems. It is merely for clarity of presentation, therefore, that only medical systems that commingle aspects of biomedicine and aspects of African pluralistic medical medicine are referred to here as syncretic (Baranov, 2008).

These healthcare systems operate in communities where people's beliefs are not only deeply rooted in superstitions and supra natural entities, but strong family values and informal social structures are part of the environment as well (Fadiman, 2012). Beliefs systems are constructed around narratives of illnesses origins that have been caused by natural agents, supra natural and spiritual agents. In most cases, people in these communities, to lesser or greater degree believe in spiritual healers who are well known members of the community with values and norms similar to people they serve. They also believe in faith based healers who were seeking to convert people and help solve many social issues; herbalists who turns out to be the only practical avenue when other type of treatments was not successful and in doctors and medical experts claiming to cure the impossible. Aderibigbe (2006) study points out that the concept of medicine is central in the Yoruba culture. He distinguishes two types of medicine: Simple medicine and complex medicine.

The first one refers to illnesses curable with available herbs administered by anybody in the society. For instance, headache and stomachache can be cured by simple medicine. These illnesses are often the result of some sort of infection from germs, insects, bad foods, weather and carelessness on the part of the sufferer. They are physically recognizable and treatable. The sufferer is usually not bedridden. Complex medicine on the other hand involves both physical and metaphysical illnesses. They are often considered serious and are treated by professionals who are custodians of the traditional healing system. These illnesses are the result of evil forces, other spiritual agents or human enemies. Yoruba medicine also includes a religious component. The notion of illness in the Yoruba worldview is perceived as holistic which explains why the healing process is

considered to be multidimensional. The physio-biological manifestation of an illness can also be a symptom of a deeper moral and mystical problem. For instance, when the natural causes are dismissed in the diagnostic, the Yorubas believe that the following agents are responsible: Bewitchment, sorcery, broken taboos, and various other causes. The next step is to have a healer use divination to know if he should in fact treat the patient or not because the witch(es) who inflict the illness, will have to be consulted and asked what they will accept as ransom (sacrifices to) in order to make a cure possible (Ibid). 2006).

All these social realities then dictate migrant's attitudes and the subsequent interactions with the healthcare system in Oregon. Another key distinction that impacts migrants' experiences in the United States when interacting with the Western medical system is their prior understanding of illness and symptom. According to Rosny (1998), the term "illness" differs from "symptom". He states, "What is usually called *illness* at the hospital would be better translated as *symptom*, the symptom of an evil, which is gnawing at the group". The soothsayer-practitioner task is to discover or allow the family to discover the internal evil, which is undermining the unity of the family. He goes on by saying that: "For their success, the practitioners do not depend on their art; they regard themselves as working for a hierarchy of invisible powers-ancestors, deities, and God himself". In contrast to this sacral vision of sickness and healing, hospital medicine itself is perceived as essentially secular and depending on the competence of the hospital doctors".

Based on his analysis, I argue that symptoms associated to an illness have different meanings depending on the healthcare system in which ones operates; the origin of an illness varies between the Western and the non-Western perspectives, as do health and healing practices (Kleinman 1980, 1986). The studies referenced here present migrants'

healthcare systems which includes the formal healthcare system such as clinic and healthcare centers both public and private and the informal healthcare system (personal and folk arenas) which are based in non-Western medical paradigms. In the latter, rituals, blessings, and offerings are an integral part of the healing process.

Migrant's healthcare system features and healing practices are fundamentally different from their U.S. counterpart. In the U.S. healthcare system, healthcare providers and practitioners rely on science-based knowledge in order to recommend treatments, which is not the case for someone who operates in the informal healthcare system. The worldview embraced by biomedicine limits health related phenomena almost exclusively to the natural world (Baranov 2010)

Another aspect of Kleinman's (1980, 1986) health care systems is that HCS are socially constructed. They differ from one society to another and from one arena to another within the same health care system. As I will discuss in relation to my data, most migrants use the popular and folk arenas in their countries of origin. For example, in the Igala's study conducted by Agbali (2006), treatment first occurs in the family or within the household using the family medicines, a collection of herbs, tea, concoctions collected around the house or the garden, the nearby forest or the market place. Almost all Igala's adults possess fundamental knowledge of traditional medicine. (Ibid). 2006).

An important concept that helps connect Kleinman's three arenas of care is medical pluralism, which can be understood as the ability to access and methodically navigate many health and healing systems to restore health. In the case of the Igala's study, the author noticed that it is still common knowledge that while many Igalas accessed and visited the medical institutions, they utilize medicines prescribed from the traditional

medical order. Accessing the modern medical sphere indicates their attitudes at exploring all available options towards ensuring wellbeing. Often, the decision to seek medical help from the Western medical source depends on the functional outcome of the traditional medicines in effecting maximal medical results (Agbali, 2006).

For migrant's communities, oscillating between two or more healthcare systems is not necessarily due to the health benefits they receive in each system, but is a response to either their beliefs system or an inadequate healthcare system. Abubakar's (2006) analysis for instance focuses on the misunderstanding of the core strengths and values of migrants' healthcare system and the ways by which African leaders and the international community as a whole should approach healing. He strongly suggests that it is imperative that African heritage, in respect of health and medicine, should be intensively and extensively studied with a view to developing indigenous skills and interventions through the medium of modern technology. This will ensure the proper combination of arenas of the HCS.

While in their homeland, these communities of Africans have managed to adapt their healthcare system to the needs of their communities. In a very unique way, an informal structure fueled by family's values, strong support system has reshaped the ways in which they interact with the healthcare system (Janzen, 1978). They navigate both the Western and non-Western medical spheres in selective ways. The benefits of using non-Western medicine compared to Western medicine is the focus of Aderibigbe's study. According to him, traditional medicine for treatments are more prevalent in the Yoruba community because they present many advantages. They are not toxic and do not present any side effects; they build the body's immune system, they are the result of experience and practices passed down from generation to generation. They are also affordable and easily

accessible, as well as deeply rooted within the Yoruba cultural system. These medicines are using local ingredients that are compatible with the immune system (Aderibigbe, 2006).

While the literature on African's health and healing practices predominately focuses on cultural perceptions, meanings, and beliefs systems surrounding the concepts of health, illness and healing of African in their natural environment (Falola et al. 2006, Flint 2008), there has been little said about the manifestations of how these practices play out in a different health care system, particularly when people relocate to a new environment. When voluntary or forced migration occurs, migrants who have relocated to the US are faced with a number of unfamiliar social realities within the healthcare system (Morris et al. 2009, Muecke 1992). In this new environment, medical encounters between patients and providers are based in the very rigid rules in the Western medical system.

According to Philbert (1998), patients and provider's interactions in this environment becomes regulated and based on one treatment option. He states that: "consciously or unconsciously, sick people bring to their doctors their whole lives, that is, not only their concern about their families, their work, their continuity in a community of relations, and their anxiety about their ability to remain or return to their personal and creative occupations. Even those who are fortunate enough to have access to a competent physician are often limited to a summary dialogue about their symptoms and their medical history. The assessment, diagnosis and treatment of the sick depend upon immense structure of laboratory science that demands clinical distance from the person treated" (Ibid).

For migrants originating from societies where informal structures and strong support system were part of the healthcare ecosystem, the tendency is to turn to known and

familiar practices giving the fact that they now have to abide to the rules of rigid and heavily regulated and science based healthcare system. For example, in their country, people who had persistent illnesses caused by sorcery, transgression, or spirit possession sought indigenous treatments but these assumptions and mode of treatments do not exist in their host countries (Coppo et al. 1992, Sharp 1994), Young 2002). Migrants' selective treatment preferences pattern based on the illness, such as this example, can easily resurface during their interactions with healthcare providers in their host communities. The effects that health knowledge or more appropriately, that knowledge about health which a person or a group chooses to believe, affects the way that health seeking behavior, health treatment options and discourses on health issues are pursued (Falola et al. 2006).

I argue that the medical pluralism practices in which migrants engaged before relocating to the US guide their healthcare preferences in the US. I will also discuss that is reasonable to expect that among migrant population in the US, this use of traditional notions of health may not be understood by health care providers operating within the biomedical model. This mismatch may affect access to biomedical health services and health outcomes among this population.

CHAPTER III

RESEARCH METHODS

This research focuses on exploring the effects of prior socialization on the healthcare seeking behaviors, attitudes and preferences among a segment of the African migrant population in Eugene and Portland, Oregon. Prior socialization is used in this study to describe people's internalized experiences. My main hypothesis is that healthcare seeking behaviors are culturally derived and impact peoples' attitudes towards healthcare systems. The host country HCS structural factors have a compounding effect on migrant's healthcare preferences. While not unique to African migrants, these preferences have particular implications for healthcare delivery. I argue that to more effectively serve these communities, healthcare providers need to understand these contextually developed perceptions of health and healthcare seeking behaviors of migrants.

I test this hypothesis using three types of data. First, participant observational data collected during my time as an intern in Portland, Oregon with the Immigrant and Refugee Community focusing primarily on African migrants. The second set of the data was collected using focus group interviews. The focus group interviews were conducted to learn about the opinions of African migrants' health needs and health access challenges at the existing institutions serving them. These were followed by 22 in-depth interviews, and four life histories⁶ all conducted over a period of 18 months in Eugene and Portland Oregon. The qualitative data collected from these processes do two things: First, they will be used

⁶ The justification for conducting life histories is driven by a need to identify and document migrants' prior experiences and health patterns. The strategy allows the researcher to systematically explore participants' micro-historical experiences. Life histories are a good way to understand peoples' current attitudes and behaviors and how they may have been influenced by initial decisions made at another time and in another place (Gubrium and Holstein 2002; Russell 2006).

to test the main hypothesis that migrants' prior socialization shape their healthcare preferences and second expose how this impacts the realities of migrants' experiences within the US healthcare system and how it does not meet all of their culturally based needs.

3.1. Fieldwork

The exploratory phase of the study was conducted in fall of 2013. It started with meetings with officials working with African immigrants in the Portland metro area. I held initial meetings with a coordinator from the Africa House, an agency within the Immigrant and Refugees Community (IRCO) in Portland and the director of the Inter Professional Global Health Education at Oregon Health and Science University (OHSU). The purpose of these initial meetings was to get a sense of migrants' health issues as understood by service providers, find out who the key players were and how to better educate myself on this topic.⁷ I quickly realized, after reviewing a couple of meeting notes that the cultural and social background of this migrant population was a recurring subject. According to those interviewed, these two factors were not adequately taken into consideration by the healthcare system in Oregon. This created an opening for me. Following these meetings, I contacted the relevant officials to discuss the possibility of conducting further research. I also contacted and met with some of the Africa House Community Health Workers to establish relationships and present the project.⁸

In the summer of 2014 I interned with IRCO's Africa House whose office solely focuses on sub-Saharan African migrants. As an intern, I was involved in health literacy and

⁷Both organizations are involved in providing healthcare services to the uninsured including immigrants.

⁸ Efforts to include the Lutheran Community Services did not work out, and I am grateful for my initial meetings with officials from the organization.

outreach efforts. I also attended meetings on ongoing health related projects, and shadowed the health coordinator and the community health worker on their daily interactions with community members. This provided important opportunities to learn first-hand the various challenges faced by newly arrived migrants. I systematically recorded my observations of these interactions and culled my initial ideas that informed how I developed my research. This participant observation phase of the project informed many of the institutional questions dealt with in this work.

Over the course of my internship, I attended three conferences and many community events. I first attended the *World Refugee Day Celebration* held on June 20, 2014 in Portland Oregon. About 200 people attended. I also had the opportunity of attending a conference on *Refugee's Needs Assessment* held in Portland, Oregon on Saturday June 21, 2014. On July 15, 2014, I took part in the senior migrants' weekly gathering meeting held at the IRCO Africa House office in Portland and on September 26, 2014 I met with the Africa House Health Coordinator to discuss the health needs assessment project sponsored by Cover Oregon. On October 3, 2014, I participated in the Immigrants Community Health Workers meeting during which we discussed details regarding community specific health needs assessment project. The meeting was held at the Asian House in Portland, Oregon.

On January 30 2015, I had a meeting with the IRCO Africa House Community Health Workers to talk about the possibility of organizing a discussion with community members on the Ebola related stigma that ensued after the Ebola outbreak. The following day, I observed the field operations of the African immigrant health screenings mobile clinic; this event was held in the main office of IRCO in Portland under the supervision of

Professor Valerie Palmer of OHSU. These clinics provided valuable hands on learning opportunity for medical students, allowing them to be acquainted with immigrant communities' health access issues. For uninsured community members, it was a chance to get screened at no cost. On October 1, 2015, I attended the *We Can Do Better Conference* held in Portland, Oregon. The main focus of the conference was to identify ways to improve healthcare and healthcare systems, building on the knowledge of the participants and with the intention of moving towards a "Patient Centered Approach". On January 2, 2016, I met with a Multnomah County Community Health Worker for African migrants to discuss the challenges migrants face in the healthcare system. On January 9, 2016, I attended the second Refugee Youth Day event held in Portland.

These meetings provided more insights on current migrants' issues as based on their own experiences rather than the perceptions of those providing them with services. These events provided a platform needed to introduce myself and my research project to African migrants living in Portland, gain trust in the community before starting the data collection process. By the time I was launching the data collection phase in fall of 2014, I was a familiar face and had gradually built relationships with many individuals, community leaders and groups. During focus groups meetings, I had a chance to spend an average of three hours with participants. I seized the opportunity provided by focus groups meeting in both Portland and Eugene to announce the next stage of the research.

At the end of the 1st focus group session, participants manifested their interest to participate in the next phase of the research. Potential participant's contact information was gathered during these encounters. At the end of each focus groups, I introduced my study and individuals volunteered for interviews, thus using a convenience sampling method, and

preselecting them for in-depth interviews and life histories. The interviews were conducted based on the individuals' availability. The rest of the sample was selected using a snow-ball sampling methods based on interest in participating and availability.

Participants were grouped by category based on the need for an interpreter or not. Interviews with participant who could communicate in either English or French were scheduled first because I would have only had to accommodate two schedules: The participants' schedule and mine. For interviews requiring an interpreter, I had to schedule one language at the time and accommodate the participant, the interpreter and my schedule as well as a convenient location. Swahili and Fulani interpreters were present for interviews requiring a translator. Interpreters were selected base on criteria set by participants: be fluent in the Swahili from Congo and the Fulani from Chad or Central African Republic. Participants indicated that they had been very frustrated with inappropriate translations services which often did not correspond to the type of Swahili they spoke. One of the example cited was sending someone fluent in Kenyan's Swahili to provide translation services for a patient from Tanzania or Eastern Congo. Two female translators who were known by participants were selected. It is worth mentioning that participants who needed translators made it clear that they felt more comfortable working with someone they were familiar with. Many trips were taken to Portland and in some cases, last minute emergencies on the part of participants made it impossible to conclude an interview. Additional trips and make -ups sessions were taken to Portland to complete interviews

The survey sample was made of 9 refugees and 13 migrants. The same recruitment technique was used for the focus groups and in depth interviews conducted in Eugene and Portland. Participants in the Eugene, Oregon area did not need any translation services due

to the fact that they were fairly fluent in English, French and in some cases both languages. I had been in contact with many members within the Eugene's African community prior to launching data collection process.

3.2. Selection of Participants

Participants for the study were recruited using a combination of sample selection techniques. First, using professional connections, I sought out migrants using my professional connections with different migrant organizations. During this phase of my work, I told these professionals about my research interests and asked for introductions into the communities I wanted to study. Then using a snowball sampling method, relying on participants to refer friends and acquaintances to participate in my study. Participants were also referred to me by potential participants during the initial contact.

Through snowball sampling I actively recruited participants for the larger study. It became obvious that migrants' status for instance was not going to be the selection criteria giving the fact that status disclosure remains problematic and a politically charged concept for this group. I was apprehensive in delving in the demographical aspect of the research which involved asking questions related to participant' status but I came to the realization that participant's migration story will be indicative of their immigration if not will be easily associated with a particular status in cases where the interviewees, for the reason mentioned above were reluctant voluntarily disclose their current immigration status. Final participants were systematically selected from the pool of potential candidates. While I recruited these candidates using snowball sampling I also wanted to maintain and ensure as much as I could a fair geographic coverage (twelve African countries)⁹ and

⁹Participants were from Mali, Gabon, Senegal, Burkina-Faso, Congo, Togo, Cameroon, Nigeria, Liberia, chad, Central African Republic, Ethiopia.

multilingualism (seven languages spoken).¹ Each group of interviewees was comprised of Muslims and Christians and an age variance of 28-65 years old with both men and women. When those selected to represent a wide geographic and multilingual demographic were unavailable, participants were selected based on their availability and access to an interpreter of their choice (convenience sampling).

Early on, I noticed that participant felt a sense of relief knowing that there were other community members participating in the project and that they were not singled out in any way. After the first two semi-structured interviews, I quickly realized that the format was not appropriate for few reasons: Some questions related the respondents' demographical information were among subjects that respondents from this community did not feel comfortable sharing or discussing in a one on one type of setting. I learned from a refugee, who had spent ten years in a camps that these were questions deemed politically and emotionally charged. These questions reminded them the ordeal they had to go through countless of times in order for refugee's resettlement workers to determine if they were part of the militia that created terror in their home country before fleeing and finding refuge in camps. This was also a process they were subjected to or went through prior to be granted or denied the permission to enter the U.S by UNCHR investigators. Two of the four scheduled semi-structured interviews were cancelled because of the reasons mentioned above. I changed gears, moved away from semi-structured interviews to include both paired interviews and life histories for Portland and Eugene' participants. The interview script was mostly based on an open ended format which allowed participants to structure their own narratives surrounding their migration history and experience, their healing practices before the relocation process in the U.S as well as their experiences in the

U.S health care system and their healthcare preferences. Next, a total of four focus group discussions were conducted in each of the two cities. The two Portland focus groups had 18¹⁰ and eight¹¹ participants each, while those conducted in Eugene were made up of 12 participants each.¹²

The main objective of the focus groups was to tease out the health needs and health access challenges faced by the groups. Each meeting lasted about three hours. As in other cultures, food and beverage were provided to attendees in accordance with culturally appropriate norms of hospitality and appreciation. The meetings were conducted in community rooms.

The focus groups proved useful on many levels. For example, the level of cohesion amongst the groups created a space where participants enthusiastically responded to questions and most importantly, respondents were eager to discuss issues that they faced in their lives, which resulted in more input from other participants. From the lively discussion at these focus groups and participants seeking me out, it was apparent that many respondents had a strong desire to share their personal challenges in a more private setting. This led to private interviews based on convenience sampling and follow-up which included the systematic use of a questionnaire ($N=22$)¹³ and an even more detailed and

¹⁰ The 18 people who attended this focus group were from the Democratic Republic of the Congo and the Central African Republic. Members from other African countries were contacted but they were not available.

¹¹ All participants were Amharic and English speakers.

¹² The Eugene focus group was a more diverse pool with participants from eight countries, almost all were fluent in either or French.

¹³ Prior to conducting the life histories, I set up few appointments to collect data using semi-structured interview questionnaire but after just two semi-structured interviews, I came to the realization that some questions were politically charged and emotionally disturbing for respondents. I was told by a translator that respondents were not feeling comfortable answering questions because the interview process reminded them of some events that took place in the transition camps. I moved away from semi-structured interview to pairing respondents in groups of two with an open-ended script to ease out the process. Paired interviews meetings were set up based on respondent's availability. This approach yielded many in-depth conversations around topics that were important to this project. I conducted 6 paired interviews; two in Portland and four in Eugene. They took an average of two hours each.

intense study of life histories. These conversations took places in interviewees' homes for an average of two and half hours and in two cases, husbands were presents and actively engaged in the conversation. I also followed four pregnant women for a period of twelve months, from the beginning of their pregnancy up to three months after birth. These women were selected via convenience sampling as these are women I had met at community gatherings among the African communities. One was in Portland and three were in Eugene. I met with the participants in Portland once every 3 months and monthly with those living in the Eugene area.

3.3. Identification of Variables and Data Analysis

To systematically evaluate and understand the effects of prior socialization on healthcare preferences, I used a questionnaire with 22 people. Questions in the survey were as followed: I asked participants if one, they believed in non-Western medicine?¹⁴ Two, if they used non-Western medicine back in their home country?¹⁵ Three, what their first preference was when it came to seeking medical assistance?¹⁶ Four, how often did they resorted to non-Western medicine?¹⁷ Five, if they had a condition that required medical attention?¹⁸ Six, the type of illness?¹⁹ Seven, if they consulted and used spiritual healer²⁰ and finally, if they combined Western and non-Western medical practices?²¹ The answers to these questions taken together gives us insights into participants' socialization processes and its impact on their preferences. These same questions were also used in the life histories

¹⁴Q1. Do you believe in nonwestern medicine? Coded: [0] No, [1] Yes

¹⁵ Q2. Did you used nonwestern medicine_ Home Country? Coded: [0] No, [1] Yes

¹⁶ Q3. What is your first preference when it comes to seeking medical assistance? Coded: [0] Western, [1] Nonwestern

¹⁷ Q4. How often did you resort to nonwestern medicine? Coded: [0] Never, [1] Sometimes [2] Very Often

¹⁸ Q5. Do you have a condition that requires medical attention? Coded: [0] No, [1] Yes

¹⁹ Q5. Type of illness? Coded: [0] None, [1] Chronic, [2] Non Chronic, [3] Neither.

²⁰ Q6. Still consult and use spiritual healer. Remedies. Coded: [0] Never, [1] Yes

²¹ Q7. Do you combine Western and nonwestern medical practices? Coded: [0] No, [1] Yes

and expanded upon to understand the in-depth experiences people had around these issues. All coding, data entry, data cleaning and analysis was done by the author. The quantitative data is analyzed using Stata. The results of the data analysis are presented next in Chapter Four, Five, Six and Seven.

The presentation of results will be divided into four chapters. Chapter Four will present migrant's personal accounts and experiences covering subjects related to their healthcare needs, beliefs, practices and preferences narrated in a personable way. Chapter Five focuses on the analysis of focus group data which were mostly migrant's narratives on healthcare access issues that matter the most to them. Chapter Six and Seven will be dedicated to the presentation and analysis of survey data.

CHAPTER IV

PRESENTATION OF FINDINGS: LIFES HISTORIES

The central argument of this study is that migrant's health care seeking behaviors, attitudes and health care preferences were acquired and shaped before their migration to the US. The table below provides an overview of the structure of the presentation of the results and the logic that guides the choice for mixed methods to support the central argument of the study.

Number of participants	Depth of information	Richness of details	Potential for generalization
Life histories (<i>n</i> =4) Small	Very deep information	Most rich details	Least generalizable
Focus groups (<i>n</i> =44) Large	Moderately deep info.	Somewhat rich details	Somewhat generalizable
Survey(<i>n</i> =22) Medium	Least deep information	Least rich details	Most generalizable

Table 1: Presentation of results overview

I conducted mixed methods data collection using focus groups first, followed by life histories and finally survey. These three approaches yielded data that that will be analyzed in the following four sections below. Focus groups had the larger number of participants and were conducted in two different cities: Eugene and Portland, Oregon. The wealth of information gathered from this method was what I considered to be moderately deep when compared to life histories, with some rich details, but this method was somewhat limited in terms of its potential for generalization. On the other hand, life histories had the least potentially generalizable results, the smallest number of participants. The depth of the information gathered was the highest. The richest and detailed information of participants' very personal experiences were collected during life histories. The survey sample was medium in terms of participants, but it was the least rich of all, but with the highest potential for generalization.

In this section of the data analysis, I will give a brief overview of participant's demographical information, their health needs if any, and their experiences and healing practices of their place of origin followed by their experiences in US healthcare system. The last section of our life's histories chapter will examine their health care preferences. Not all life histories presented in this section obey to this format. There are cases where participant did not mention having any health needs. In such cases, the healthcare section is non-existent. The number of people who participated in this phase of the study is relatively small, but they provided very personal and very descriptive accounts of their experience, the richest data but the least generalizable information.

4.1. Life History One: The Bona Family

4.1.1. Migrants Profile

The Bona Family migrated to Portland, Oregon from a war-torn zone in Africa. After spending almost ten years in a refugee camp in Eastern Africa, the family relocated to Oregon with five children, but three of their children are still stranded in a southern African country awaiting the completion of their immigration family reunification process after being separated by the war. Both parents are in their early forties raising five children between the ages of three to fifteen. Given the nature of their displacement and the relocation pattern from the refugee's camp to Oregon, they are legally under the refugee status. The prolonged war in the Eastern part of the country that they considered to be their native land forced them into finding refuge in a nearby country refugee's camp after days navigating a dangerous terrain by foot with young children.

Ani, the wife, did not have any formal education, but her husband on the other hand had a vocational training, which helped him establish, after four years of training, a small repair shop in their hometown. As he explains, “Back home, I was the go to person for repairs ranging from cars, bicycles and even houses electrical installations. These skills helped me generate enough revenue to support my wife and my children. We also have farms, raised livestock and chicken.” Before relocating to the US, they lived in a refugee’s camps where Mr. Bona traded his handyman skills for food, blankets and others family daily necessities. The Bona’s family spoke two native languages and French before fleeing their country. They landed in a camp located in a country where Portuguese was the national language. Bona’s school age children started learning Portuguese in a makeshift center for children, while he and his wife learned the language during daily interactions with residents. According to him, it took them two to three years to fully converse in Portuguese. By the time they were relocating to Portland, Oregon ten years later, they were fully fluent in Portuguese.

Some of the disheartening aspects of this family migration journey are the loss of not only the land, but the shift in languages spoken in the household. Their school-age children who were speaking two native languages and French at the time of the displacement have lost these previously learned languages and have substituted them with the only language (Portuguese) they were exposed to during the time spent in the refugee’s camp. On the one hand, both parents have kept, to some extent the four languages previously learned and are now learning English. On the other hand, they have four school-age children who only communicate in Portuguese and are now immersed in a new cultural and linguistic environment. The observation made during the four visits with the family

revealed a well establish pattern in terms of default language. There was a permanent switch in the language spoken in the house depending on who was involved in the conversation and what subject was discussed. Exchanges between both parents were often made in Lingala, but when there was a third interlocutor who spoke Swahili was in the midst, they would immediately transition from Lingala to Swahili. When children were present or were participating in the conversation, the language spoken in the house was mostly Portuguese. When it comes to children, most of their conversations were in Portuguese because they were still learning English at the time of the study. Mr. Bona came to the realization that, migration has taken away the privilege his children had to communicate with their grandparents left back home in Lingala, a language they so well knew but came to lose.

4.1.2. Migrants Health Needs

The Bona family did not have any ongoing medical condition requiring medical attention at the time of the study. They attributed this relatively good health to the use of non-Western medicine that, according to them, reinforces the immune system. The youngest child of the family who was a toddler was diagnosed with bronchitis during a routine health screening visit. Even though the primary care physician prescribed treatment, the family did not agree with the diagnosis. Both parents believe that the toddler's condition is related to a lung's disease resulting from the lack of appropriate traditional preventive care. According to Ani, none her children had ever had this condition only because they were giving a traditional plant-based concoction once a week for three months after their sixth-month milestone. Mr. Bona is convinced that this condition is easily treatable with non-Western medicine. They expect that the leaves needed to treat the

condition will be sent to them from a fellow tribe member living in a different state or by a family member back home.

4.1.3. Healthcare Beliefs, and Practices in Home Country

The family consults and uses a spiritual healer medicine. In fact, they have a spiritual healer in the family. They often call him for advice and guidance when needed. They indicated that before their forced migration ten years ago, they exclusively used non-Western medicine. For instance, to cure female infertility, Mr. Bona's mother has been a very resourceful traditional practitioner in her community and had been providing medication to assist women in their quest for procreation. His mother is also a very well-known and respected traditional doula and birth attendant who has delivered many babies in their region. Mr. Bona himself, according to his wife, was born in the house instead of the clinic.

Ani, the wife, explains that throughout their life in their home country they had access to a broad range of non-Western medicine at no cost. They self-diagnosed and prepared treatments, mostly concoctions. With these practices, they were always able to find appropriate cures for every illness that affected their family. Most medicinal plants needed for treatment were found in their garden or the nearby woods.

For women who had issues with their fallopian tubes, the wife recalls non-Western treatments options available to them in her hometown. She describes her hometown has been: "A mini paradise. We had everything we wanted, gold diamond, silver, and traditional medicine." Mr. Bona goes on to say that, "Western medicine believers always stated that we (believers in traditional medicine) don't have an accurate dosage of traditional medicine, but nobody has ever died from overdoses and people have been using these treatments for centuries now. They are making us think that something is wrong with

the way we treat ourselves, but that is what we know, and that is what our bodies are used to,” he nostalgically said. He continues by saying, “What we had there was magnificent. We went from our country to the refugee camp with five kids under difficult terrain and conditions, but our children have never had any health issue.”

Mr. Bona further discussed how health care was practiced at home as follow:

With the colonization, state hospitals were implemented in many cities throughout our region. But we came from an area where accessing the hospital was a little challenging. When women cannot get to the hospital to give birth because of lack of transportation, other women always assist with homebirth. Many women are familiar with home birth methods as it is common practice in our community. After birth, it is a custom for mothers go through the ritual of hot water massages that last between two weeks and two months. These massages are administered by experienced women in the family or the community and are believed to have therapeutic benefits. Fast recovery, lactation flow, and post-baby weight loss were listed as health benefits.

4.1.4. Migrants Medical Preferences

This family’s health care beliefs and practices illustrates the thinking process leading to the binary medical choice many migrant’ families are confronted with when interacting with the healthcare system. They have to either engage with a very formal, somewhat familiar healthcare system available to them in Oregon with very limited language skills to communicate with healthcare providers or resort to informal, more familiar healing practices, which some still prefer but that are no longer available to them in Oregon as much as they were in their country of origin.

The Bona family’s preferred treatment option remains traditional medicine. According to Mr. Bona, his family has almost always resorted to non-Western medicine, whether they were in their home country, during their time in refugee camps, and in Oregon. Mr. Bona describes his favorite medicinal products in these terms, “I have some spices here that are known to treat almost every condition. They have tremendous healing

powers. It is very easy to combine them for treatment. Amoebas or parasites, hemorrhoids, and diabetes can be treated by these plants.” He goes on by stating that there is a treatment for people who have seizures, but the procedure requires a particular rope. He could not share more about the rope in the presence of children due to the belief that their ears should not be exposed to stories related to death and other funeral’s rituals.

I raised the question once again when I was in the driveway with no children in sight. He seized that opportunity to explain that, the rope used to commit suicide has spiritual powers not only because it is rare to find, but an increasing number of people suffering from seizures in that community were treated with powers extracted from the rope retrieved from the bodies through the medium of traditional healers.

Ani, the wife, explains that for women who have pain in the lower belly, her mother treated them by putting a specific medication in the woman’s private part for half an hour to relieve the pain. Mr. Bona said, “When we were at the refugee camp, my wife had a C-section as the result of not having access to traditional prenatal medicine. We were devastated. Vaginal birth is always highly recognized as the best birth outcome. C-section is believed not to be the best or the most sought delivery outcome.” Ani recalls a time where in her community, Aumona was frequently used before and after birth. She said:

When women sit in the water full of Aumona, it pulls out all the dirt from the women’s belly and helps accelerate the after birth purification process. Aumona also alleviates the vaginal birth pain and accelerates the overall delivery process, which is why C-sections are so uncommon. Expecting mothers usually used Aumona before and after birth.

Ani continues by describing her own birth experience in during her stay in the refugee's camp in these terms:

I did not have ‘Aumona’ when we were in the refugee’s camps, which is why my son, who is my seventh child, was born by C-section. I would have never had this

issue if I was in my home country because I would have had access to some traditional medication to prepare for the birth process.

She showed me an oversized leave of Aloe Vera while explaining that she can cure up to forty different illness with that “special leave”. When I asked her how she learned to identify these diseases in order to provide adequate treatments, she said, “I learned from my mother, but there is no specific training. You learn by being exposed to it. I was always surrounded by women who were using all types of medication. At some point, you get used to it.”

When I asked the couple what they will contemplate doing if they are sick, they both replied that they had not had any illnesses in a long time and did not remember having to take any child to the hospital because they use some home remedies. They came to the conclusion that they will use whatever resources they still possess. Their biggest issue is that, so far, they have not been able to find trees and plants or leaves they need for treatment in Oregon. Mr. Bona concludes the interview by saying, “If I can find these leaves here, I will be so relieved. I will no longer worry about having some of them shipped to me from back home.”

4.2. Life History Two: The Nyango’ Family

4.2.1. Migrants Profile

Nine years ago, Nyango and her two young children left their Central African country to be reunited with her husband in Oregon. The pursuit of better educational opportunities combined with the need to learn a new language were among the motives behind her family decision to migrate to the US. As a student, her husband presence in the US falls under the guidelines of the F1 visa status. Nyango and her two children, under the immigration guidelines are considered to be dependent of an F1 visa, which also exclude

them from receiving any social and medical benefits under the. US immigration rules and regulations.

Given the fact that their relocation to the US is qualify as been voluntary by nature, the Nyango's family have very limited resources in terms of accessing income based services for families for which most refugees qualify for. She claimed that, for few years, they had to rely on the husband's Teaching Assistant stipend to meet the needs of the family. The family was covered by the husband's student insurance, but with the high cost premiums, he had to drop both the children and her in other to keep the co-payment low and afford the cost of their basic needs. Community clinics and urgent care were their only healthcare providers' options. Both Nyango and her husband were in their early thirties when they made the decision to venture in greener land hoping to profoundly change the course of their life's and better future for their children.

Nyango had both a nursing and a college degree earned while in her home country. At the time of the relocation, she was working as a nurse, but these credentials and her experience as a nurse could not lead to a job without additional fee based training in the US and a working permit. In addition, they were coming from a French speaking country making it difficult for her to interact with anyone without her husband's assistance. Early on, she found herself, as she herself describes it, living under unthinkable circumstances, having to rely on food banks, family and philanthropic organizations to meet the needs of her family. According to her, the frustrating part was the fact that she was an able body falling under a status based work restriction which prevented her to seek for a job. Her family cohesion quickly deteriorated leading to a separation three years after arriving in Oregon. She declared:

A job would have made a profound difference in my life, my family security and my marriage. I became a victim of verbal and emotional abuse because I went from a co-bread winner in my country supporting my nuclear and extended family to a stay at home mom fully depending on my husband for things as little as pads and cologne, a life I have never before lived. This has created so much stress, anxiety to where, I now have a heart condition topped with high blood pressure and panic attacks.

4.2.2. Healthcare Beliefs, and Practices in Home Country

Nyango does not believe that her anyone in her family has a condition that requires medical attention at the time of the study. She acknowledged that she has been under immense pressure, which led to two trips to the Emergency Room. Her kids had their routine health screening done at a local county clinic at a reduce fee. She also took advantage of programs offering medical and dental services to uninsured individuals and school age minors in the area.

Nyango grew up in a middle class family with five siblings. She always self-diagnosed and recalls that as a child, her mother used to treat them with home remedies only. She said, “I do not recall going to the clinic as I was growing up. Many childhood illnesses were treated at home either by my mom, grandma, or other relatives in the family. My parents were educated, but they used what they knew best. Traditional medicine remains my first choice for my family.”

Nyango uses non-Western medicine very often. She has a non-chronic illness, but feels comfortable using non-Western medicine when she is not well. She said the following about her medication use:

In Oregon, physicians mystify medicine and do not directly proceed to prescribing a treatment. In my country, if a child has a stomach ache, the mom will take a stool sample with her because the doctor will prescribe a stool exam anyway. No need to make an appointment; the only time you make an appointment is when you need to see a Gynecologist.

She then went on to describe in more detail her health care experiences here in Oregon:

It is very hard to have insurance here, it is very expensive. When I am sick, I always ask my family to send me medication via express mail. Sometimes, when I have someone coming to the US, I often have the family refill my stock. I still consult my mom over the phone when I need guidance on how to treat an illness, particularly if I do not remember the exact combination.

Nyango also focused in on the health care system as a whole in the US and said:

This system here is discouraging, we feel hopeless, because you go to the hospital many times and you are sent home without treatment. To get labs or clinical exams done, you need to go to the clinic a few times and insist on getting them done before the practitioner will even send you to have labs done. On one occasion, I was told that my daughter has eczema because I bathe her too often.... It is against our customs to not bathe a child once a day. By not bathing your child every day, you take the risk of being portrayed as a careless, uncaring mother. Making appointments is discouraging at times. I had to schedule a Pap smear. The wait to get in was four months. In my home country, you did not need to wait for that long.

The wait time mentioned in Nyango's description of the healthcare system in the US can be in part associated with the lack of health insurance, which results in receiving care from county clinics. The harsh reality is that, the wait time for exams such as Pap smear or other non-emergency procedures in county clinic is longer due to the high number of uninsured population seeking medical attention.

4.2.3. Migrants Medical Preferences

Nyango describes her healthcare preferences for non-Western medicine by saying that:

I by far prefer traditional or non-Western treatment than Western medicine. I am trying hard to fully connect with it. In general, I have never liked pills. I have always had very bad side effects when it comes to Western medicines. It is pure chemical substances and poison that we put in our system. Western medicine believers make us believe that traditional treatments were not safe because there no dosage, but the reality is that traditional medicine is based on natural plants that God created. I think getting to a symbiosis of both options helps because White Man Medicine does not cure all illnesses and sometimes, just the list of side effects is very scary.

When asked to elaborate more on her preferred treatment option, she chose the natural and traditional treatment as her first choices. According to her, it is less expensive, more effective, has no side effects, and it reinforces the immune system. She also feels that

people not only live longer, but they get stronger and they are less likely to get sick often times.

4.3. Life History Three: Meeka

4.3.1. Migrants Profile

Meeka was born and raised in a rural Eastern Africa village where English was the national language. She attended high school, but her family had limited resources, which made it difficult for her family to support her while she was attending college in a neighboring city. She made a living by braiding hair and selling snacks to cover some of her college expenses. According to her, she was fortunate to meet a handsome small business owner who supported her educational endeavors by providing funding for her college tuition for two years. By the third year of college, she got a little job and finished her Bachelor degree at age 22. She became very involved in her church as her faith grew deeper and stronger.

Her most pressing prayer request was to get married to someone who could provide for her and support her family. She routinely visited spiritual leaders in her area who were known to be powerful enough and spiritually capable to change the course of her life. Meeka said that during one prayer session what she called a “prophecy” came through. She explains it has been a spiritual message sent to her by God revealing what her near future would be made of. The lady who received the message was a very well respected Pastor in her church. She was told that she will see the man who is meant to be her husband through the medium of dreams; he will be coming from far away, will marry her and they both will relocate to the US. The pastor prophesized that be relationship was a spiritual match. She was expected to keep praying and fasting until the prophecy is fulfilled. According to her, it was the message she has been hoping and praying for.

Less than three months after the prophecy, she finally met a man in her village who happen to be an Oregon resident. She remembers that when she saw him for the very first time at a gathering in her hometown, she immediately knew that this was the realization of the prophecy because he fit the profile. Meeka ended up celebrating her wedding within six months and moved to Oregon. Meeka remains in contact with the pastor whom she calls her spiritual guide. She remains connected to the pastor; every Monday, she contacts her for spiritual consultation and sometimes need to wait about a week to get spiritual responses for issues ranging from trouble in her marriage, dispute with close relatives, her husband's business related issues, and illnesses.

4.3.2. Migrants Health Needs

Meeka's family did not have any health concerns requiring medical care at the time of the study but she was expecting her fourth child. Pregnant women are often times subjected to a monthly routine health screening after they reach the twelve-week milestone. Meeka shared with me that she has always practiced self-diagnosis first and subsequently done self-medication with non-Western medication before attempting to call the clinic. She acknowledged that she has insurance, but she will try self-medication that primarily consist of herbs, concoctions, and specific oils for at least three days. Most of the times, these home remedies functioned perfectly; when they don't, she consults her spiritual guide(s) who resides in her home country for advice and recommendations over the phone. She has always methodically followed their instructions.

She mentioned that she avoids calling the clinics much as possible unless it is necessary because every time she had made a call in the past, her appointments are two weeks away regardless of her condition. Sending her to the emergency room has become a norm that is hard to comprehend. She noted major differences between the health care

systems in her home compared to Oregon where she now resides. Even though she has insurance, she felt that she is billed regardless of the outcome of her illness.

4.3.3. Healthcare Beliefs, and Practices in the US

Meeka shared with me that since her relocation to Oregon, she had been very frustrated (on many occasions) by clinics visits with health care providers. The most impactful one involved pre-natal consultations during her fourth pregnancy. Prenatal visits were the reasons behind her very first major interaction with the US health care system after relocating to the US. Meeka did not need a translator, but she remembers nurses and providers asking her to repeat her answers when questioned over and over again. Making appointments over the phone became one of her most resentful task because she was asked to repeat herself countless of times due to her “heavy accent”, even though she was fluent in English.

During the third trimester of her fourth pregnancy, Meeka was scheduled to see her primary care physician. According to her, what followed after the routine vital signs procedures (weight, height, temperature) was a long explanation concerning the baby’s weight and why it is important for her to get a C-section delivery before or by the 39th week of her pregnancy. She was told that her baby was 9.5 pounds at 36 weeks and by the time she will hit the 39th week, the baby would be over 11 pounds. For her primary care physician, at 11 pounds, the baby and the mother would potentially be at great risk if Meeka was to choose natural birth.

Meeka panicked; her first three children were delivered vaginally even though they each weighed a little over 10 pounds at birth. The thought of a C-Section was also concerning as it is taboo in her culture to go through such a procedure. According to her, attitudes and meanings attached to C-section delivery are negative and represents a failure

on the part of the mother of not strictly following prenatal traditional treatments aimed at preparing and facilitating the natural birth process. The shared beliefs were that traditional prenatal treatment is a preventive option for C- sections delivery. Meeka, believes that only lazy, and weak women chose to have C-section to avoid enduring the childbirth pain. She felt that C-Section was imposed on her by the physician for safety concerns. Meeka was totally convinced that she was capable and ready to have a vaginal delivery for many reasons: she had vaginally delivered 12 pounds' babies in her home country in the past and she has been relying on traditional medicine and prayers from her spiritual healer to have a natural birth. She quickly realized that vaginal delivery for 10 pound babies is not an option available to mothers, but C-section is the only recommended option in the US medical context.

Meeka, however, viewed C-section not as a pain free birth, but as blockage that would impact her abilities to use the after birth hot purification baths required to rejuvenate, enhance her milk flow for breastfeeding, and strengthen her pelvic muscles. These were few benefits of natural birth. Meeka, was also concerned about her family's reaction to the C- section saying, "This news will be devastating for my family. They will have to consult a traditional healer and do some sacrifices because C-Sections are the result of failing to follow traditional pre-natal regimen and not being spiritually in accordance with the ancestors."

Meeka was saddened and grew frightened to the thought that she may have been the victim of a curse. For her, the most excruciating aspect of this decision was that base on her self-diagnosis, she never felt that the baby was that heavy because her body was not reacting to what it usually does for a 10 plus pound baby. She was still effortlessly climbing

stairs and was not feeling an intense pressure on her pelvic compared to her previous three babies at the 37-week margin. By experience, her first three pregnancies were a whole lot heavier. Fearing the negative implication of the C-section in her life, she asked the physician if she could get an ultrasound done before her due date appointment, but her request was denied for the sole reason that it would probably not have any impact on the physician decision. She insisted and nevertheless scheduled an ultrasound for the following week. When she got home after that horrible prenatal visit, she started to drink traditional cleansing tea meant to be used by week 37 to help reduced the extra fat she might have gained. The next day, her water broke and her husband rushed her to the hospital for delivery.

After reading the notes left in her chart by her primary care physician, the on-call doctor informed her that he would have to follow the instructions for C-section because her physician thought it was the best and safest option. Meeka insisted that this decision was made against her will. After a long conversation with the attending doctor, her husband authorized the procedure. According to her, the birth process of her fourth child was one of the most devastating events that had happened to her in the US. She was saddened when right after the C-section, the baby weighed only 8.6 pounds. Meeka was devastated for many reasons. She felt that she was bullied into having a procedure done that did not respect her rights, wishes and beliefs: her rights to get an ultrasound and rights to have a vaginal delivery were denied to her.

Her life was shattered by the C-section delivery. She claims that the implication of the C-section delivery and the consequences resulting from it will impact her life, health and well-being. Following the delivery, she was not able to have a purification bath, which

to her led to a weight gain. Her uterus muscles loosened because she did not go through the contraction process, which allows muscles to contract back to normal after natural birth. Meeka remembers that she was not able to get back to her workout regimen before 6 months after the C-section because of the pain. She underwent Kiegel muscle physical therapy to regain some elasticity in her uterus. One fascinating aspect of this story was that Meeka chose to get pregnant again; by doing so, she hoped to give birth naturally. Natural birth was able to help her reestablish the physiological, psychological, and spiritual equilibrium broken by the physician impose C-section. She has been using traditional medicine with the support of a spiritual healer to give birth naturally.

4.3.4. Healthcare Beliefs, and Practices in Home Country

When it came to recounting her experiences with healers in her home country, Meeka explains that illnesses are often based on symptoms that are known to be related to a particular disorder. Parents and close family members bear the responsibility of making decision following a first diagnosis as of where to seek treatment. She emphasized that in her community, traditional healers were both men and women with various specialties. They were well known around the area and each had the reputation of successfully treating particular diseases. Healers' specialties ranged from the Western style mental illness, which is associated with the term 'Ogbanje', to seizure-like diseases, infant's illnesses, bones repairs and female infertility. Healers and patients shared the language, values, beliefs, and are members of the same community.

Meeka recalls a time where she got sick many years ago. She described the beginning of her illness at age 20 was associated with hearing voices. She started having conversations that were, more often characterized as being out of context. She remembers

having the feeling that something was off. She was first taken by her mother to the nearby healer in order to have a complete diagnosis. She said her mother suspected that what caused her illness was the manifestation of an evil eye. The healer was known to have the ability to do what she calls a consultation. The consultation process was done in about 15 minutes. It involved throwing some special beads on a specific sand, followed by analyzing the results and providing the family with explanations on not only the nature and origins of the disturbance, but the steps that need to be taken in order to address the issue.

The healer informed the family that Meeka's symptoms were the manifestations of an attack from an unhappy female spirit. The spirits' frustration originated from a request that was not fulfilled and the person ended up passing away without ever receiving what she had asked for. The healer suggested to get in touch with the spirit later that night in order to determine what type of compensation is needed from the family in order to appease the spirit, and liberate Meeka from hearing voices that were continuously harassing her. Meeka and her mother both went home and resumed their daily activities. Meeka surprisingly did not hear any voices after the healer's visit. The reality is that, based on the symptoms, Meeka's illness found its meaning within her socio-cultural context. Her illness was, according to her, spiritual in its very nature. In the Western context, these same symptoms may have been associated with mental illness symptoms.

She introduces the story of the second visit with the healer by saying that the day after the visit, her mother consulted with her paternal uncle who decided to go with them to get to the bottom of the problem. According to Meeka, uncle's presence was crucial because he could identify which family member was at the center of the dilemma. Her uncle had the reputation of easily establishing contact with spirits which he did and pleaded

for the release of Meeka. Financial contribution was collected from close family members to cover the cost of the treatment in order to guarantee Meeka's full deliverance.

Upon their arrival at the healer's compounds on the second visit, the healer immediately directed Meeka and her family to his treatment room. The healer reported getting in touch with the spirit who agreed to a settlement, which resulted in a list based on what she wanted in order to be appeased. The healer handed the list to Meeka's uncle who acted as the spokesperson for the family. Her uncle immediately said that it was a very exhaustive list. He expressed the desire to speak to the spirit in order to renegotiate that a number of items be removed from the list for the sole reason that they were beyond the family financial capabilities.

Meeka recalls growing very anxious. She was not at ease with the idea of negotiating with spirits. Her remarks were that it is commonly not a good approach, nor best practice because the spirit might get very irritated and aggravate her symptoms; the spirit has the upper hand and controls her life. Her mother noticed her demeanor and asked to consult with her uncle outside of the healer's compound. At that time, the healer had no other avenue, but to wait for them to return before proceeding. After 15 minutes, Meeka's mother and uncle both returned to the treatment room. The uncle informed the healer that they will return with the items needed by the spirit later that day. The spirit demanded a specific type of rare dry beans, a bottle of Fofu (traditional drink made out of corn), and a piece of handmade traditional fabric. The treatment for itself cost about 18 USD total. According to Meeka, the healer was usually not paid until the symptoms subside. Once the recovery is completed, the healer could be paid in goods and mostly non-monetary gifts. The family will often give the healer a large rooster, rice, palm oil, and a bottle of foreign

liquor to show their appreciation for the treatment. According to Meeka, sometimes, if the family can afford it, the payment can range between 15 to 20 USD, which is often times greatly appreciated by the healer.

Meeka also mentioned that she did not need any appointment to see the healer for the first visit or any follow ups because the healer had the spiritual capacity to always sense that someone will come for treatment. Meeka said they bought what was needed by the spirit. Immediately after receiving what was requested, the healer went to the cemetery while they waited and made the offering on the tomb of the identified spirit. She emphasized that sometimes, the spirit can reject the settlement and bargain for more goods or products. The healer and the patient always have between one to twenty-one days of observance to make sure the deal is accepted and the patient is healed. If the illness persists, it is undoubtedly because the spirit is not satisfied and more negotiations will be needed. These negotiations could involve family and community members, a spiritual leader, and one or two other powerful healers to settle the matter. People suffering from hearing voices or saying odd things were never taken to the hospital in her home town.

Healers and family members take part in the decision making process of which illnesses, based on their assessment and self-diagnosis can be dealt with by a healer or at the clinic. Meeka claimed that she has never heard any voices in head since that treatment. She fully recovered few days after the offerings.

4.3.5. Migrants Medical Preferences

I must mention that throughout our multiple conversations, I noticed that Meeka's mother of three with a fourth child on the ways used three healing methods to treat her family illnesses. Meeka goes off symptomatic manifestations of an illness, her ability to self-diagnose as a way of identifying an illness before deciding to choose one form of

treatment over another. Meeka showed me samples of leaves and bottles of remedies she gets from her home country mostly via mail.

In her home country, paying the healer for his services was contingent to feeling better and there were many payment options: farm goods, game farm meat, chickens, fabric, oil, liquors, and sometimes money. It was always depending on what the family could afford at the time of the treatment request. In the US, patients have the obligation to cover the consultation and treatment bill regardless of the treatment outcome.

4.4. Life History Four: Mama Mina

4.4.1. Migrants profile

Mama Mina, known for some as Mina, was born in a now war torn Central African country. She was married before her sophomore year in high school as it is a custom in her tribe. She recalls growing up in a very poor family but her dad, at some point in time, managed to secure a police guard job at a foreign army representative's house. Her family was forced to leave their village due the war in 1996. She lived with her family (husband and three children) in the woods for almost three years. She and her husband returned once in a while to see if things were settling down, but the situation remained too dangerous for them to return home. When she realized that she was pregnant, they made a final attempt to see if the situation was favorable for a safe return. They arrived in the village, but had to leave few days later because the rebels were still roaming in the area forcing them to walk their way to a nearby border in hopes of catching a boat ride to safety. She and her husband, along with their children, finally made it to the location where they could board the boat heading to a refugee camp. Some members of her family were untraceable, but they were finally reunited in the camp.

Mina, who was about seven months pregnant at the time, along with her family were walking at night when she fell in a ditch and broke her leg. With no access to proper medical care, the infection worsened. There was a hospital in the refugee camp, but by the time they made it there her infection had reached to the point where it was no longer possible for the medical staff to properly care for her. According to her, the hospital at that specific camps had inadequate and improper treatment for her case due to the scarcity of medical resources and supplies. After giving birth, she managed to reach out to family members living overseas for financial support in order to get to the General Hospital outside of the refugee's camp. As soon as she received the money she was able to sneak out of the refugee camp at night and made her way to the main hospital in the nearest town with the assistance of a fellow refugee. She recalls receiving medical attention upon her arrival. The medical staff quickly realized that her leg could not be salvaged. The physician explained to her that her entire femur will be removed and replaced by a steel and it will take approximately three months for her to recover well enough to use a cane and return to the refugee's camps.

Three and half month later, Mina returned to the refugee's camp. She described the camp as being a little makeshift village with a hospital, grocery stores and a school, but the biggest issue was food. Food access, inadequate food ratio per family and food quality were the biggest problems during their time in camp. The food allocation was insufficient for her family and for many other families around. Prior to fleeing the war, they were growing their own food, had access to fresh seafood and maintained a balanced diet without having to spend money. In the camp, her family was introduced to food that was far from

being part of their staples diet. She recalled spending days without knowing when the next meal will be provided, which is something they were not prepared for.

4.4.2. Mama Mina's Health Needs

Mina had limited mobility with the leg that was injured while fleeing her war torn village. Her handicap played a determinant factor in qualifying her and her family to relocate, but she was unaware of where they would be sent after ten years in the refugee camp. The relocation process in itself was time and energy consuming with too many interviews, paperwork, and multiples agencies involved. Mina is still uncomfortable every time she has to answer questions or to fill out paperwork because it reminds her the process they had to go through time and time again before securing the approval for relocation. She was excited at the prospect of leaving the refugee's camps and have a fresh start with her family. Her family was excited and overjoyed when they were announced that they will be going to the US. After ten years in the refugee camp, they finally arrived in Oregon. Upon their arrival, they fairly quickly realized that language would be one of the biggest challenge in Oregon. For a few years, she was taking her mail to IRCO in order to have them translate it for her.

According to her, she was told before leaving the camp that physician in the US will be able to perform surgery on her handicapped leg and restore some mobility allowing her to bend her knee while walking, climbing stairs or sitting in the car. Mina is now considered disabled because of her limited leg mobility.

4.4.3. Healthcare Beliefs, and Practices in Home Country

She remembers that her family had a great traditional pharmacopeia available to them when they were growing up, but when her dad joined the Police Department as a security guard for the government it changed their perceptions of traditional medicine. At

the time, there was a push by the government, due to the fact that they were still under the Belgium colonial authority, to ban the use of traditional medicine by local communities in her region. As a police guard family, they lived in a camp and had to go to the local clinic for their healthcare needs. She recalls that these were the events that represented a turning point in the rupture of their connection with traditional medicine in her family. In fact, there were many propaganda campaigns stipulating that traditional healing practices were from the pre-modern era, unscientific, and unreliable. The colonial government was forbidding the use of traditional medicine and imposing Western style medical institutions as part of its development strategy. Her family ended up only frequenting local clinics, hospitals, some of which were American Hospitals.

Mina feels stranded, misunderstood and at times lost in this healthcare system since she moved to Oregon. She continues to self-diagnose, but she lost the ability to treat minor illnesses and relies on advice from fellow community members when she is in search of home remedy to treatment. She believes in spiritual healers who by essence are part of her community and share many values and attitudes she identifies with. She misses her home country and hopes to be reunited and spent the rest of her life with her extended family.

4.4.4. Mina's Healthcare Access Experiences in Portland

Mina's chose to elaborate more on her healthcare preferences in Portland instead of her home country as she explained it is that, back in her home country, they were not allowed to use any traditional medicine for treatment under the Belgium protectorate. In many cases, it was considered illegal for families to resort to non-Western medicine especially in certain urban areas. As long as she can remember, fear for breaking the rules as member of security guard families prevented them from using traditional medicine,

which they knew how to use and had access to. From that time on, they only were able to seek treatment from Western style clinics.

As a refugee with young children and limited income, Mina acknowledged that she has always had insurance since she entered the US. Few months after her arrival, Mina was referred to a specialist to have her leg reassessed in hopes that a surgery could help regain the ability to bend her knee which represents more than a quality of life for her. Mina explains that getting in and out of the car or sitting in an airplane seems to be an ordinary task for some people, but for her they required logistical planning such as sitting in the front seat of the car or only getting an aisle seat in the plane. It has been practically impossible to visit her relatives in other parts of the states because she cannot travel with her leg straight up on the train or airplanes. On a few occasions, passengers were willing to let her sit on the aisle, but she was denied that favor many other times. After the specialty clinic visit, Mina was inconsolable when she was told by the physician that the insurance could not cover that surgery even though they knew that getting back the ability to bend her knee would tremendously improve her quality of life. She noted a disbelief on the face of her primary care physician when she reported what the specialist had told her. Her primary care physician took it on himself to check with the insurance company and confront the knee surgeon. The surgeon reviewed his decision and later performed the surgery, which resulted on Mina ability to bend her knee. She is now able to ride the bus, take the train and fly to visit family members.

For Mina and her family, limited English language has led to many misdiagnosis resulting in wrongfully prescribed medication. She recounts the latest episode. A few months ago, she was feeling a burning sensation on her right side for two days when she

decides to seek medical treatment. After explaining her symptoms to the physician with the support of a translator, a quick diagnosis was made and Mina was prescribed antidepressant and pain killers. She had the medication filled before heading home. Mina reported feeling very sick for a few hours after taking both medications. The next day the burning sensation on her upper torso was unbearable. This time she chose to seek medical care from the local county clinic and explained her symptoms to the provider. He diagnosed her with shingles and prescribed new medications. As she explains, experiences of this nature have contributed to her resentment with the healthcare system in general and her reluctance to seeking medical care when needed.

CHAPTER V

PRESENTATION OF FINDINGS: FOCUS GROUPS

Number of participants	Depth of information	Richness of details	Potential for generalization
Life histories (<i>n</i> =4) Small	Very deep information	Most rich details	Least generalizable
Focus groups (<i>n</i> =44) Large	Moderately deep info.	Somewhat rich details	Somewhat generalizable
Survey (<i>n</i> =22) Medium	Least deep information	Least rich details	Most generalizable

The number of people who participated in focus groups was considerably large ($N=44$) in comparison to life histories ($N=4$) and survey ($N=22$). The contribution of focus groups to the central argument of the research was not as rich in terms of depth when compared to life histories. I considered the data from focus groups to be moderately deep and not as generalizable as data from the survey but the data provided moderately deep information.

Focus groups conducted in Portland and Eugene were a way to get acquainted with community members who could be potential candidates for my research and at the same time provide a platform where participants could share their most pressing challenges related to accessing health care. The issues raised by respondents were mostly structural factors primarily related to health care access challenges and in some cases their healing practices and healthcare preferences. Attendees were both voluntary migrants and refugees. In this specific focus group session, there were migrants whose place of origin was traced to the same location. As we explained earlier, the nature of their flight and the decision to migrate, under the immigration and naturalization policies of in the US, determines how they are treated specially in terms of social services and benefits. There was a clear divide when it came to who had insurance or not. All refugees were covered under the state

sponsored insurance, while migrants were not. As we mentioned earlier, the way migrants are classified greatly impacts their ability to access healthcare services in Oregon. I will give a brief overview of participant's profile, their health needs if any, and the issues raised during the session.

5.1. Focus Group with the Swahili and Fulani Speakers' Community Portland, Oregon

5.1.1. Participants Profile

12 participants attended this focus group session: ten women and two men. There were no particular selection criteria put in place to recruit participants. Participation in the focus group was predominately based on participants' availability, location and interest. The observation made during this session led to the assumption that location, network connection and prior knowledge of the project played a significant role in decision to participate in the focus. First, 85 percent of participants claimed to live less than a mile away from the community center where the focus group was held. Next, almost 80 percent of them were refugees who all belonged to the same church, social network or have lived in the same refugee's camps prior to relocating to Oregon. Circulating the information in this network was done by word of mouth. This remains one of the most effective and culturally relevant way to disseminate an information in this community.

The age range in the group was between 26 and 55 years. All participants were parents and had an average of two underage children per household. Multiple languages were spoken. Among them were the Swahili, Lingala, Fulani, and French. Two interpreters provided translation services from French to Lingala and Fulani.

5.1.2. Participants Health Needs

Few participants in this session declared having chronic conditions such as diabetes and high blood pressure. One participant needed a knee surgery, another one had a heart condition. One participant was raising a severely brain injured child.

5.1.3. Issues Raised by Participants

5.1.3.1. Translations Issues

The first issue that participants discussed in regards to healthcare navigation and interacting with healthcare providers was that interpreters were not always providing an accurate account of their symptoms, issues, or health care needs. According to Swahili participants, there were many versions of sometimes the same language. The Swahili language differs in Kenya, Tanzania, Somalia, Rwanda and Congo. Depending on the Swahili spoken in their place of origin, it may be difficult for interpreters from areas such as Somalia, Kenya and Rwanda to give accurate interpretation and translations during medical encounters between patients and providers if the patient by ethnicity is more familiar with the Swahili from Congo or Tanzania. This mismatch in translation leads to major misunderstandings, frustrations, and breakdown in trust for both providers and patients. Participants said that translation issues can be blamed for the multiple trips they have to make to the clinic for the same issues, often without success. Patients' dissatisfaction with interpretation services was the root cause for patient's unwillingness to go to the clinic seeking urgent medical care only when the condition worsened. Many of them reported dealing with the same health crisis for many months now. Going to emergency room for medical care was often sought when the pain is unbearable and the condition deteriorate.

5.1.3.2. Health Literacy and Healthcare Navigation Issues.

Language and level of education are also major issues in understanding procedures and prescriptions. Most participants are not fluent in English. They have little experience with preventive care in the US; healthcare navigation system in general and unfamiliarity with the US healthcare system are cited as very concerning. More than half of the group in attendance reported living in rural areas in their home countries. They had no formal education before the relocation process took place. Accessing information and going through the required paperwork to have healthcare coverage and establish care with a provider is very challenging for the majority of them. Almost the entire group acknowledged that by the time they understand how the process unfolds, their health insurance coverage is due for renewal. Missing the deadline due to difficulties related to accessing the information in English and filling out the paperwork on time was said to be a common problem. Participants who were older adults with chronic health conditions, were more likely to utilize preventive care because they had established relationships with their healthcare provider after many failed attempts.

5.1.3.3. Access to Healthcare Coverage and Lack of Health Insurance Literacy

Access to healthcare was another issue among participants. Migrants without healthcare insurance were using the emergency room rather than seeking out medical care or primary care from local clinic for uninsured adults. One participant stated that she had used the emergency room five times in the past few months. Access to healthcare can also be an issue in terms of transportation. Some participants qualify for medical transportation

to and from medical appointments, but cited issues such tardiness from drivers or not been aware of such service.

5.1.3.4. Experience with Discrimination and Lack of Cultural Competency

Participants talked about a power dynamic between providers and patients stating that they often feel belittled, powerless and their health concerns not addressed in most cases. They often leave the clinic without prescriptions. This effects their health because if the explanations of the symptoms are not well described by translators or they are not given the time to explain how they feel, it can easily result in a misdiagnosis or unneeded exams and mistreatment.

5.1.3.5. Discomfort with Interpreters and Providers

Even if translating what is being said and limiting their involvement in the interaction between patient and providers is the main duty of translators, community members see them as advocates and advisors. Focus group participants talked about their lack of confidence in expressing their needs and issues with doctors when it comes to not being comfortable taking certain medications, and decisions made during the appointment. For the Swahili speaking Community Health Worker, cultural norms are among the reason why migrants are uncomfortable openly disagreeing with a healthcare provider in general.

5.2. Focus Group with the Amharic Speakers' Community in Portland, Oregon

5.2.1. Participants Profile

This focus group was the Amharic version of the first focus group. The decision to have two separate sessions came from the fact that firstly, it would have been logistically complex to have three translators and divide participants in two groups during the session.

Secondly, the group's dynamic and cohesion during the session would have not been at its best because members of both groups usually do not interact because of language, culture and religious differences. Because food was provided, it was easy to plan the menu as Amharic, and non-Amharic do not share the same diet whereas Fulani and Swahili speakers have similarities in terms of diet. From what I had observe as routine mode of operations during gathering at IRCO, both groups activities are often schedule at different times. Eight participants attended this focus group session: seven women and one man. No particular selection criteria were deployed to select participants it was based on participants' availability and interest.

Just like in the first focus group, the observation made during this session led to the conclusion that location, network connection and prior knowledge of the project played a significant role in decision to participate in the focus. All of those who participated received the information from their community leader and they lived less than a mile away from the community center where the focus group was held. Next, almost 90 percent of them were refugees. The age range in the group was between 40 and 65 years.

This high percentage holding refugee status can be explained in part by the fact that Ethiopian and Somalian were among the very first African refugees who were relocated to the Portland area in the late 1970's and early 1980's. This first flow of refugees was followed by a large group of Eastern Congo refugees in the late 1990's based on anecdotal stories recounted by refugees. When compared to the first focus group, the age range between both groups sharply differs. Most participants spoke Amharic, but four were fluent in English.

5.2.2. Participants Health Needs

Participants in this particular session did not rapidly disclose their health needs when asked. During conversations related to healthcare access, it quickly emerged, through the examples they were given that a number of them had serious chronic illnesses ranging from diabetes to high blood pressure requiring some sort of frequent monitoring or management strategies by medical professionals. One interpreter attended the session.

5.2.3. Issues raised by Respondents

5.2.3.1. Health Literacy and Comfort with Providers

Health literacy as well as healthcare system navigation varied greatly in the group. Participants who spoke English fluently also seemed to have a fair amount of education, as well as an understanding of how to navigate the healthcare system in Oregon. The other four had little to no knowledge of health literacy and health navigation systems. Language seemed to be linked to participants' healthcare access and literacy in general. Participants with less English proficiency and limited education had challenges in understanding and navigating the healthcare system in Oregon. They reported a lot of confusion and little to no understanding of the healthcare systems. This was compounded by with a language barrier which resulted in the inability to effectively communicate with providers about their health issues. A participant mentioned that he had avoided seeking care for his wife who had a chronic health condition because he wasn't sure where to go. Participants with no English language barrier reported being confident with their health literacy skills, advocated for themselves, asked for a second opinion and felt at ease communicating with providers.

5.2.3.2. Navigating the US Healthcare System and the Need for Support Programs in the Community

All participants expressed the need for a navigation support service and CHW assistance in their specific community. Most of them rely on friends and family members who in most cases, might not be available when needed or be qualified to provide guidance and advice regarding healthcare and healthcare navigation questions in order to make informed decisions. One participant, who relies on her daughter for all of her healthcare related issues, is an example of the heavy burden placed on family members.

This participant did not even know if she had health insurance. She realized how totally dependent she was on her daughter when it comes to scheduling medical appointments, clinic visits, and refilling medications. This same participant stated that if she does not agree with her diagnosis or what they tell her, she will not take her medication. In the case of this participant, the belief that she might be clinically misdiagnosed by Western practitioners is always at the forefront of her concerns. The fact that patients and providers emanates and operates in two different beliefs systems still has an effect on how patients perceive their diagnosis and whether they abide by the providers' treatment plan or not. This is consistent with what I have stressed throughout this study.

5.2.3.3. Limited Treatment Options

This issue was raised by the interpreter who recalls a time where she had to advocate for a client to see if they could reduce the number of medications she was taking as she needed more support with lifestyle and to explore other treatment options. According to her, when the patient got a second opinion, the doctor could not believe how many medications the patient was on. The health seeking behavior of migrants in the

context of this study is based on a medical inclusion approach to treatment. This means that with or without the consent of medical providers, patients access and utilize to a broad range of medicine and medical practices. As discussed in the literature review, the healthcare system in Sub-Saharan Africa needs not to be compared to other medical systems, rather to be understood within its own socio-cultural context. According to Slickered (1990), we need to understand social, language and cultural factors affecting illness and health in order to better contribute to addressing health problems and health seeking problems in this specific population.

Multiple appointments and trust in healthcare providers were issues raised by two participants in the focus group. From the Amharic report compiled by IRCO, it is clear that structural barriers are still plaguing the level of utilization of healthcare services by this community.

5.3. Healthcare Access Assessment and Maternal and Child Health in Eugene, Oregon

5.3.1. Participants Profile

Twelve participants attended this focus group session. This group was a women's only group due to the fact that the subject was strictly related to maternal health. This was primarily based on the idea that, culturally, African women are often guardian of the pharmacopeia heritage, but they are also the ones making decision regarding treatment choices and selection in the family. This focus group was aimed at collecting women's perspectives on questions related to healthcare access in Eugene. Like in the two previous focus groups, there was no particular selection criteria put in place to retain participants. Participation in the focus group was predominately based on participants' availability, location and interest. The observations made during this session led to the assumption that

location, network connection and prior knowledge of the project did not affect the decision to participate in the focus group.

The distribution of the group could be described as more reflective of any college town in terms of demographics. The common denominators among participants were being African and a mother. Participants in this group claimed either the refugee or the voluntary migrant status. Over half were here for educational purposes, while the rest of the group came to Oregon for family reunification, were attending school, pursuing a vocational training or were planning on doing so in the near future. Circulating the information regarding the focus group was done via emails and phone calls. The age range in the group was between 26 and 45 years old. All participants were parents and had an average of one under age child per household. Multiple languages were spoken, but because this group was fairly well educated and had a good grasp of either French and or English, the language used during this session fluctuated between both languages depending on the level of comfort of each participant.

5.3.2. Participants Health Needs

The majority of participants did not mention having any medical needs at the time, but three of them were expecting babies at the time of the study. Most of participants had either coverage through their school for those who were in school, while those who were pregnant had coverage through the Citizen Alien Waived Emergent Medical Prenatal (also known as CAMWEN) for prenatal Medicaid services. The rest of the group was not insured.

5.3.3. Issues Raised by Participants.

5.3.3.1. Health Navigation Issues

Many participants claimed that they were not familiar with the US healthcare system and did not know how to go about getting health insurance, where to go if they need medical assistance or to how start the process of getting medical care. They found the system to be very complex even when language was not an issue. Most of the time, they faced challenges getting through the paperwork, locating a clinic and communicating with providers. The group agreed that it was and remained a very challenging process for all of them. Getting insurance was a very long and difficult process and sometimes case workers were not very helpful. Participant reported that most of the time, they get information from other community members, but usually after making many mistakes in the process.

5.3.3.2. Multiple Trips to the Clinic for the Same Health Issue

Participants at this focus group reported having to resort to non-Western medicine for their family's minor health issues because they became irritated for making multiple unsuccessful trips to the clinic for illnesses they felt capable to cure. Home remedies and non-Western medicine were reported to be commonly used among the group, especially when Western medicine failed short of treating what one participant called a "tropical or spiritual illness."

5.3.3.3. Health Concerns Not Addressed

The majority of participants said that their health concerns were often times not resolved. One participant felt that she was given a treatment that she was not familiar with. Many reported being frustrated by multiple trips to the clinic resulting in no prescription and leaving them with a bill far higher than what they could afford.

5.3.3.4. Healthcare Practices and Preferences

Participants all engaged in self-diagnosis and traditional medical practices during and after the pregnancy. They unanimously agreed that using non-Western treatments was their preferred treatment option. These healthcare practices were never disclosed to providers or shared with outsiders. They relied on non-Western medicine to treat their family illnesses especially when they are familiar with the symptoms.

5.3.3.5. Cultural Misunderstanding by Healthcare Providers

A participant summed up her thoughts about cultural misunderstandings by making the following statement:

Sometimes providers do not take the time to listen to our concerns. There are some illnesses that they are not familiar with. Instead of referring you to someone who understands tropical diseases, they just ignore your concerns. In Africa for instance, women get tested for toxoplasmosis during the pregnancy to protect the baby, but here they do not provide that. Some of us just use medicine sent to us from our countries with other traditional treatments that are good to protect our children.

One participant added, “When you explain your healing practices, they tend to look at you as if you were crazy one.”

5.3.3.6. Need for Healthcare Navigation Support

The leader of the Eugene African Women’s Group concluded that having someone guide you through the process will be very beneficial for newcomers. She said, “It takes us a while to understand what to do and where to go when we need help. Friends are always the ones giving us advice. We feel misunderstood in the system. Having a health center or a clinic that serves African will make the process much easier because sometimes we think that we are misinformed and have to make so many trips because it is a very unfamiliar system.”

Conclusion

While these focus groups seemed to provide less generalizable information, they revealed a pattern in term of issues raised across all focus groups. Health navigation issues, which can include applying for healthcare benefits, setting up appointments and interaction with healthcare providers was the main concerns across all focus groups. Healthcare practices and preferences as well as cultural misunderstanding between patients and providers were also considered important for participants. From this section of the analysis there is a dire need to integrate a healthcare navigation services in the current healthcare landscape in order to assist newly arrived migrants in navigating the healthcare system and utilizing healthcare services available to them.

CHAPTER VI

PRESENTATION OF FINDINGS: BACKGROUND INFORMATION

Number of participants	Depth of information	Richness of details	Potential for generalization
Life histories (<i>n</i> =4) Small	Very deep information	Most rich details	Least generalizable
Focus groups (<i>n</i> =44) Large	Moderately deep info.	Somewhat rich details	Somewhat generalizable
Survey (<i>n</i> =22) Medium	Least deep information	Least rich details	Most generalizable

The survey was the last data collection method used to test the central argument of this research. The survey data results, when compared to the two other methods has a greater generalizability level even if they provided less details. The sample is medium compared to focus groups; the depth of information is not as deep as in life histories and not as rich, but the potential to generalize this data is the highest.

In this section of the presentation of the findings, I will start by providing an overview of the demographic profile of migrants who participated in this research and the issues they face when seeking medical care in the US. I will follow up by taking a look at the health care access in their home country in comparison with health care access system in the US. Finally, I will delve into an in-depth description of migrant's health care beliefs, practices, and preferences in Oregon. The data presented here is based on the answers to 22 coded in-depth interviews.

6.1. Migrants Profile

As shown below in figures 2 and 3, 55 percent of the participants (*n*=22) in the in-depth interviews were from the Portland Metro area: the rest (45 percent) were from Eugene. The sample is also mostly female (73 percent).

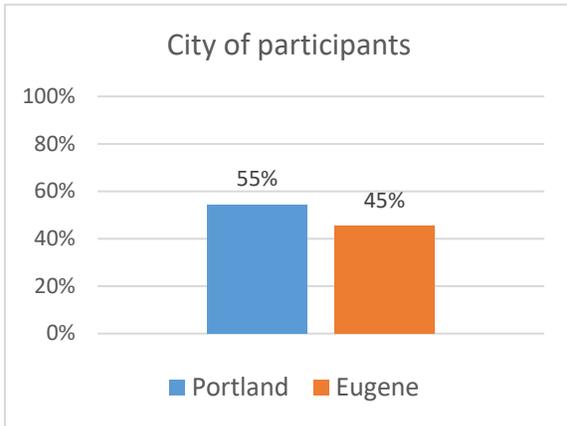


Figure 2. Location of Participants ($n=22$)

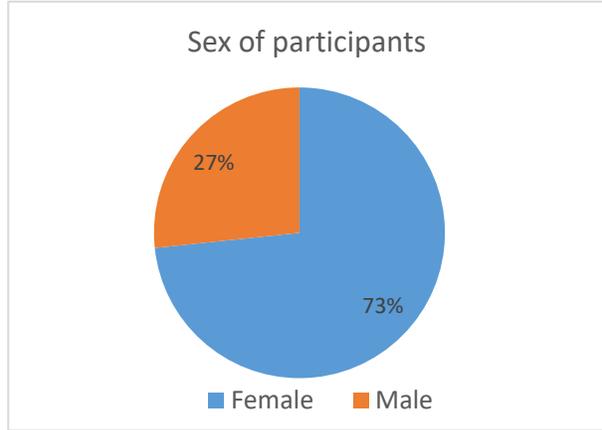


Figure 3. Sex distribution of participants ($n=22$)

For the purpose of this study, respondent ages were grouped by range. In this case, the majority of participants were between 40 to 49 years old. The youngest participant was in her mid -twenties while the oldest was over 65 years old.

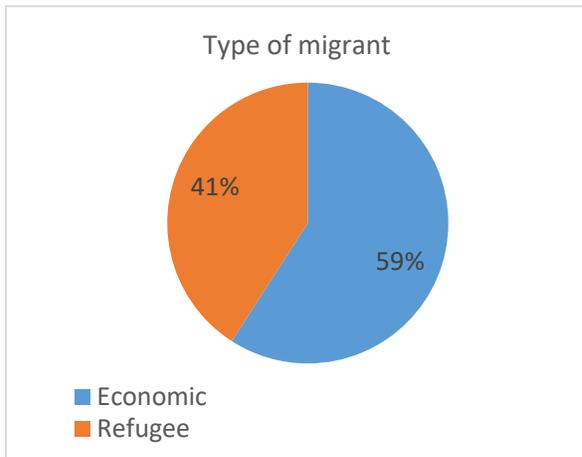


Figure 4. Migrants classification ($n=22$)

As seen in figure 4 above, the data shows that 41 percent of the sample was refugee and 59 percent were migrants and not associated with the refugee status with reasons such as education, family reunification and diversity visa as being motivating factors behind their relocation in Oregon. Economic migrants in figure 4 is referred to voluntary and non-refugee migrants.

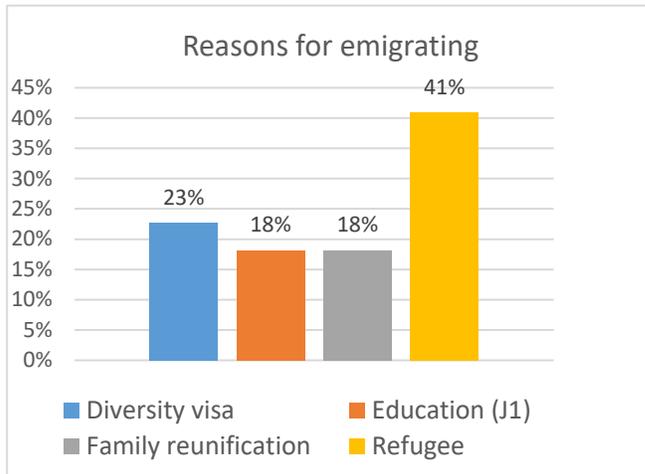


Figure 5. Reasons for emigrating ($n=22$)

Figure 5 above demonstrates the diversity of reasons why participants have chosen to migrate. The diversity visa sub group within the economic migrant's groups claims the biggest share with 23 percent of the sample. In the case of this study, entry to the US is contingent on holding either a visa, an entry permits or any other legal entry authorization. Many migrants have found it beneficial to enter the diversity visa lottery in order to have a chance of securing a legal entry to the US. I will not use participant real names or any other information susceptible to reveal their identification for privacy purposes instead, I will refer to them throughout this section by pseudonyms. Esta, a diversity visa migrant respondent explains why her family decided to leave in these terms:

We decided to leave our country because we thought that life will be easy, affordable, nice and really not difficult compared to my home country, but it is not. You have to speak the language to get a job. It takes so much time to understand the system and it is hard for people to help you out; you have to fend for yourself. You cannot leave your kids home unattended, your neighbor cannot check on your kids if you are not home. But back home kids can stay unattended, you neighbor can help with baby-sitting.²²

Eighteen percent of participants entered the US for the pursuit of their education. Family reunification was the last sub sample category represented in this migrants group.

²² Interview: Diversity visa participant. September 5, 2015 in Portland, Oregon.

As shown in figure 5, 41 percent of participants fled their home countries as refugees for a variety of reasons. In this context, civil strife was the most commonly cited reason for flight. Many refugees in the sample had transitioned through refugee camps before reaching the safety of the US with the support of various refugee resettlement programs. Meenah, describe their journey to camps when the conflict started this way:

I left our home, farm, cattle and fled by foot with my wife and four young children. We reached Gondjee (after walking for many days), which is at the border of my country and Democratic Republic of Congo. We made our way to Bangkok. From there, we were transported to the refugee camp in Dossey, Chad. We spent a year in Bangkok and 4 years in Dossey. We left the refugee camp and arrived in the US about 3 years ago with 6 minor children; 4 born in my home country and two born in the refugee camp.²³

The Laban's family's story of their journey fleeing their country when war began was recounted in these terms, "A long boat ride towards the unknown with my family leaving everything I cared for behind and spending the next 10 years of our life in a refugee camp before making it here."²⁴

The vast majority of participants emigrated with at least a secondary education. There were three participants with no formal education. According to them, they made a living as herders, living off the land and migrating internally as part of their nomadic tribal affiliation and customs. In sum, migrant decision to leave their home countries and migrate to the US was both voluntary and involuntary.

The data collected indicates that as many as 45 percent of participants have a college degree. 45 percent of the sample with a post-secondary education earned their degree either in their home country or in the US and in some cases in both educational systems. The educational level of the sample is reflected in table 2 below. The educational

²³ Interview: Refugee family. December 24, 2015. Portland, Oregon.

²⁴ Interview: Refugee family. January 2, 2016. Portland, Oregon.

level trend observed in this sub-sample was similar to what was indicated by participants in focus groups and life histories.

Education Level	<i>n</i> = 22	Percent
No formal education	3	14%
Post-Secondary	10	45%
Primary	6	27%
Secondary	3	14%
<i>Grand Total</i>	22	100%

Table 2: Level of Education (*n*=22)

One other demographic characteristic of the sample is the marital status of participants. As presented in table 3, the overwhelming majority of the sample is married. These relationships were established prior to relocating to Oregon. In the particular case of migrant’s marital status, a comparison with Figure 5 (reasons for emigrating), reveals that 82 percent of the sample represents not only the total percentage of individuals who are married but they also primarily belong to the refugee, diversity visa and family reunification sub categories.

Marital Status	(<i>n</i>=22)	Percent
Married	18	82%
Divorced/ Widowed	2	9%
Single/In a relationship	2	9%
<i>Grand Total</i>	22	100%

Table 3: Marital Status (*n*=22)

When it comes to age, the constitution of the sample is reflected in figure 6 below. Allowing participants to choose an age range instead of asking them to disclose their age seemed to be a less intrusive option. Over 75 percent of the sample is 40 years old or more.

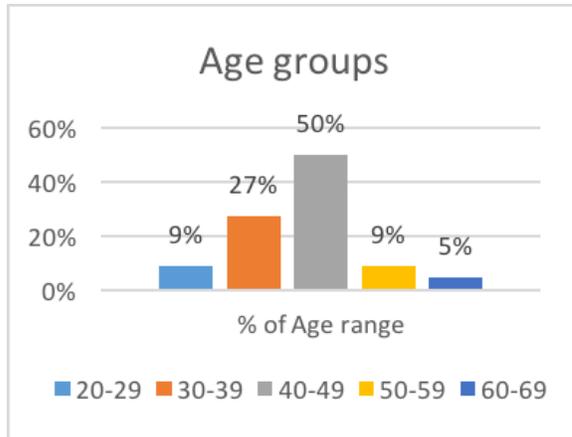


Figure 6. Age distribution of participants ($n=22$)

Migration, both voluntary and involuntary, in this context did not happen early in life, but rather the decision to migrate was for each case circumstantial. As presented in figure 5 and supported by participant's accounts, 23 percent migrated with young children in the quest for better paid jobs and additional training for themselves and educational opportunities for their families. Eighteen percent of voluntary migrants who relocated for family reunification claimed that the prospect of starting afresh in a new country was very scary.

Two female participant shared with me that their families had received the dowry from their husband's families, which is the custom for traditional marriages in some parts of Africa. They were from that point on required to leave their jobs and be reunited with their husband once he completed the immigration requirement enabling to get an entry permit allowing them to enter the US. Participants holding a F1 visa were recipients of merit-based scholarship to enter the US for educational purposes while refugees and their families were forced to relocate. Mina, a refugee participant noted that:

Leaving my village had never been an option for my family. When war broke, we left our home, found refuge in the woods and settled there because it was safe at the time. My husband used to sneak back in the village once a week to see if it was safe for us

to return. This lasted for about six months. On one occasion he was confronted and threatened by the rebels for his refusal to join the militia. When he returned two days later, he decided that it was time to leave the area. I had three young children at the time and was expecting the fourth child. We walked day and night for days before reaching the lake for a boat ride to Tanzania.²⁵

Most refugees who participated in this study claimed that their youngest children, age ten and below were born in a refugee camps. Birth rates remain high in the African migrant’s community. The high birthrate in this particular community can be attributed to their traditional and religious beliefs, higher mortality rate, and the need for labor in areas where subsistence agriculture is still practiced. In my sample, the average number of children per respondent is close to 2.4, which is still high for the US, an environment where the cost of living is higher compared to migrants’ home countries as shown in table 4 below.

# of Children	<i>(n=22)</i>	Total # of Children
1	7	7
2	7	14
3	4	12
4	4	16
<i>Grand Total</i>	22	49

Table 4: Number of children per participant (*n=22*)

The sample’s demographic information showcases a group that has many common denominators among which are languages, but attitudes and beliefs systems differs from one ethnicity to another. Attitudes and beliefs will be part of descriptive analysis that will follow.

When it comes to language, migrants originating from Africa speak their native languages and other dialects besides the ones they inherited from colonization. English,

²⁵life history participant. Portland, Oregon. January 8. 2016

French, and Portuguese are learned through the channel of formal education. As we saw in table 2, 14 percent of participants have no formal education; they can only communicate in their native language. In our sample, 60 percent of the participants spoke French, 18 percent English, 14 percent Swahili and 10 percent Fulani.²⁶As seen in the Table 5 below, the vast majority (60 percent) had limited to no knowledge of the English before their entering the US and relocation to Oregon.

Primary Language	(n=22)	Percent
French	13	59%
English	4	18%
Fulani	2	9%
Swahili	3	14 %
<i>Total</i>	22	86%

Table 5: Primary language spoken (n=22)

In addition, all participants were fluent in at least one or more native language specific to their particular place of origin. Migrants’ demographic information as presented above is the entry point to a more detailed analysis in which I will first tease out their health issues, beliefs and health care practices and preferences in Oregon. Understanding who participants are provides an important context for understanding the medical conditions they may have immigrated with, as well as barriers they may have.

²⁶ 14 African countries were represented mainly Burkina-Faso, Cameroon, Central African Republic, Congo, Ethiopia, Gabon, Kenya, Liberia, Mali, Nigeria, Chad, Togo, Senegal, Somalia. The migration mostly happened from central, Eastern and Western parts of Sub-Sahara Africa to the US based on this sample.

6.2. Migrants Health Care Needs

Migrants relocating to Oregon have health care needs that require medical attention in some cases. For the purpose of this study, illnesses were classified as either chronic or non-chronic depending on the nature of the illness and the extent of medical care required. 86 percent of the sample had a condition for which they will need medical care at some point in time. 55 percent of participants had a chronic illness while 9 percent had a non-chronic illness. Pregnancy represents 27 percent of the sub-sample and is labeled as a “neither” category as shown in the figure 7 below.

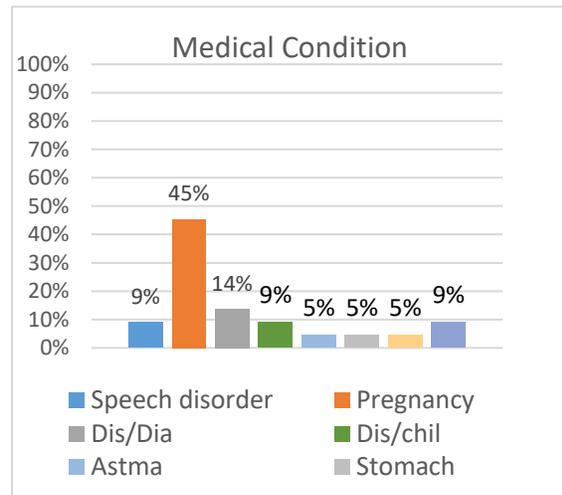
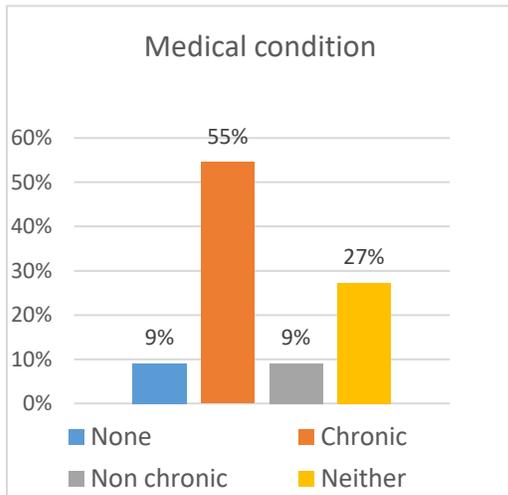


Figure 7. Types of Medical condtions ($n=22$)

Figure 8. Types of medical conditions ($n=22$)

The medical conditions cited in this research ranged from diabetes, blood pressure, physical disability, mental impairment, speech disorder, and minor illnesses such as stomach pain and asthma as seen above in figure 8. It is expected that migrants will seek medical care when they reach the safety of the US, but they reported that there were many factors preventing them from accessing medical services. These factors were in some cases a combination of both structural and non-structural factors, but they were grossly related to the health care system features, health care beliefs, and health care preferences. Nine

percent of participants reported not having a condition that requires medical attention at the time of the survey.

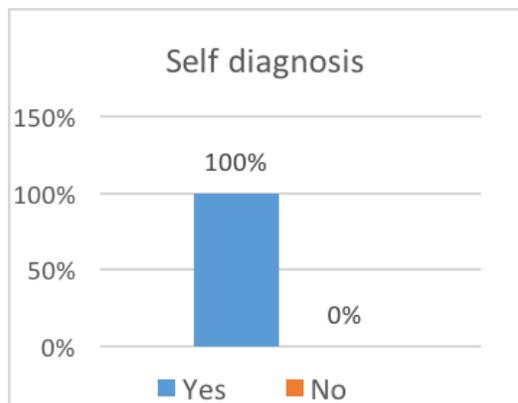
6.3. Health Care System Features and Health Care Access in Migrant’s Home

Country

Migrant’s health care system differs from the US health care in many ways. As Rassah explained:

If my child is not feeling well, I just go to the market place and explain the symptoms to the traditional healer. She will give me what I need to treat that disease, but she will ask questions just to have more details about the symptoms. The age of the child is also important. She will assemble the accurate quantity I need base on the age of the child, give me the instructions on how to prepare the medication. When followed properly the illness will subside and after 3 days, the sickness is gone.²⁷

Self-diagnosis and self-medication are widespread practices among this population both in their home countries and in the US. One-hundred percent of the sample was involved in self-diagnostic practices, as seen below in figure 9. This trend was also observed in focus group and life histories analysis. Migrants predominately tend to self-diagnose regardless of the environment in which they find themselves living in. The system from which they were socialized in allows space for patients to interact at their own discretion with traditional healers, spiritual healers, and western medical providers.



²⁷Interview: migrant family. February 12, 2016. Eugene, Oregon

Figure 9. Participants who self-diagnose ($n=22$)

On the same note, migrants described the health care access process in their home countries as being very easy compared to processes in the US. Table 6 below presents a summary of the characteristics of migrants' home countries health care system. According to participants, they were not required to pay health insurance premium or to have health insurance in order to seek medical care at local clinics. According to the data, access to clinics was easy for participants in the majority of cases in the sample. This was not the case for Laban, a life history participant who claimed that his family lived in a very remote area in Central Africa. He said, "Accessing the hospital was a little difficult. Often women who were expecting could not get to the hospital to give birth because of lack of transportation. Home birth was the go to option for women living in that particular area."²⁸

Health care access in home country	Very easy	100%
Getting to the clinic	Easy	100%
Did you have health insurance	No	100%
Making appointment in home country	No	100%
Provider listens to patient's concerns	Yes	100%
Provider prescribes medication	Yes	100%
Medical refills in home country	Very easy	100%
Language issues in home country	No	100%
Cost	Low	95%
	High	5%
Payment	No bill	100%
Did you needed a translator	No	100%

Table 6. Home country health care access features ($n=22$)

²⁸Life history interview with a refugee family. Portland, Oregon. January 2.2016.

Participants also reported that they did not need to schedule an appointment for a consultation with health care practitioners, nor did they needed a translator during hospital's visits. Providers, if not nurses were in most cases, fluent in the language commonly used in medical facilities and health centers in their localities. Migrants felt that their relationship with their healthcare providers was less formal, less structured, and more personable. Language was shared by both patients and the providers. Patient had the opportunity to explain their feelings, explain their health concerns in great details and touch on more personal subjects when necessary. Many respondents noted that time was not problematic during clinic's visits.

Esta said that, "My doctor will listen first and then examine me. If necessary, he will prescribe. The next step is to pay the provider. We did not have a bill sent to us." When asked if she needed to call the provider to make an appointment ahead of time she frantically responded, "No! No! No! You just need to go to the clinic."

She continues by saying, "Going early will always get you in sooner, but if you go in the middle of the day, the wait time will be longer and you still get treated. In my specific case, I could spend on average an hour to an hour and half for both the physician consultation and the labs. The physician was not rushing, we used to cover almost every subject related to me and my family's life. Sometimes the physician will have required a stay in the medical facility for observation....nobody was really rushing."²⁹

The fact that clinical encounters between patients and providers in Western style and Government founded hospitals in some migrant's home countries allowed space to explore subject not strictly limited to their conditions, contribute in to shaping their

²⁹Interview with a migrant. Portland, Oregon. September, 5. 2015

expectations in terms of time spent with providers and content of the medical examination process in their receiving countries. When expectations from both providers and patients are not met, a climate of frustration takes place and language and cultural barriers exacerbate these already fragile relationships.

One-hundred percent of the sample was sent home with a prescription in their home countries. This suggests that most clinic visits resulted in a prescription with or without conducting labs exams. Patients' expectations were often highly predictable, which suggest that either patients were taken to medical facilities when their condition had already worsened or this practices was integrated in the healthcare system. The entire sample in this case study insisted that consultation fees were collected at the time of the visit. In this healthcare system, medical bills are not sent to patients, which is the contrary with the US healthcare system. According to 95 percent of the sample, the cost of treatment was overall very low compared to the US and refilling their prescription was an easy task because most clinics had some sort of pharmacy with generic medications at an affordable price. Five percent of the sample (($n=22$) indicated that the cost of treatment in their home country was considered to be high. This may be explained by the fact that healthcare facilities were often located in urban areas. For families living in rural areas and seeking medical care, getting treatment resulted in an extra travel and lodging expense.

According to focus groups participants, the health care system of their country of origin had similar characteristics as mentioned above. As I will discuss below, focus groups participants all agreed that seeking medical care form Western style clinics was not their first treatment option. The came to the conclusion that accessing health care services was very easy and the cost was low. As one focus group participant explains:

Prior to seeing a provider, you had to pay 2500 CFA (\$5) for the hospital medical booklet or carnet de santé, 5.000 CFA (\$10) for to see a general medicine practitioner, and 20.000 CFA (\$10) to see a specialist. Baseline labs exams were another 15.000 CFA (\$30) and prescription were generally cheap because we could get them from the clinic or local vendors at the market place.³⁰

6.4. Health care System Features and Migrant's Health care Access in the US

The literature review regarding African migrant's health care attitudes and practices revealed that in their home countries, migrants had access to traditional medicine, faith based healing, rituals, and if available, clinic-based treatments. The characteristics of their health care systems are quite different when compared to the US health care system. These healthcare and healing options are unavailable if not inexistent to them in the US. Biomedical clinics and alternative types of medicine, such as naturopathic and acupuncture, are the most common health care and healing options available in the US. The health care system is densely formal and heavily structured and appears to migrants as a very opaque system. Accessing health care services in the US requires migrant's ability to communicate in English or use translations services, have insurance coverage, be familiar with setting up appointments, and getting to the clinic on the time to see the providers. These steps are not required from migrants in their home countries as discussed in the previous section.

As presented in table 6, 73 percent of the sample has government-sponsored health care insurance. Twenty-seven percent of respondents did not have healthcare coverage based on the type of visa and their status at the time of the survey. Many migrant's categories such as students, diversity visa and family reunification visa holder for example have very limited or no coverage at all unless they get insured through their school,

³⁰Focus group. Portland Oregon.

employer or a private insurance companies. Pregnant women had insurance throughout their pregnancy through the state emergency coverage program. Most participants reported that setting up appointments with providers and even getting to the clinic was difficult. Unfamiliarity with the US health care system, which is structured in a way that every medical visits needs to follow certain rules, contributes to challenges related to accessing medical care for migrants. These concerns were raised by Peery, a migrant’s mother during one of the interviews. She said, “To see a physician here in Oregon, there are many steps that need to be taken before the patient even gets a chance to see a doctor.”³¹ Five percent of the survey sample, which is one participant out of 22, did not have any issue getting to the clinic and refilling prescriptions. This is due to the fact that her husband has lived in the States a little longer and was familiar with the overall process.

Question	Response	Percentage
Do you have insurance in the US?	No	27%
	Yes	73%
Do you have to make appointment in the US?	Yes	100%
Does the provider listen to your concerns?	No	95%
	Yes	5%
Does provider prescribe medication?	No	100%
How is the medication refill process in the US?	Easy	5%
	Difficult	9%
	Very Difficult	86%
How about getting to the clinic in the US?	Easy	5%
	Difficult	95%
Do you have any language issues in the US?	No	18%
	Yes	82%

³¹ Interview with a migrant. Portland, Oregon. September, 5. 2016.

just to moisturize the nose...even an inhaler can help.’ The doctor did not want to prescribe medication until she gets the result of the tests. That was really difficult for me to wait for the results of the test before they could do anything to calm her down. So for me to relieve her symptoms, I used to melt shea butter, let it cool down and every night before going to bed I will put one or two drops in her nose and that helps a lot.³³

For participants in the sample, the unsettling reality of not having lab tests ordered or a medical prescription from a provider after a clinic visit is a concept they are still grappling with. As we have mentioned earlier, migrants had access to many forms of treatments option available to them in their home countries. Seeking medical treatment from the clinic, as I will discuss in the next phase of the presentation of the findings, was not the first treatment choice. Over 90 percent found the prescription refill process difficult despite the fact that 41percent of the sample found the cost of treatment low. This may be in part due to the fact that 73 percent of the sample had some sort of health care coverage through either their employer, school or the state sponsored health coverage at the time of the interview. Almost 60 percent of the sample still believes that the cost of treatment is relatively high compared to their home countries while 41 percent considered the cost of treatments in the US to be low compared to their non- refugee’s counterparts. I anticipated that participants who claimed the refugee status will have no out of pocket medical expenses because they were insured under the state sponsored healthcare programs which created a disconnect between their perception of the cost and the reality about medical expenses in the Western medical system.

Eighty-six percent of the sample needed a translator during medical appointments. Language and translation issues in the US health care system were also reported by participants in focus groups and life histories. This not a surprising fact because only 18

³³ Interview with a migrant. Eugene, Oregon. February, 12. 2016

percent of the sample had the ability to communicate to some extent in English, which for some participants was the national language of their country of origin and for other was the language they learned while studying in the US. It is expected that language can be an impediment during communication between health care providers and patients in medical facilities. Sadiki expressed her frustrations during a prenatal visit by saying that:

In one occasion, I was explaining to the physician that I came from an area of Africa where pregnant woman suffers from toxoplasmosis. I had a vivid memory of my cousin who painfully lost her life as the result of this illness. The translator did not know how to explain what my concerns were and what type of testing I was talking about. After that visit, I had to do some research to find the name of the illness in English and decided from that day on to have a friend of mine who had better understanding of both English and French accompany me for my prenatal visits.³⁴

The disconnect between migrants and translators was a decisive factor in migrants resorting to only seeking care when their conditions worsened. The Meena's family reported the following:

When we first arrived in the US, we used to not receive any treatment when my family was sick; the doctor did not understand us so we were always sent home without treatment. This went on for over 6 months. The case manager was usually able to explain and we would get treatment, but when he was not available nothing would be given to us. If the child's condition was getting worse, we would call the case worker. But most of the time we had to just stay home with the sick child because we used to spend so many hours waiting to be seen and it will be useless because we would be sent home without treatment. I had nurses getting mad at me and saying that I refused the translator that was provided. On many occasions, they would bring in a translator who they believed spoke my language but in fact, he spoke a language that is different from the one I am familiar with. Now my teenage kid is the one translating because I have no options.³⁵

Caren also reported that:

I was going with the translator who understood my language well, it was easy. She was the one helping fill out the forms, but now I have no idea what is written in there. My teenage daughter's hair has been falling out and we have no idea

³⁴ Interview: Diversity Visa participant September 5, 2015. Portland, Oregon.

³⁵ Interview: Refugee family. December 24, 2015. Portland, Oregon.

what is happening. When you see the doctor, communication is key. If they do understand you and accept your explanation you are sure to get the right treatment and will address the issue, but if they don't understand you or agree with what you are saying it is waste of time.³⁶

One refugee reported that, communication had driven her and her family to move from a southern state to Oregon because it became impractical to get medical attention due to lack of proper translation services. Aminata explains that:

In the US, we used to not receive any treatment when my family was sick as the doctor did not understand us so we were always sent home without treatment. This was in Texas, the state where we were first relocated. This went on for over 6 months. Communication was an issue and this is the reason why we left Texas to come to Oregon because refugees who were living in camps before were relocated to Oregon a year before us. We were told by them translators were better in this state.³⁷

She concludes that, “When you see the doctor, communication is key. If they do understand you and accept your explanation you are sure to get the right treatment and will address the issue but if they don't understand you or agree with what you are saying it is waste of time. You will go home without treatment.”

Translations inaccuracies were raised by many participants as particularly challenging during clinic visits. Participants who needed translators the most were the ones who had both limited to no formal education and English language skills. For instance, the Swahili language varied from one region to another. Most participants in the sample revealed four types of Swahili spoken around the Eastern and Central regions of Africa. The “Kiswahili” is generally used in Congo, the “Ki Rwanda” is spoken by Rwandese living on both sides of the border with Congo, while the Swahili language is preponderant in Tanzania and Kenya but nuances in the vocabulary, meanings and structures of sentences makes it challenging for Congolese and Tanzanian to fully comprehend Kenyan Swahili.

³⁶ Interview: Refugee family. December 24, 2015. Portland, Oregon.

³⁷ Interview: Refugee family December, 24. Portland, Oregon.

Pehpeh, a Swahili translator I spoke to emphasized on the fact that in order to provide accurate translations and to avoid frustrations and miscommunication between the parties involved, it is highly recommended for migrants to indicate which Swahili language they are more familiar with.

Fulani speakers within this sample acknowledge having trouble with finding translators in their particular Fulani. Many nomad groups in Central Africa speak Fulani, but Caren, a refugee respondent mentioned that the only Fulani language she can understand and communicate in is the Fulani from Central African Republic or Cameroon. She reiterated that she was not familiar with other forms of Fulani such as the one used in Chad. Chanty, another participant referred to the translation dilemma she faces and said:

The physician at the clinic was very nice but the communication between me and her was very difficult because I was not able to understand her and was not able to ask questions as I would have wanted to. She was asking me questions but it was hard for me to understand. I felt like the interpreter was not giving the full account of what I was asking. I knew where to go to refill medication because it was a clinic, but from what was writing on the bottle I could not tell how many pills I was supposed to take...or what the dosage was.³⁸

One factor that need to be considered is the miscommunication in patient-provider relationships that can lead to misdiagnosis, prescribing the wrong medication, and increasing the burden of diseases in this community. This can result in African migrants putting off clinic visits and finally deciding to seek care when the condition becomes severe, costing more to the tax payer or even introducing strains of new viruses and diseases.

In conclusion, over 80 percent of migrants have health conditions that require medical attention, while 73 percent have health insurance coverage. One will expect

³⁸ Interview: Diversity visa migrant's. September 5, 2015. Portland, Oregon.

migrants to seek medical care for their health concerns, but it is not often the case. A number of other structural factors, such as the unfamiliarity with the US health care system and language barriers, could be listed among common factors preventing them from doing so. I argue that a number of structural (as mentioned above) and non-structural factors such as health beliefs, attitudes, and practices acquired prior migrating to the US shapes migrants' preferences during their interaction with the health care system in Oregon. These beliefs, attitudes, and practices are less salient and greatly impact migrants' interactions with the health care system in Oregon.

CHAPTER VII

PRESENTATION OF SURVEY RESULTS: BELIEFS, PRACTICES AND PREFERENCES

A quick description of the health care ecosystem is useful to better understand this stage of the data analysis. In the African healthcare ecosystem, the average person self-diagnoses. In the case of this study, 100 percent of the sample still does so (see figure 9). Thus it is not uncommon, as in the United States that someone who feels a sore throat coming on, combined with chills, starts treating a cold. Likewise, for many African migrants, chills, general body ache, and lethargy are commonly assumed to be signs of malaria. A person feeling these symptoms will more often than not buy malarial treatment from one of many neighborhood resale shops, or if there is a nurse in the neighborhood have the nurse inject the person with the proper medication. Should symptoms persist, the person then visits a neighborhood clinic at which point tests might be ordered depending on the ailment, or treatment given based on the doctor's diagnosis or in cases where the doctor is unable to do this, the patient is then referred to a state hospital. These health care beliefs and practices that now shapes and determine migrant's interactions with the health care system in Oregon were acquired prior to migrating to the US.

7.1. Migrants Health Care Beliefs and Practices

After the relocation process in Oregon, African migrants now experience life in a new and totally different environment. The health care system as a whole is based on a more formal structure, with rigid processes, and is highly structured. Every clinic visits needs to be scheduled in advance with 15-minute tardiness accepted and in most cases, a fee based penalty is applied if cancellation notice is not received within a specific time

period. Fees for office visits for non-insured patients are collected not before services are rendered as migrants were accustomed in their home countries, but they are billed after all clinic visits. Only co-payment and down payment are required in some cases. There are no exceptions to the rules and procedures, which makes mobility from one stage of the health care system to another very challenging for people who are unfamiliar with how the system operates in the US.

In general, there are few ways people approached and interacted with the health care system in their home countries when faced with a health crisis. Most of the time they engage in self-diagnosis practice without performing any medical testing. Many people in this same context acquired medication from the neighboring medication vendors if they do not want to go to the clinic. Frequenting non-western traditional healers and spiritual healers is also common practices among African migrants in their home countries. My data shows that an overwhelming majority (100 percent of the sample) acknowledge that they not only believe in non-Western medicine, but they also have used it as a form of treatment in their new home. Ninety-one percent of participants use non-Western medicine and they resort to this form of treatment as often as 86 percent of the time. Beliefs in non-Western medicine and resorting to non-Western treatments is an integral part of migrant's health care ecosystem both in their home countries and new environment as indicated in figures 10 and 11 below. African migrants not only retain traditional health and healing practices, but also hold on to strong preferences for non-Western medical practices in Oregon. This was also a trend in life histories

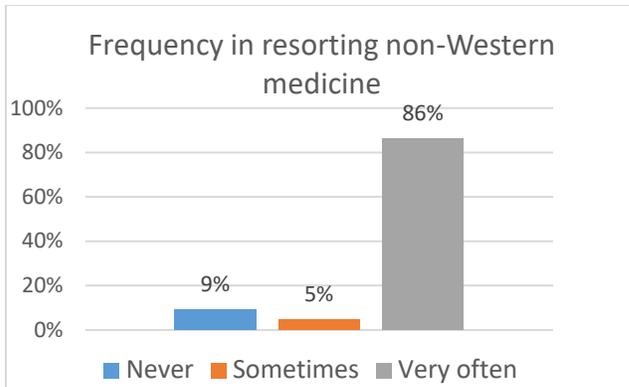


Figure 10. Frequency of use of non-Western medicine in the US ($n=22$)

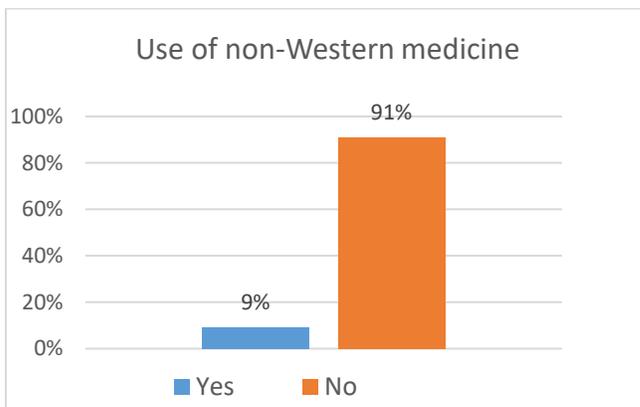


Figure 11. Use of non-Western medicine by participants ($n=22$)

Laban, a mother of five points out the following:

Throughout our lives, especially before fleeing our home country, we had access to a broad range of non-Western medicine at no cost. I do not remember having to take any child to the hospital because we used home remedies. We self-diagnose for every illness and were able to treat every illness that affected my family. Most medicinal plants needed for treatment were found in the garden or in the nearest woods.³⁹

Her husband went on to say, “I now have an issue finding some of these herbs and plant in Oregon.”⁴⁰

Nyango, a post-graduate respondent made the following analogy, “If organic is recognized and identified as being good for our health, this means that traditional

³⁹ Interview: Refugee family. January 2, 2016. Portland, Oregon.

⁴⁰ Interview: Refugee family. January 2, 2016. Portland, Oregon.

treatments are also good and the best option for us. All you need is to get the plant, make an infusion then drink. One does not run the risk of an overdose.”⁴¹

In 87 percent of cases, African migrants living in Oregon seek non-Western medicine treatment after using home based remedy for a broad range of illnesses depending on their ability to diagnose the problem as well as during the late stage of their pregnancy. Bandem, a mother of two describes her pre-birth ritual as follow:

For my second child, my sister asked me from Italy to do the rice offering, which means to put 7 hands scooped rice in a wrap or scarf or sheet under the bed before going for delivery and give that as an offering to anyone when I get back home after having the baby. I never question it because as a younger sister, I should not question advice given to me by elders. It is not culturally appropriate. It is easy to give that offering in in my country because there are always people in need, but it is not the case here in Oregon, but I gave it to a lady in my community and she cooked it. This ritual protected me from having a C-section delivery as well as providing blessing for the baby and I.⁴²

Laban on the other hand explains a homemade remedy for diarrhea. According to him, and depending on the smell of the stool resulting from the diarrhea, he could determine if a ‘lavement’, Colgate, or ingurgitating a concoction is the appropriate treatment. He continues in his description of the facts with the following statement: “We were even able to threat cholera, which is a deadly viral form of diarrhea. Colgate with flowers is commonly used to offset some forms of diarrhea. We have always used this for sick kids and even adults.” Laban’s family still use these forms of treatments when needed and sometimes engaged in recommending treatment to community members who reach out to them for “minor illnesses” such stomach ache preceding a running stomach, high blood pressure, and toothache when necessary in Oregon.

⁴¹ Family reunification migrant. April 22, 2016. Eugene, Oregon.

⁴²Interview with a migrant woman in Eugene. March 19. 2016.

Nine percent of the survey sample never resorted nor used to non-Western medicine both in their home countries and in the US for either themselves or for their family members. They explained their non-adherence to this form of treatment for religious beliefs. They believe that God is the most powerful healer and its healing powers go beyond any other healing practices.

Forty-five percent of the sample mentioned having a kin relationship with a healer or have been raised in a household by or with a traditional healer. These variables did not affect migrants' beliefs in non-Western medicine in any way, form or shape.

7.2. Migrants Medical Preferences

As seen in my data, migrants resort to non-Western medicine and treatments under the label of home remedies, traditional medicine, and faith based medicine. Over 80 percent of participants living in Oregon still opt for non-Western medical practices as their preferred option when it comes to seeking medical treatment (see figure 12 below).⁴³ Because migrants are the byproduct of the health care ecosystem from which they originate, it is not uncommon for individual to retain practices that are familiar and more relevant to a specific health crisis than engaging with the unknown, particularly when they are away from their home countries. Eighteen percent of the sample cited Western medicine as their preferred medical option for reasons ranging from unfamiliarity with non-Western treatment and for religious reasons. One participant explained that having a father who was a religious leader and a Pastor, non-Western medicine, in her family, was often associated with animist practices which were against their Christian beliefs. This rejection

⁴³ Participants were not asked what influences shaped these preferences.

of non-Western medical practices is also reflected in their choice to not combine those two forms of treatment as compared to the rest of the sample as we will see in figure 12.

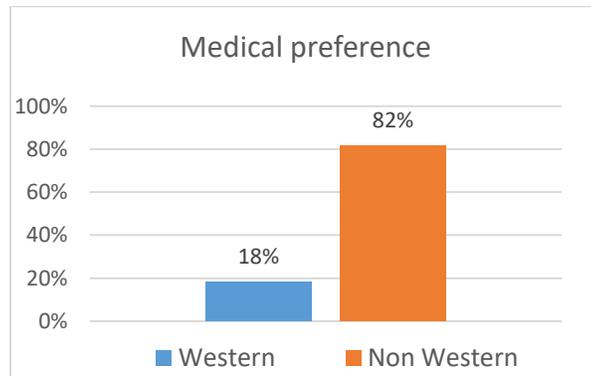


Figure 12. Migrant’s medical preferences ($n=22$)

Dodo, a mother of two, refers to non-Western medicine in these terms, “Massep and enemas are our go to medicine.”⁴⁴ Celenah added that:

In my tribe, when you are pregnant, you drink hot concoctions and you also drink “Quiquelibat” at least twice a day to avoid nausea and vomiting. They also advise you to use enemas two times a week to help with the childbirth and to easily go to the bathroom during the pregnancy avoiding at the same time the constipation dilemma. I use and will always use traditional treatment first before going to my prenatal visit here in Oregon.⁴⁵

Kaneetah reflects on their health seeking practices in these terms:

We have a list of diseases for which we only seek traditional treatment and it works. For others we use Western medicine first; if it fails then we used traditional medicine. When you have broken bones, for instance as the result of an accident, after the removing a cast, you always go see a bone settler who has supra-natural powers and who have been healing bones for many generations.⁴⁶

Dodo though about her medical preferences, paused and said:

When I left my hometown, my mom asked me to take the ‘Poire’ with me and she used to send me some dry leaves from back home to use for treatment; I will by far prefer traditional medicine or nonwestern treatment than Western medicine. I am trying hard to fully connect with it. In general, I have never liked pills. I have always had very bad

⁴⁴Herbal medicine found in the Central region of Cameroon.

⁴⁵ Interview: Family reunification migrant. April 22, 2016. Eugene, Oregon.

⁴⁶Interview: Family reunification migrant. April 24, 2016.Eugene, Oregon.

side effects when it comes to Western medicines. It is pure chemical substance that we put in our system.⁴⁷

Migrating to America seems not to have much of an impact on participants' preference and use of non-Western medical practices. The data points to an overwhelming majority of participants acknowledging that they not only believe in non-Western medicine, but they also use it as a form of treatment in their new environment; 91 percent of respondent used non-Western medicine and they resort to this form of treatment as often as 87 percent of the time. Laban, a father of 5 children, nostalgically said, "I have some spices here in Oregon; when I use them I feel good. For instance, Musungou Purry is known to treat almost every condition...it is a white tree that has wonderful healing powers. It is very bitter but great. I do miss that one since I left my country."⁴⁸

Meena said that: "I think that my child is suffering from a spiritual disease, her head and belly hurt, she has fatigue and feels dizzy. Doctors have not been able to help her. If we were back home, a traditional doctor would have helped her"⁴⁹.

Pregnant women in the study were also strongly attached to non-Western medicine as well as spiritual healing practices deemed important for the mother and the baby's well-being. Ten out of ten pregnant and young mothers who participated in the interviews reported using mostly non-Western medicine and spiritual healing throughout their pregnancy for the protection of both the mother and the baby. There was a shared sense among participant in the Eugene focus group that some practices such as wearing a long beaded necklace around the neck or the waist by either adults or children was always subject to questioning by medical providers. Tanti, explains that:

⁴⁷ Interview: Family reunification migrant. April 22, 2016. Eugene, Oregon.

⁴⁸ Interview: Refugee participant. January 2, 2016. Portland, Oregon.

⁴⁹ Interview: Refugee family. December 24, 2015. Portland, Oregon

I used to wear a protective long necklace throughout my pregnancy that was given to me by an Imam and the doctor respected my choice. During the prenatal check-ups nurses were always asking me what it was and I always reply that it is a protection because the body is very sensitive and because in my culture the pregnant women is very vulnerable to bad spirits and the wind. I strongly believe in these practices and protections.⁵⁰

Migrants are now faced with the dilemma of either using these healing and protective practices for themselves and the well-being of their families in an environment where some of these practices are proscribed for safety concerns.

A number of mothers attending the focus group in Eugene and who had had at least one child born in the US reported that giving the baby water before age of one for instance was prescribed by pediatricians in the US. Kaneetah, a young mother of four explains:

Here we were told not to give the baby water, but it is very hot. How can I not give the baby water? Back home, we give the baby a bath and make the baby drink traditional medicine. I always give dates water to my babies soon after birth even if it is forbidden here. It has many protective values and helps prevent colic...So far, I have used this with my four kids.⁵¹

Another mother is reluctant to describe it but finally says that, “Massep and enemas are my go to medicine for my kids”.

Throughout conversations with participants, I came to the realization that women, particularly mothers, are more likely than not to embrace these non-Western practices. Spiritual healing is also an integral part of migrants’ healing practices. Ekotto recounts her how her friend who was diagnosed with mental illness in the US was healed by a pastor as follows:

For instance, I had a friend who had many problems. She went to see the pastor but she was going crazy because of her issues...but for some reasons she was close to me. So a friend told me to ask her to go see a pastor. She went there and was healed so I used the power of spiritual healing on my friend and she became normal. She

⁵⁰Focus group participant. Eugene Oregon.

⁵¹ Interview: Refugee family. January 2, 2016. Portland, Oregon.

used to scream as if she was seeing some spirit but she was completely healed. There are many types of healings and many traditional healers treat mental illness. Sometimes they even trace the cause to where and when the spirit got into the person or if it is something that your mom failed to do or maybe she took a wrong path which allowed the spirit to enter in you as an infant.⁵²

Their decisions to maintain these beliefs and practices and their presumptive benefits are based on the notion that so far, they have not found them harmful for either themselves or their families. In the contrary they feel is that the health and protective benefits are incommensurable. Keota goes on to admit that: “For me, I gave my baby lemon leaves the day he was born. It helps prevent colic.” Sarette, a young mother of a newborn baby living in Eugene adds, “This process is followed by cleaning the baby’ belly using an enema a week later.” Along this same line of thought, Tete, a mother of five adds to the conversation that, “Aumona is known to cure many things. I use it for purification purposes after giving birth by soaking in a bath full of Aumona. I also use another version of this same medication during the pregnancy at about 4 months to clean the baby up, make sure everything is clean in the belly and to prepare the birth process.”⁵³

Ninety-six percent of the sample still has non-Western medical treatments sent to them from their home countries using various outlets. A father mentioned that if he has someone coming from home, he will ask them to bring him some Meringa plant because it has tremendous healing powers. Dodo, points out:

It is very hard to have insurance here, it is very expensive. When I am sick, I always ask my family to send me medication via express mail or when I have someone coming to visit me. Sometimes, from here, I will call my friend who is a physician back home. I will explain my symptoms and he will prescribe medication which will be sent to me by my family. This system here is

⁵²Interview with a family reunification migrant. January 5, 2016. Eugene, Oregon

⁵³ Interview: Refugee family. January 2, 2016. Portland, Oregon.

discouraging, we feel hopeless, because you go to the hospital many times and you are sent home without treatment or any labs.

As previously discussed, utilization of non-Western medicine and spiritual healers is also common practices among African migrants in their home countries. For people living in rural towns, they self-diagnose, then seek help from a “Malam” for Muslims or from a priest or pastor for Christians for spiritual healing while using some homeopathic and homemade remedies. Because health issues, as well as treatments, are conceived holistically combining traditional and spiritual healing approaches becomes the norm in this context.

7.3. Migrants Medical Pluralism Processes

Medical pluralism refers to the historically grounded co-existence of more than one medical system which in a more or less interconnected way seeks to maintain the health status within the community (Slikkerveer, 1990). Medical pluralism, which is combining two or more forms of treatments to address a health crisis, is one of the core health care practices of African migrants in Oregon. In this specific study, resorting to non-Western medical practices does not constitute an impediment on the use of other forms of treatments. On the contrary, it is part of migrants’ beliefs system and health care system spectrum. I argue that in many cases, the medical pluralism approach that can be seen in African migrant’s health seeking behaviors is predominantly the result of the co-existence of two or more health care and healing systems in the same community. These health seeking behaviors and practices can in part be the result of the fact that prior to colonialism in sub-Sahara Africa, definitions of health, illness and health-seeking behaviors were founded on practices and beliefs that are not and still cannot be scientifically explained. Because these practices are deeply rooted in African migrants’

health care beliefs and prior socialization patterns, traditional beliefs are still enacted regardless of the environment in which they now live.

As many as 86 percent of migrants reported combining two or more healing practices in a very systematic manner as seen in figure 13 below.

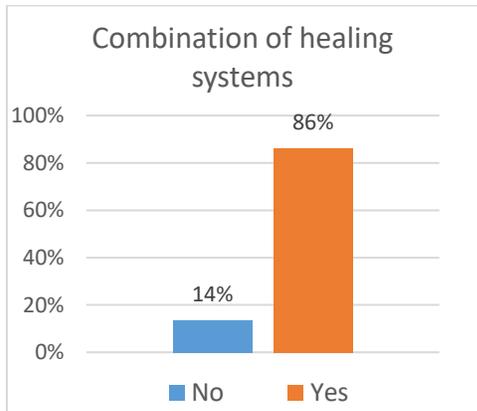


Figure 13. Participants combining healing systems ($n=22$)

Dodo claimed that, “Modern medicine is useful when you have a fibroses cyst that need to be removed and that requires the use of certain equipment or devices. I think getting to a symbiosis of both options helps because ‘White Man Medicine’ does not cure all illnesses and sometimes, just the list of side effects is very scary for me.”

People would generally try to avoid seeking medical care from the clinic as the first treatment option as much as possible for a number of reasons.⁵⁴ At some point the patient might decide to seek treatment from state hospitals or seek traditional treatment depending on the nature of the ailment. Those who decide to seek traditional remedies often cycle back to the formal Western medical system when their conditions become critical or life threatening.

⁵⁴ Generally, state hospitals are located in cities and not in small towns. They are often the last resort for patients in terms of treatment choice and cost. Patients usually explore all of available and affordable treatment options in their localities. State hospitals are ill equipped; providers are not well paid which translate into inadequate patient’s care.

My data indicates that participants not only retained strong preferences for traditional medical practices, they also still act on these preferences. Ninety-six percent still use non-Western medical treatment sent to them from their home countries. Because health issues as well as treatment are conceived holistically combining traditional and spiritual healing approaches becomes part of migrant's health seeking behaviors.

My data reveals that participants experience changes in support network. When asked about their family support networks, every single participant reported a lack of family support in the US. Participants all expressed the lack of family support in the US with 100 percent of the sample (see figure 14 below) acknowledging that relocation created a loss in the family support that they had in their home countries and a sense of emotional comfort that comes with it.

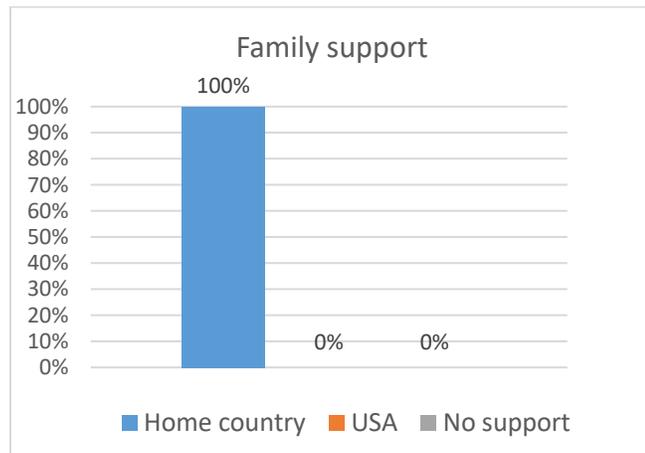


Figure 14. Views on Support in US and Home Countries($n=22$)

When discussing family support with Bukie, she stated that:

Back home elderly women are the ones taking care of young mother by providing traditional medication, hot massages, and hot bath. That way they train you on what to do when you have a baby and what type of traditional medication you should use. Sometimes family members can either move in with you, or come every day or you can

go and live there for few months. But as young mothers living in the US, we no longer have that support we so desperately need.⁵⁵

A Eugene focus group participant sums the lack of support in the following statement, “The lack of family support system each of us used to rely on in our home countries is no longer available here. This striking reality is hard to cope with, especially when we are sick or expecting a baby.”⁵⁶ The relocation process has left all the participants feeling isolated in their new environment.

In most cases, African migrants self-diagnose, purchase their medications on the black market, which has limited to no regulations and less government control. In urban settings with states actor’s involvement, the structure of the health care systems is somewhat similar to the US health care system in the sense that appointments are sometimes required for specialty clinics. There are often not many of these clinics in rural settings which may require families to travel many miles away under rough terrain to get to the closest specialty clinic. Patients are referred to these specialty clinics after a preliminary visit to the local clinic and based on the seriousness of their condition. Patients are brought in at a serious stage of an illness and they often do so after consulting other types of non-Western healers.

In this context, whether patients are seen in clinics located in the rural or urban areas, they are subjected to a fee based option to cover the cost of the treatment prior to receiving treatment. The of lack of wait times, proximity, within a healthcare system which in most cases is characterized by rudimentary infrastructure and the lack of medical equipment in comparison to the health care system in the US does not guarantee the

⁵⁵ Interview with a Diversity Visa migrant’. April, 9. 2016.

⁵⁶ Focus group: Participant in the Eugene’s focus group. August 29, 2015.

effectiveness in treating patients or the performance of the medical personnel who for most parts are underpaid.

In this context, people's attitudes are based on a set of health and healing practices commonly shared within their community. These attitudes can pose a number of challenges ranging from the ability of the US health care system to identify and effectively meet the health needs of these communities, as well as the inability of providers to effectively communicate with their patients. As stated by Cohen (2001), and applicable to the context of African migrants in Oregon, every society structured is based on a set of unique values and perceptions that will differentiate in comparison with another. Different societies are programmed by different software. Not better, not worse, just different. They have their own values, perceptions, and ways of doing things. They make decisions, communicate and negotiate according to their own cultural operational code, not ours.

7.4. Childbirth as a Measure of the Level of Satisfaction with Care

The notion of an African pluralistic–medical system does not imply a medical system that is somehow frozen in time, embracing an ancient and primordial set of health beliefs and practices. Rather, African pluralistic medical systems are dynamic, evolving medical systems that combine a wide variety of traditions, values and cultural influences. It is merely for clarity of presentation, therefore, that only medical systems that commingle aspects of biomedicine and aspects of African pluralistic medical medicine are referred to here as syncretic (Baranov 2008). In this study, female participants represented about 73 percent of the survey sample. Forty-five percent (10 women) of the sample were either pregnant at the time of the study or had had a baby in the past two years which is the main reason for interacting with the HCS in Oregon. They demonstrated a capacity for medical

syncretism rather than medical preferences that was not as pronounced when compared to other participants. All pregnant women were engaged in Western style prenatal care, which includes routine monthly visits and immunizations combine with non-Western treatments, diets and restrictions based on their respective beliefs system from the time they were pregnant till after birth.

Fazatou explains that, “Pregnancy is a very special and precious event in life. Women are required to have a certain attitude. The pregnant woman has to cover herself basically hide her pregnancy. It is absolutely forbidden to reveal the baby’s gender.”⁵⁷

Mariama on the other hand emphasizes on the fact that:

A pregnant woman is very fragile, vulnerable and needs protection from to the wind, diseases, and spirits such as maleficent or evil eyes. For these reasons, I use to cover up, mostly took hot drinks. I was instructed by elder women to stay away from ice cream, because it negatively affect the birth process. I ate ginger and mint leaves for nausea and more importantly I used incense to purify my house. I carried lemon in my purse for protection and protective prayers. I was praying a little bit more; my mother, who was back home also used to make offerings for a safe delivery and protection. I was not attending community events or going near the cemetery because it is forbidden for pregnant women to do so after the second trimester.⁵⁸

Non–Western medicine for both pre-natal and post-partum care, as well as protection and treatments were guided by their beliefs and practices learned while in their home countries generally from their mothers, aunts and grand- mothers. Ngonda recalls that in her tribe pregnant woman drink hot concoctions and quinquelibat to avoid nausea twice a day. They also use an herbal base enema two times a day to help with childbirth

⁵⁷Interview: Refugee family, January 2, 2016. Portland, Oregon.

⁵⁸ Interview with a J1Visa migrant’. April, 9. 2016 Eugene, Oregon

and constipation around the third trimester of the pregnancy. She recounts following this regimen while keeping up with her routine prenatal visits in Portland.⁵⁹

According to figure 15 below, women who received prenatal care in the HCS in Oregon were satisfied with the prenatal care they received throughout their pregnancy and at the time of childbirth. One-hundred percent of the sub-sample declared that they were dissatisfied with the HCS for non-prenatal care, but when it comes to prenatal-care especially during the pregnancy and childbirth, 70 percent of them reported being satisfied with the overall care receive during pre-natal visits and childbirth. They were all covered under state sponsored healthcare plans. Healthcare coverage (based on their income), which was free of charge for these families was not mentioned as a contributing factor to their level of satisfaction. Thirty percent of the sub-sample claimed to be dissatisfied with the care they receive during prenatal visits and childbirth.

Teresa sums up her experience in these terms:

What I liked in the US was the care I received during the pregnancy because I had more privacy, and physicians and nurses cared about me and my baby. I was well attended, nurses where always checking on me. The childbirth itself was painful but it was rewarding at the end.⁶⁰

⁵⁹ Interview with a Diversity Visa migrant'. April, 9. Eugene, 2016

⁶⁰Interview: Refugee family. January 2, 2016. Portland, Oregon.

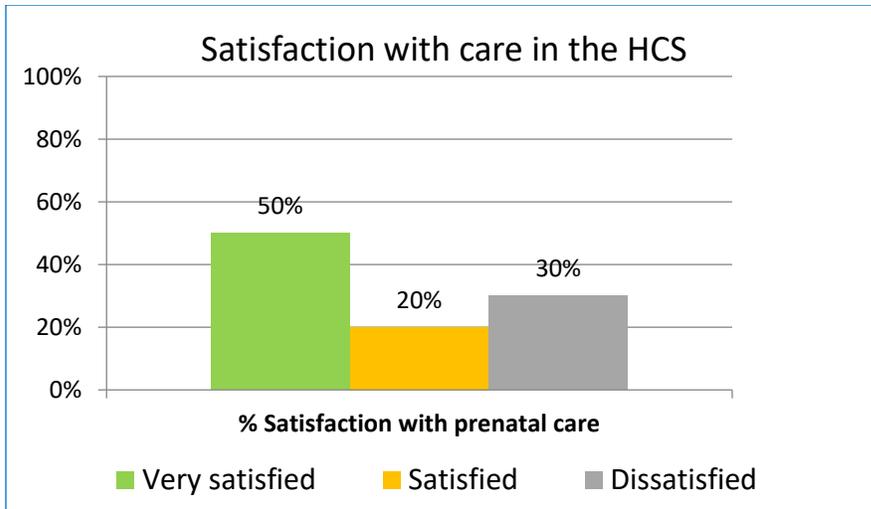


Figure 15. Pregnant women satisfaction with prenatal care ($n=22$)

The level of satisfaction seemed to be intrinsically linked to what participants, who underwent C-section procedure referred to as “forced C- section” and to the lack of family and community support in Oregon especially because the recovery after surgery according to them was long, painful and traumatizing compare to vaginal birth. Nana recounts her experience in these terms:

I didn't want to have a C- section because C-section was believed to be a sign of and evil eye that could lead to the death of either the soon to be mom or the baby. In my case, I was told that the baby had an irregular heartbeat. To save the baby's life, I had to undergo a C-section if not she could die. I got scared and did a C-section. It was very painful because I had no one to help me besides my husband. I could not breastfeed because I was on pain medication.⁶¹

30 percent of pregnant sub sample who were not satisfied with the HCS as well the prenatal care received during the childbirth process underwent “involuntary C-section” in some cases or had an epidural. According to them, physicians opted to go that route for medical reasons and for mother's and newborn's safety concerns without their consent.

⁶¹ Interview: migrant family. February 12, 2016. Eugene, Oregon

Angela noted that, “If I was in Africa, I would have had a natural birth. Back home, women really encourage you to have a natural birth, they are very patient’s but here, as soon as I got to the hospital they started asking why I am not taking an epidural or doing a C-section? Am I sure I want to go that route they kept asking me.”⁶² She continues by saying that one particular nurse was very persuasive in talking her into getting an epidural or a C-section. She summarizes her experience by saying, “One nurse kept saying ‘Honey, I see that you are in a lot of pain are you sure that you don’t want a C-section?’” She recalls that it was very disruptive and upsetting because there was a cross hanging in the room wall and she was praying and trying hard to focus on the cross but nurses kept standing between her and the cross. She said, “I knew I wanted to go natural no matter what. I kept praying to God. At some point they said that the baby’s heart beat was not normal....so they will do a C-section. I finally took the epidural, which considerably slowed contractions. The physician decided to put me on OxyContin to increase the speed of contraction”. Angela concludes by saying that:

I will never advise anyone to give in like I did under pressure. The epidural has left me with a shooting pain in my legs and a back pain that doesn’t go away. I have never had that before. At age 24, I have difficulties cleaning my house or taking the stairs...I use to spend hours on my feet now I can’t. Back home I would have never had an epidural. I would have had women around me.... nurses are tough for lazy women but it helps them get through the pain. I deeply regret the epidural decision but everything else went well besides that.

The dissatisfaction with the HCS was often associated with women’s experiences as the result of their interactions with practitioners prior to giving birth or during the labor period.

⁶²Interview: J1 Visa migrant. February 12, 2016. Eugene, Oregon.

Drawing upon her experience in both HCS, Nana declares that, “I like the professionalism of US nurses, but they lack the type of traditional practical knowledge and core values of Dualas. On the other hand, African nurses are equipped with the traditional practical expertise, but they are far from being professional. There are pros and cons in each system.”

Africans willingness to utilize services based on a biomedical concept of health does not undermine their traditional views on health or vice versa. In much of the Western world, biomedicine is dominant, but not all sections of the populations share the concepts associated with that body of knowledge and its mode of practice. (Feierman 1979). The analysis of the health practices surrounding the pregnancy and childbirth processes in the African migrant’s population living in Oregon help illustrate the difference between the African healthcare structural and cultural system and the U.S healthcare system in Oregon.

CHAPTER VIII

CONCLUSION AND SUGGESTIONS

8.1. Conclusion

This study explored the effects of prior socialization on healthcare seeking behaviors among the African migrant population in Eugene and Portland, Oregon. We found evidence for my main argument that culturally derived worldviews, attitudes and norms create and sustain a particular set of behaviors towards healthcare systems in Oregon. While not unique to African migrants, this finding has particular implications for healthcare delivery in a time of increased migration and shrinking healthcare dollars.

My research showed that the usual demographic factors such as gender, age, level of education, do not affect this population healthcare utilization pattern in Oregon. For instance, when the participants age and medical preferences were compared, they suggested that 80 percent or more preferred non-Western medicine across all age groups. Three ages groups were predominately attracted to this form of treatment: 20-29 years, 40-49 years, and the 60-69 years' age groups, as seen below in figure 16.

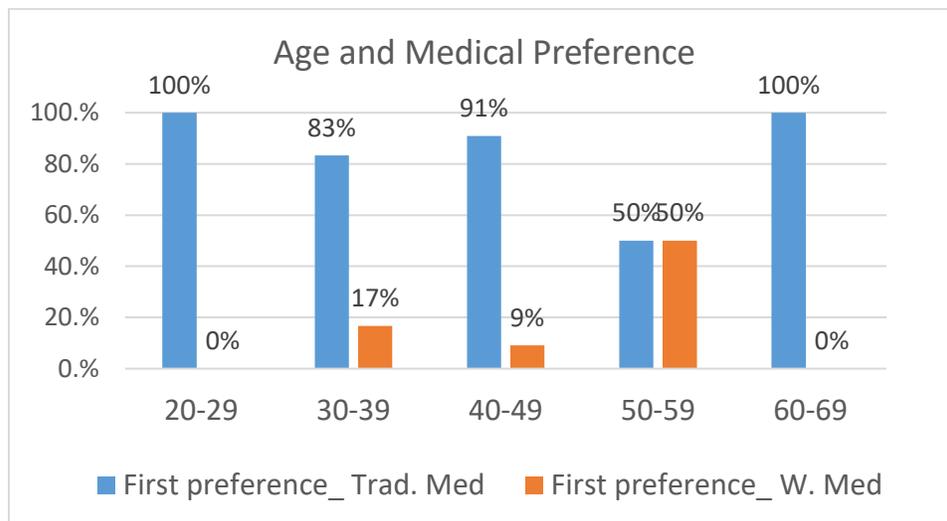


Figure 16. Age and Medical preferences ($n=22$)

The data showed that 96 percent of the sample still have non-Western medical treatments sent to them from their home countries and that 91 percent of the sample uses non-Western medicine in Oregon. The sample also revealed that people with no formal education, primary education, secondary and post-secondary education were more inclined to use Non-Western medicine as their preferred treatment option at a rate of 80% or more as demonstrated in Figure 17.

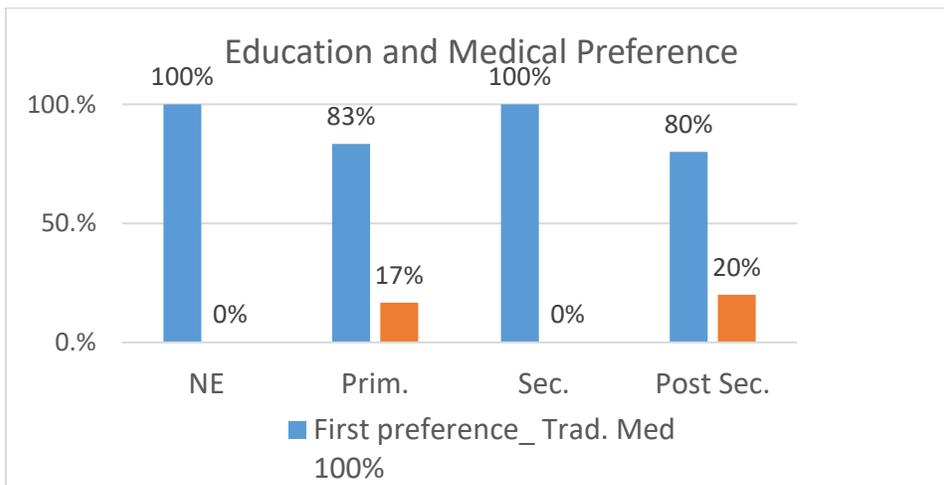


Figure 17. Education and Medical preference ($n=22$)

What seems to matter, as shown by the data, is first and foremost migrants' prior socialization to health and healthcare seeking behaviors are the most important factors. The structural factors of the US healthcare system have an adverse effect on migrant's access to healthcare services, which results in the overwhelming preference for non-Western medicine. Migrants struggle with language when it comes to describing and communicating with their healthcare providers. This problem is compounded by the imprecise nature of translations. Participants repeatedly stated that they felt misunderstood

by healthcare providers. Participants also reported feeling misguided at times; their health needs and concerns were not being adequately addressed in a timely matter. For many migrants, leaving healthcare premises without prescription remains highly unsettling. Navigating the US healthcare system as a whole is a challenging process in terms of application processes, setting up appointments, and follow-up procedures, as well as cost and prescription refills.

The decision to choose a particular healing method to address a health crisis or an illness is not made by an individual but by family members, community leaders based on symptoms, which includes physical and spiritual components. Some illnesses are treated in a clinical setting and some are treated by a healer and spiritual leader in their community. In some cases, combining both methods can be deemed beneficial but the decision is made on a case by case basis. Acquiring and using home remedy is a predominately shared practice in this community and one that they are familiar with. Respondents reported getting non-Western treatments from their home countries using both formal and informal networks. They also engage in combining non-Western and Western medicine during the course of an illness in 87 percent of cases. As Brodwin (1996) states, “the delicate navigation of the plural healing arena is constructed as both a product of past political struggles and a crucible for emerging forms of identity and collective action.”

The structural and contextual issues faced by migrants appeared to leave many respondents with few options: resort to home remedy or non-Western medicine sent by relatives from their home countries and other parts of the US, seek medical care when or if their conditions appeared to be worsening or not seek medical care. Regardless of the nature of the illness for which they seek or do not seek medical attention, African migrant,

both refugee and immigrants, engaged in self-diagnosis in every case (100 percent). Respondents strongly believed in non-Western medicine and have non-Western medicine as their first and preferred treatment option in as many as 82 percent of cases.

In general, African migrants living in Oregon are faced with numerous healthcare access challenges regardless of their socio-economic status, level of education and status. 95 percent felt that providers did not listen to their concerns, and 100 percent did not get a prescription after the clinic visit. There is clear sense of dissatisfaction with the US healthcare system due in part to the fact that many of them had to make many trips to the clinic for the same health crisis and communication between patients and providers, which was hindered with reported translation issues in 82 percent of cases.

It is apparent that researchers have not been studying the extent of the challenges faced by migrants and refugees during and after the relocation process in general. The case study of Africa migrants in Oregon demonstrates a disconnect between patients and providers based on worldviews. While the size of the sample (72 participants) does not allow for making any correlational arguments it provides evidence on the impact of prior socialization on issues related to illness, health and healthcare access of African migrants in Oregon. Policy makers could improve existing programs and redesign policies by including culturally specific practices and flow sheets that can educate individuals involved in providing services to migrant's communities as well as the community they are serving.

A common understanding of these practices by healthcare providers can lead to a more informed set of expectations from both parties and a less paternalistic relationship between patients and healthcare providers in Oregon. Appiah-Kubi (1981) emphasizes on the fact that "holistic philosophy needs to be taken into account in public health policy."

The author advocates for more conscious integration of the health care systems and a more delicate effort on the part of western scientific medicine to accommodate to the holistic viewpoint of traditional people. Overall, African migrant's unfamiliarity with the US healthcare system in an environment dominated by the biomedical model of healthcare and the lack of support system sharply contrast with their healthcare system which affect their healthcare utilization in Oregon.

8.2. Suggestions for the healthcare delivery system in Oregon

I anticipate that the benefits of accurately collecting ethnic, racial and demographic information could facilitate identification process of migrant who have worked or who are interested in reintegrating in the health care sector in Oregon. With an incessantly growing need of culturally trained Community Health Workers and Healthcare Workers in Oregon, entry level health care professional such as Certified Nurse Assistant (CNA) and Home Health Aide (HHA) can be selected, trained to meet the US standard before placed in areas where their skills are needed the most.

In Oregon, the Community Health Worker Program is based on a curriculum designed by the Community Capacitation Center (CCC) staff. The agency is within the Multnomah County Health Department in Portland, Oregon. The program requires 90 hours of training of selected participants who possess language and cultural skills specific to the target population. This training could constitute a stepping stone for migrants who were in the healthcare sector in their home country to enter or pursue a career in healthcare instead of remaining unemployed or relegated to service sector or other low-skilled jobs. Having trusted members of the migrant's community in the role of CHW will put at ease African migrants especially first time health care services seekers. As the needs to address

the lack of culturally inclusive healthcare systems and healthcare access challenges of African migrants in Oregon became an incessant demand from the community, the CCC in partnership with IRCO responded by adapting the existing CCC curriculum into a culturally relevant format. As of November 2016, the first class of African CHWs will be working with both healthcare providers and newly arrived migrants.

A Cultural Integration Support Service could be added to cultural competency trainings of healthcare providers to a system that integrates healthcare workers and professionals from diverse background in the healthcare delivery system in Oregon. In this system, patients will be assigned providers and healthcare workers who are either familiar with patients from specific ethnic and racial groups or have experience working with this population. This will create a trusting atmosphere between patients and providers during clinics visits. A program such as the Interprofessional Community Health and Education Exchange has proven to be successful in engaging medical students and health professionals with culturally diverse populations in the Portland metro area. If replicated, this model can be combined with existing cultural competency training in both medical and nursing school but also medical facilities providing services to underserved population.

Another potential benefit of the Healthcare Integrative Support Service is to create Health Mapping System database where migrants demographical, ethno-racial as well as language information is stored. This will help anticipate and tailor services based on migrant's specific challenges and needs. Migrants could be paired with a CHW or a Health Navigation Specialist for a pre-determined period of time; monthly well check and a report system could be put in place for needs assessments purposes and for tracking progress.

Funding for research on migrant's population in Oregon is lacking. Investing resources on research could yield not only data, but provide more insights on these communities' health needs and healthcare challenges. Public health agencies and policy makers can reformulate priorities and allocate resources based of tangibles information. Advocacy groups for African migrants are inexistent; without these entities, a push for policy change in terms of healthcare access for all will be practicably unobtainable.

APPENDICES

A. INTERVIEW QUESTIONNAIRE

These interviews were conducted in French, English and in some cases translators were involved for both Swahili and Fulani participants.

1. Migrant's demographical information
2. Did you leave due to war?
3. Why did you decide to leave?
4. What language do you speak?
5. Age (range)
6. Marital Status
7. No. of Children
8. Do you have a condition that requires medical attention?
9. Which one is it?
10. Health Care Access in Home Country
11. How did you get to the clinic?
12. Did you had health insurance

13. Did you needed to make an appointment to get to the clinic in your home country?
14. Did the provider listen to your concern?
15. Did the provider prescribe medication?
16. How did you refill medication in Home country?
17. Did you had any language issues in home country?
18. Health Care Practice?
19. Did you had to pay for the visit at the clinic?
20. What was the cost?
21. Did you need a translator?
22. Did you had access to Traditional medicine?
23. Did you used traditional medicine?
24. How Often did you used it?
25. Did you had a healer in your Family?
26. Do you self-diagnose?
27. When do you decide to see the healer?
28. What is your first preference_ Traditional Medicine? 1
29. First preference- Western Medicine? 2
30. Do you believe in traditional medicine?
31. How Is the process of getting home remedy?
32. How is the process of getting healer Remedy/medicine?
33. How is the process of getting Western medicine in Home Country?
34. Do you use more than one treatment method?

35. Do you use Traditional medicine during the pregnancy?
36. No (0) Yes (1)
37. If yes, how often?
38. Do you have access to non -Western medicine in the US?
39. How do you get it?
40. Health Care Access in the US
41. Do you have insurance in the United States?
42. Do you have to make appointment in the United States?
43. Do providers listen to your concerns?
44. Do providers prescribe medication?
45. How do you refill medication in the US?
46. How do you get to the clinic in the US?
47. Do you have language issues in the US?
48. Do you have to pay for the visit at the clinic?
49. What was the cost?
50. Do you need a translator?
51. What is your level of satisfaction with translation?
52. How is the overall process?
53. What is the level of satisfaction with the Medical care in the US?
54. What is the level of satisfaction (prenatal care) participant?
55. How many times did you have to go the clinic to have a health issue taken care of?
56. Do you have community /family support in home country?
57. Do you have community /family support in the US?

B. PAIRED INTERVIEWS PROMPT

1. Where are you from?
2. Do you have children and where were they born?
3. What was it like to be pregnant/ what does it represent in your culture, tribe, family?
4. Any specific restrictions, treatments, diets during the pregnancy, childbirth and after birth for both you and the baby?
5. What is (are) the difference(s) when compare to your experience in the U.S. experience? Anything else you will like to share, a specific detail or a story you will like to share?
6. Do you self - diagnose?
7. How do you know when to use what?
8. Do you use believe in traditional medicine?
9. Do you use traditional medicine during the pregnancy? How often?
10. Do you have access to traditional medicine in the US? If yes, how?
11. Do you combine one or more treatment method for you and the baby?

12. Which one do you prefer? Western or non - Western? Why?

13. Do you have any support system from your family or community in the US?

C. PORTLAND'S FOCUS GROUP

Health Literacy, Health Navigation: A Needs Assessment of Portland's African migrants under the supervision of IRCO.

Portland Focus Group Question Script:

The following questions will help us find out more about our community's experiences with healthcare. This will help us to understand how to better support and advocate for our communities to help people stay healthy and happy. Please feel free to share as little or as much as you feel comfortable.

First, let's talk about you or your community's experiences with doctors:

1. What are the reasons someone would go to the doctor?

(Brainstorm- get group consensus- do they agree?)

2. How do you decide when to go to the doctor?

Probe: How do you know how soon you should go? Or when it is necessary?

3. Related to question above, how often should someone go to the doctor?

4. What makes it difficult or easier to go to the doctor?

5. What do you expect from the doctor or clinic to make you feel better?

6. If you had a problem with your insurance or with communicating with the doctor's office, what do you do? Does anyone help you?

7. Where do you go to learn about insurance or healthcare systems?

8. If you don't understand what the doctor is telling you or you disagree with them, what do you do?

9. Do you feel comfortable calling provider/calling insurer about concerns you have? Probe: Why or why not?

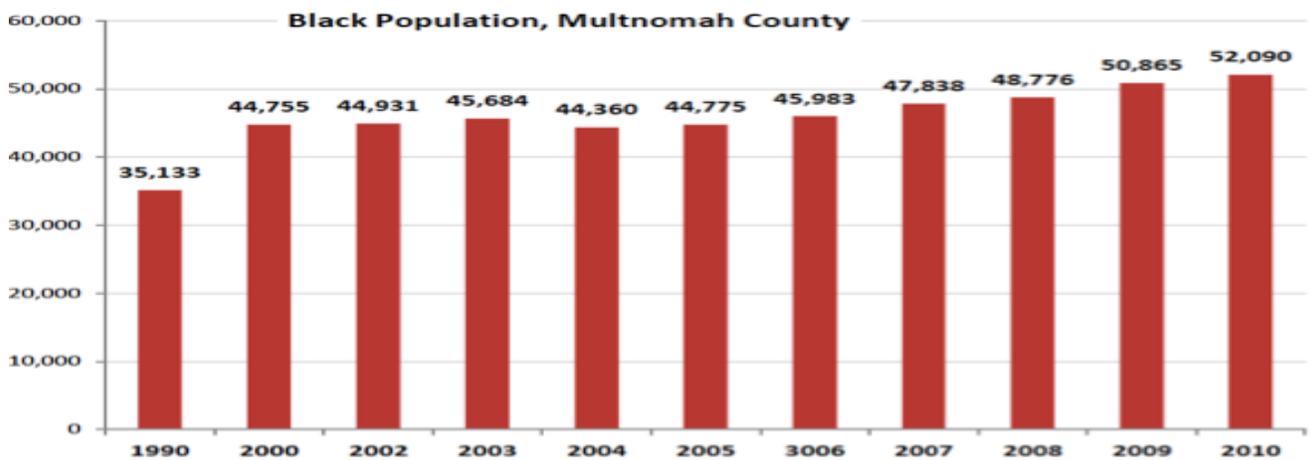
10. What does prevention mean to you when you think about health and healthcare?

D. MIGRANTS RACIAL AND ETHNIC CLASSIFICATION

In order to adequately identify factors susceptible to constitute road blocks for African migrant's access to needed health services in Oregon, it is necessary to take a closer look at how they are identified and classified by the census bureau and non-governmental agencies such as the Department of Health and Human Services, the United States Immigration and Naturalization Services, and the healthcare delivery system in Oregon. Identifying this population in terms of their African ethnicity within the African -American racial group is the entry point leading to a more complex classification based on their status before and after entering the U.S. Status based typology is key in defining who qualifies for health coverage and social services in the U.S.

The fact that African ancestry data is not typically captured by state and local governmental agencies or the US Census Bureau makes it difficult for organizations serving this group to accurately identify trends in terms of population growth within this population. By lumping them with African-Americans, the specific needs of African migrants in terms of health, social services utilization, or health access needs cannot be met.

Oregon's African-American population as a whole has steadily grown in recent years because many new migrants have come from the African continent and are classified by the census bureau and most governmental agencies as African -American (see Figure below).



Source: Census from 1990, 2000, 2010 and American Community Survey

Figure 18. Black population in Multnomah County from 1990 to 2010

Most public agencies do not differentiate between people who have migrated from Africa and African-Americans and they are categorized by race regardless of their ethnicity.

See sample intake forms of several public service agencies in appendix E.

There are still considerable gaps in identifying migrants of African descent both by governmental agencies and nonprofit organizations. According to Curry et al. data on the experiences of this group is lacking, as all conventional databases subsume their identity within that of the African American community. Yet, while there may be strength in numbers and a shared legacy of oppression, the experiences of the two groups are profoundly different.

In January 2016 the Oregon Health Plan (OHP) introduced for the first time, a more detailed application (figure 5). This application clearly acknowledges and reflects the breakdown in term of ethnic and racial identity of individuals applying for services in Oregon. This will provide more statistic details about specific groups applying for services

in the state of Oregon as opposed to previous government sponsored health insurance forms where African migrants applying for services were classified as African-American.

According to the Director, The Immigrant and Refugees Communities in Portland recently partnered with a private company that specializes in demographic data collection software and database analysis to support their ongoing efforts in documenting African migrants in Oregon. This partnership's objective is to document the demographic, ethnic characteristics of individuals migrating from Africa to Oregon. Making this population visible by various entities involved in providing services is a starting point in addressing their health access challenges due to adaptation to the new environment, language and healthcare preferences affecting their interaction with the U.S. health care system.

Policy makers, public agencies, and nonprofit organizations working with migrants rely on data in order to create services that address the barriers and challenges faced by this particular community and allocate resources for specific support programs to better meet their needs. According to Curry et al. (2010), inaccurately identifying African migrants made them invisible and powerless to the point of being left out of the policy making process on issues affecting this population: "while policy makers turn to us for advice on refugee matters, we are left out of more conventional policy practices in mainstream health and human services. This culture of omission serves to leave our voices out of the debated and all of us lose ground when we engage in practices that center the needs of a limited set of communities of colors".

For the Immigrant and Refugees Community (IRCO), there has been a steady growth in the African-American population; but because the African ancestry profile is not reflected in most forms as mentioned earlier, it is impossible for nonprofit organizations

like IRCO to receive grants and funding necessary to create, sustain, and in some cases reinforce existing services. It is also very difficult to add personnel with cultural competencies in working with this specific demographic of recent migrants in their agency and to keep up with the steadily growing demand for services such as housing and energy assistance, job search, health insurance applications.

The need for a clear distinction between the African identity and ethnicity from the African American racial and ethnic group was among other subjects raised in Carson (2004) study conducted in the African community in Minnesota. Her study doesn't only inform the needs for a clear distinction within the African- American ethnic and racial group but she analyzes the race and ethnicity question from the perspective of African migrant personal account living in Minnesota. Although Minnesota has, compared to other states in the U.S, one of the largest African refugee and migrant population, they are, just like in Oregon, hardly identified as African but rather lumped with the ethnic and racial Sub group.

Minnesota has the most diverse black population in the U.S. according to the 2000 Census bureau data (Carson 2004). During the *Understanding African Refugees in our Community* conference held in Minnesota few years ago, the author mentioned that a woman from African descent describe herself in these terms: "If you want to build bridges, then look at me as African. When you look at me you see the spirit of Africa. Look at me as African; I am not here by choice. Politically I am African-American, but in my soul and spirit, I am African.

Even if a distinct ethnic identification between African migrants and African – American is reflected in governmental and non- governmental forms, one relevant aspect

that needs to be consider is the different variations in terms of sub - groups exiting within the African migrant's population as well as their migrations experiences which are both so often not captured or overlooked. Documenting their migrations experiences is an important aspect in determining who qualifies for health care coverage and subsequently other social services benefits and who does not qualify in the U.S.

E. AGENCIES INTAKE FORMS SAMPLES

1- Social Security Identification Application Form

1. Tell us about the people in your household	
<p>Please complete below for everyone in your household. You can choose not to give your ethnic group and racial heritage information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.</p>	<p>Please answer below for those who want benefits.</p>
<p>Full name (last, first, middle initial) _____</p> <p style="text-align: center;">Self</p> <p>Date of birth (mm/dd/yyyy) _____ Relationship (mother, son) _____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married, but separated</p> <p>Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino</p> <p>Racial heritage: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American</p>	<p>Check below the benefits for this person:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Food <input type="checkbox"/> Child care <input type="checkbox"/> Cash <input type="checkbox"/> Domestic violence help</p> <p>Does this person have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For food and cash benefits, does this person have an outstanding arrest warrant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Last grade completed: _____</p> <p>Social Security number: [] [] [] - [] [] - [] [] [] []</p> <p>U.S. citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No If no complete the information below:</p> <p>Alien Resident number: [] [] [] - [] [] [] - [] [] [] []</p> <p>Place of birth: _____ (City/state or country)</p>

2-Department of Motor Vehicles (DMV) application

APPLICATION FOR DRIVING PRIVILEGES OR ID CARD										
<input type="checkbox"/> ORIGINAL <input type="checkbox"/> RENEWAL <input type="checkbox"/> REPLACEMENT										
<input type="checkbox"/> DRIVER LICENSE		<input type="checkbox"/> LT CONVERT		<input type="checkbox"/> INSTRUCTION PERMIT		<input type="checkbox"/> MOTORCYCLE		<input type="checkbox"/> ID CARD	<input type="checkbox"/> AT-RISK	
<input type="checkbox"/> CLASS C <input type="checkbox"/> CLASS C RESTR'D		<input type="checkbox"/>		<input type="checkbox"/> CLASS C <input type="checkbox"/> MOTORCYCLE		<input type="checkbox"/> ENDORSEMENT <input type="checkbox"/> 3-WHEEL		<input type="checkbox"/>	<input type="checkbox"/>	
LAST NAME (PRINT NAME)			FIRST NAME			MIDDLE NAME		SOCIAL SECURITY NUMBER		
OREGON DRIVER / ID NUMBER		DATE OF BIRTH (M-D-Y)		MOTHER'S MAIDEN NAME		APPLICANT'S PLACE OF BIRTH (CITY & STATE OR COUNTRY)				
RESTRICTIONS		Do you want your license or ID card to show that you are an anatomical donor? <input type="checkbox"/> YES <input type="checkbox"/> NO			HEIGHT		WEIGHT	SEX (CIRCLE)	HAIR COLOR	EYE COLOR
RESIDENCE ADDRESS					MAILING ADDRESS (IF DIFFERENT FROM RESIDENCE ADDRESS)					
CITY, STATE, ZIP CODE					CITY, STATE, ZIP CODE					

3- Oregon Health Plan application

Step 2 – Social Security number and ethnic or racial identity, continued		
Person 4	First/MI/last name:	Birthdate:
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Does this person have a Social Security number (SSN)?	<input type="checkbox"/> YES. If YES, give us their SSN _ _ _ - _ _ - _ _ _ <input type="checkbox"/> NO. If NO, tell us why: <input type="checkbox"/> Refuses to obtain an SSN due to religious reasons <input type="checkbox"/> Applied for SSN <input type="checkbox"/> Refuses to provide an SSN OR Does not have an SSN <input type="checkbox"/> Does not have an SSN and may only be issued an SSN for a valid non-work reason <input type="checkbox"/> Newborn without SSN <input type="checkbox"/> Not eligible for an SSN based on immigration status	
Ethnic or racial identity	<p><i>The answers to this question are optional and will not affect the decision about your coverage.</i></p> <p>Check here if you want to decline to answer <input type="checkbox"/></p> <p>African/African American/Black: <input type="checkbox"/> African American <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Other</p> <p>American Indian/Alaska Native: <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Canadian Inuit, Metis or First Nation <input type="checkbox"/> Indigenous Mexican, Central American or South American <input type="checkbox"/> Other</p> <p>Asian: <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Hmong <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino/a <input type="checkbox"/> Japanese <input type="checkbox"/> South Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other</p> <p>Hispanic, Latino: <input type="checkbox"/> Mexican <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Other</p> <p>Pacific Islander: <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Micronesian <input type="checkbox"/> Tongan <input type="checkbox"/> Other</p> <p>White: <input type="checkbox"/> Western European <input type="checkbox"/> Eastern European <input type="checkbox"/> Slavic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Northern African <input type="checkbox"/> Other</p> <p>Other: <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p> <p>If more than one is chosen, tell us the primary identity:</p>	

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