Children in French-Speaking African Immigrant Families: Assessing Health Disparities, Cultural Resources, and Health Services*

Tshilemalema Mukenge
Morehouse Research Institute
Ida Rousseau Mukenge
Morehouse College

Abstract

Research on African Americans in the United States assumes a native population and greater cultural homogeneity than exists. African immigrants, especially those with limited English proficiency, seem to be an *invisible* minority in research initiatives. We chose to study African immigrants because it is necessary to understand the cultural resources and practices of this population if public policies and programs are to address effectively the problem of health disparities. The present paper reports on a pilot study that focuses on the health and nutrition of children in French-speaking African immigrant families. We explored children's health implications of nu-

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trition, parents' concern with health issues, social networks, and patterns of health service utilization. Ethnographic interviews were conducted with 14 families in metropolitan Atlanta, Georgia. Preliminary findings suggest little concern for the relationship between food consumption patterns and children's health or the family's health overall. With few exceptions, culture, rather than nutrition or health considerations, dictates what the family eats and how it is prepared. Insurance coverage and eligibility for health benefits are the principal barriers to health care. In this report, we also discuss expansion and replication of such studies for other cultural groups. This kind of knowledge is invaluable for developing culturally competent methodologies and for implementing and evaluating culturally sensitive community intervention programs.Children in immigrant families are the fastest growing population of children in the United States (Research Forum 2002; FAIR 2001). The Urban Institute (2002) reports that welfare reform is reducing immigrant children's access to vital social and health services. Those with limited English proficiency are the most vulnerable (Zimmerman and Fix 1998; Fix and Passel 1999). For example, only half of the children receiving Medicaid saw a dentist in 2001, but only 30 percent of Black and Hispanic children saw a dentist in that year. In addition, more than one-third of America's children lack proper immunizations (AHRQ 1999 and 2001). These reports point to a need for studies that focus on the health disparities of children, especially those in immigrant families.

Almost 20,000 of Georgia's foreign-born population of African descent came to the U.S. in the decade between 1990 and March 2000. That is more than 65 percent of all the Black immigrants (30,608) from Africa in Georgia (USBOC 2000e). Atlanta's more recent African immigrants have greater adjustment challenges than earlier groups who came for education or business. Many have limited English proficiency or live in linguistically isolated households, or family contexts in which "all members 14 years old and over have at least some difficulty with English" (USBOC 2000a). Fourteen percent of the households in the nine-county Atlanta metropolitan area (Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry,

and Rockdale) where the household language is not English, Spanish, other Indo-European languages, or Asian and Pacific Island languages are linguistically isolated (USBOC 2000a and 2000b). These are primarily the African immigrant households. In households where all members speak a non-English language, almost 18 percent of the linguistically isolated are children between the ages of five and 17.

Some of Atlanta's African immigrants are refugees fleeing war, ethnic conflict, political repression, and economic hardship. Georgia averages about 3,100 official refugees per year (FAIR 2001; IRC 2000 and 2003). Public policies and programs must address social adjustment and health care for this population. To do this, we must also expand our knowledge of their culture and our ability to communicate with them (Research Forum 2002).

There is a dearth of knowledge about the health of the immigrant population in the United States. We have begun to see more studies, but they are still disconnected and limited in scope. Overall, African immigrants, especially those with limited English proficiency, seem to be an "invisible" minority in research initiatives. This pilot study is designed to address that gap in knowledge. Typically, research that focuses on African Americans assumes a native population and thus greater socio-cultural homogeneity than is warranted. The study examines links between culture and health, also raising the broader issue of cultural diversity within the Black U.S. population and the importance of that diversity in addressing health disparities. Within this context, our work supports two broad research goals.

The first is to expand our understanding of the impact of socio-cultural factors on health outcomes of children in African immigrant families, applying ethnographic methods and strategies of data collection and social science theories for data interpretation. We seek to locate, identify, and interpret cultural resources for good health and cultural barriers to good health. This kind of understanding marks a significant step toward mobilizing resources to improve health outcomes for vulnerable populations. The second is to advance insights for prevention and treatment models to be used in communities that have limited language skills, limited resources, or other impediments to vital information, services, preventive measures, and recommended behaviors. Particular emphasis is on children's health.

Theoretical Framework

This study applies the tools of ethnography and sociology in a framework to understand social and cultural factors related to health outcomes. Sociology brings concepts such as family functioning, protective processes and resiliency, relational resources, cognitive resources, and family ideology (Taylor et al 2000; Murry 1995, McCubbin et al 1998a and 1998b; Williams 1995; Stepick 1998; Quane and Rankin 1998; Hill 1971, Martin 1978; Stack 1997 [1971]; Clark 1983; Furstenberg, & Hughes 1995; Kibria 1994). Family functioning, rather than family size, structure, or household composition, is a fundamental concept for understanding health outcomes of children living in vulnerable environments. The theoretical framework assumes that families initiate protective measures to deal with risks. They adapt to challenges in their social environment by using cultural resources available to them to develop particular strengths or competencies to address the challenges. Research on Black families, going back at least to the 1970s, supports this assumption (Hill 1971; Stack 1997 [1971]; Martin 1978; Clark 1983; McLoyd 1990; Scott and Perry 1990; Jackson 1993; Lamborn, Dornbusch, and Steinberg 1996). These competencies, once identified, can be applied in intervention programs for at-risk children (Patterson and Garwick 1998; Taylor et al 2000; Felix-Ortiz and Newcomb 1992; Murry and Brody 1999).

Resiliency is the ability to overcome adverse circumstances in the environment or to recover from misfortune, even by families deemed fragile or fractured (Barabin 1993). It is an outcome of protective processes developed from cultural resources. Cultural resources may be cognitive, relational, or material. Identity, self-esteem, self-concept, and spirituality are examples of cognitive resources (Kamya 1997). Relational resources include social networks, voluntary group membership, and participation. Material resources refer to items from material culture such as food, technology, educational credentials, and housing. Recognition of protective processes derived from these types of resources defines the kind of research needed to inform culturally sensitive health promotion programs (Felix-Ortiz and Newcomb 1992; Furstenberg and Hughes 1995; McCubbin et al 1998; Spencer and Chen 2004). Our theoretical framework acknowledges cultural resources and the protective processes that may evolve from them.

Family ideology consists of the beliefs about family life that define the norms and expectations for internal household functioning and external relationships of the household and its members. Examples of family ideology include value constructs and definitions concerning family and non-family, obligations, rights and privileges, duties and performance standards, and patterns of authority. Studies of immigrant families (Portes, Kyle, and Eaton1992; Kibria 1994; McCubbin et al 1998a; Stepick 1998; Laguerre 2002; Gellis 2003) and other vulnerable populations such as the elderly (Johnson 1999) show that behavioral responses to certain aspects of family ideology can function as protective processes. For example, Haitian household configurations serve to integrate Haitian immigrants into the United States and continue to support needy family members back home (Laguerre 2002). Frail African American elders' expansion of kinship boundaries to include in-laws, even when the linking relative is deceased or divorced, contributes to their social anchorage and their physical and psychological hardiness (Johnson 1999). This study seeks to identify and understand cultural resources of African immigrants from French-speaking countries that are relevant to health outcomes for children.

Methodology

Context, meaning, and communication are essential to understand cultural processes that promote or inhibit positive behaviors for children's health. The ethnographic interview was our primary data collection instrument. The methodological assumption is that interviewing allows us to respond to the participants' personal and social contexts of meaning during the interview and during our analysis and interpretation. In our study, we seek to know how the participants construct their social realities and give meaning to them.Local ethnic immigrant organizations, churches, and community groups were contacted to help identify the families. A "snowball" recruitment strategy resulted in the identification of 14 families with at least one minor child in the household to participate in the study. Ten families are from the Democratic Republic of Congo, two are from Senegal, and one each from Guinea and Mali in West Africa.

After orientation and informed consent, interviews of approximately two hours each were conducted at the home of the partici-

pant family. We were sensitive to the importance of conducting the interview in a language that diminishes the disadvantage of limited English proficiency (Mishler1991). Therefore, participants were allowed to choose either French or English, whichever was most comfortable for them. Both the heads of household and the spouses were interviewed if they lived in the same household with the children. The questions were topic-focused but open-ended to allow participants to construct the contexts for meaning and communication. Topics included (1) health resources, knowledge, availability, use, and satisfaction; (2) health, diet, and nutrition practices and customs related to children's health; (3) self-assessment of personal health and children's health; (4) self-assessment of English proficiency, length of time in the U.S., and types of problems encountered since coming to the U.S.; and (5) involvement with relatives, neighbors, friends, and religious and voluntary associations. We recorded the interviews by hand and on an audio tape.

Findings

Food Choices and Preferences

Overall, families demonstrated little concern for the health consequences of eating and food preparation choices. With few exceptions, culture and affordability, rather than nutrition or health, dictate what the family eats and how it is prepared.

Staples. Eating habits are generally modeled after those from the home country. Thus, rice is preferred in West African households and, along with *fufu*;[1] it is the staple in the Congolese diet also. When the exact staple is not available, they use creative substitutes. For example, white rice, and couscous substitute for millet; instant mashed potatoes and cream of wheat substitute for cassava and corn flour to make *fufu*.

Vegetables and Fruits. Africans eat a variety of leafy green vegetables at home. Abroad, they eat the closest substitutes. All of the Congolese families cited cassava leaves and spinach as the most frequently consumed vegetables. Spinach substitutes for *lenga-lenga*, a green leaf vegetable also called *bitekuteku* in the Congo. Cassava leaves are often available in neighborhood Asian or African markets. Collard greens are also popular because their texture may be similar to squash leaves and their taste similar to another green leaf vegetable

called *muteta* in the Congo and "bitter leaf" in West Africa. Few families mentioned sweet potato leaves, possibly because of their scarcity in Atlanta markets. Other frequently consumed fresh vegetables were cabbage, green beans, broccoli, carrots, corn, tomatoes, turnip greens, okra, and potatoes. Eating raw vegetables, such as those served in salads, is rare even in urban African families. Two West African families reported that sometimes they eat salads with tomatoes, cucumbers, carrots, and avocados. Many consider eating such foods an unnecessary luxury because they do not satisfy hunger as more substantial cooked vegetables do.

Even families with limited resources eat fruits several days per week. Bananas and oranges top the list, followed by watermelon, apples, grapes, and mangoes in that order. Cantaloupe, peaches, limes, cherries, grapefruit, tangerines, pears, mandarins, avocados, pineapple, honeydew, and even coconut appeared among the wide variety of fruits consumed by these families.

Meat, Fish, and Poultry. Study families eat meat frequently but in moderate quantities. All cited chicken as the most often consumed meat, followed by beef, fresh fish, pork, goat, lamb, turkey, dried or smoked fish, liver, salted fish, and ground beef. Their priority is determined by cultural preferences, affordability, and availability

Processed Foods. Extensive consumption of processed foods, particularly canned foods, poses potential health risks because of the high levels of sodium, sugars, fats, and preservatives. Pre-cooked, frozen, and microwavable foods were rare in the diets of participating families. Even the consumption of frozen fresh vegetables is infrequent. One or two families buy frozen spinach, corn, mixed vegetables, okra, collard greens, and broccoli, but not often. The consumption of canned foods is minimal and sporadic. Together, the participants listed 16 different products that they consume from time to time. The most often cited products (tomato paste or purée, sardines, corned beef, peanut butter, green peas and beans, corned beef) figure in typical urban African recipes.

Snacks and Deserts. In Africa, snacks are usually peanuts (eaten raw, roasted, or boiled); fresh fruit such as bananas, mangoes, or oranges; boiled or grilled cassava or corn on the cob; fried plantains or bananas; and deep fried dumplings made from banana, plantain, or bean paste. America offers infinite processed snacks that can easily

be substituted for the homemade African snacks. Thus, when participants were asked to name some American snacks, they listed processed snacks such chips, cookies, crackers, popcorn, candy, gelatin, yogurt, ice cream, peanut butter, and jelly. Most families also included peanuts, an abundantly available African carryover that is inexpensive and nutritious.

Frequent consumption of processed snacks suggests a higher level of acculturation and economic security. Most participants reported that they eat snacks infrequently and irregularly Snacks are luxury foods that study families easily give up when they take away money for food that is considered essential for survival. Eight of the families interviewed are relative newcomers to America and are less secure economically. The families who eat snacks most often are headed by at least one parent who has lived for some time in the U.S. or in Europe and they are economically more comfortable. Snacks are also leisure foods. One couple stated that they did not have time for snacks because of their busy work schedules. Most of the snacks this couple listed were for the children. Participants do not usually eat deserts; if they do, it is fresh fruit at the end of a meal.

Drinks. One family indicated that the father drinks beer and the mother drinks wine. In another, family the father also drinks beer. In a third, the father drinks coffee. Parents in all families drink the recommended six to eight glasses of water. They only *assume* that their children maintain this good practice at school. Parents and children consume nonalcoholic beverages, including juices, milk, tea, and large quantities of various sweet carbonated beverages. Little consideration seems to be given to health risks that might be associated with heavy drinking of beverages that are high in refined sugars.

Cooking Styles. Water-based cooking is the main cooking style in participating families. Grilling ranks second. Frying and baking are third and fourth respectively. Sautéing, roasting, steaming, and micro-waving were rarely mentioned.

Oils. Where feasible, the families studied have kept food preferences, cooking styles, and seasoning traditions from home. Even foods that are not cooked in oil are seasoned with oil. Palm oil is very common and inexpensive in the African countries represented, but here, it is expensive and hard to find. Vegetable oils are the most

economical. They are also recommended over palm oil for cardiovascular health. Ten families listed vegetable oil and palm oil as the most frequently consumed in their households. They occasionally use corn oil, olive oil, canola oil, and soybean oil. Tradition and economics guide these choices.

Eating Out. Restaurant and carry-out foods are not popular among the African immigrant families we interviewed. Rather than running to a nearby fast food restaurant during the lunch break, they take food from home to eat at work. Even eating out with the family is rare. The few who eat out do so out of necessity rather than the desire for an enjoyable social opportunity. In any case, rarely is the choice of the restaurant or the food guided by health considerations. Only one family explained their preference for a particular buffet restaurant by the nutritional value of its foods.

Health Issues

Although not the result of *nutritionally*-informed choices, the diets and nutrition practices of the study families are overall more healthful than the typical diet of African Americans in Atlanta. However, financial constraints, inadequate insurance coverage, and hazardous working conditions introduce risks that cancel out many of the health protective effects of their diets.

Health Status of Parents and Children. In general, the parents were satisfied with their children's health. Children's immunizations are required for enrollment in school and secured yearly as required. Most parents could not provide specific information on types or schedules of immunizations, but they did know that all the requirements had been met through the school system. This attitude may pose a potential risk for younger children below school-age who also need protection from vaccine-preventable diseases.

Common children's illnesses such as colds, running nose, cough, and fever are treated at home if they do not appear serious. Children's more serious health problems included fever, nosebleed, skin and scalp rashes, ear infections, pneumonia, asthma, and eye problems (conjunctivitis). Of these health problems, only conjunctivitis was mentioned by more than one family. Parents cited a variety of health problems, including asthma, digestive disorders such as heartburn, gastritis, constipation, and hemorrhoids, dental problems, eye prob-

lems, diabetes, hypertension, heart disease, sickle cell, migraine, pneumonia, head injury, leg pain, back pain, vertigo, fatigue, and weight loss.

Four respondents, two men and two women, cited hypertension. Each of the remaining health problems was mentioned by one or two participants only. All digestive disorders were mentioned by the same individual. The person suffering from chronic back and leg pain attributed them to his job, as did the one with a head injury who cited an old work accident. In one family both parents have hypertension, but they keep it under control with diet and medication. They were aware of hypertension in the mother's family history.

Knowledge and Utilization of Health Services. We asked the study participants to identify the closest health facility to their residence. Almost all were able to name the nearest community health center or a clinic they have used or attempted to use.[2] Some health services have specialized programs. At the West End Heath Centers, for example, children under five years of age are treated free. Children beyond this age and mothers pay a minimal sliding fee based on income. Women and children in some of families have taken advantage of these services. A mother with three children aged two, five, and seven has used the services offered by this facility. She particularly appreciates the Center's inexpensive sliding fee. Another mother has received assistance through WIC, the Special Supplemental Nutrition Program for Women, Infants, and Children.[3]

Health care for adults is based on the extent of coverage available, costs, and triage-like decisions. For example, the father and the mother in a family on Medicaid have been screened for blood pressure, diabetes, and vision. Their last physical examination was within the past six months. She has also had a Pap test, but not a mammogram. She is 35 years old and seems to estimate that the health risks that would justify a mammogram are not imminent. Likewise, she says that her teeth are in perfect condition and there is no urgency to see a dentist.

Insurance and Access. Health insurance is either nonexistent or inadequate. Sometimes the only predictable access to health care is the routine screening of children for school. The health centers listed in the Appendix have some programs for assistance to needy

women and children, but there are few programs for adult men. The men who reported going to some of these health centers were either turned down or redirected to Grady Memorial Hospital. Although this is a county facility with sliding payment scales, they reported that Grady's fees are far above their means. One participant, a father of three, had his last blood pressure check and dental examination in 1998, just before he lost his health insurance.

One family has PeachCare for Kids[4] insurance for their children. They are very satisfied with this program and with the status of their children's health. The father is in good health also, but the mother suffers from sickle cell anemia and migraine headaches. Two months before the interview, the mother had a complete physical, a mammogram, and a Pap test. The father, however, has not had a physical examination in eight years or a blood pressure check in more than two years. He has never had a dental examination, an eye examination, or diabetes screening. PeachCare is only for children 18 and under who are citizens or who have lived in the U.S. for at least five years. The father was referred to Grady Memorial Hospital for care; however, one must have a social security number to receive reduced-fee services at Grady. He does not have a social security number; neither could he pay the full bill.

A family with no insurance is satisfied with the family's health. They have recently had complete physicals but without visual and dental examinations. Another family lives close to his county Department of Families and Children Services (DFACS). He knows about the services that DFACS oversees, such as the Peach Care for Kids, which he says is affordable. His application was turned down because he had not fulfilled the five-year residency requirement at the time of the interview.

Families in the study suffer many of the hardships of refugee families, but because they are not refugees, they do not qualify for many of the services that target refugee families. Newcomers especially are excluded from indigent care because of citizenship and residency rules. For example, another participant without insurance works at the Farmers Market. He lives close to the Indian Creek Trail Health Clinic in Gwinnett County. The clinic offers all kinds of health services, including preventive services and WIC. This participant, his wife, and five children do not qualify for any of these services.

The only exception is children's immunizations that are required for school enrollment.

In another family, the father who has lived in the city for one year and eight months knows where the Chamblee-Dunwoody Health Services facility is located and what services are available there. But, he has not used them except for children's immunizations because of eligibility requirements. He is being monitored for diabetes and has been screened at Grady Memorial Hospital, but not by a specialist. He would have preferred a private facility with a diabetes specialist, but he has no insurance and he cannot afford this level of care. His wife has qualified for health insurance with her employer, but it does not cover him and the children.

Four families are insured by Kaiser Permanente. One was completely satisfied. The other three deplored the absence of specialists at the clinic, difficulties and long delays, and long distances to be seen by recommended providers. Some participants with health insurance coverage complain that they cannot leave work to go the doctor. The doctor's office hours are the same as the participants' work hours. Doctors' offices close by 5:00 pm and few have weekend or evening hours. This situation often leads their being forced to substitute the emergency room for primary care.

Social Networks

Food preferences and diet are based on cultural patterns that have persisted in the new environment. How and why do these patterns persist? Health behaviors are adaptive. Study families must obtain resources to meet needs that cannot be met with their incomes or the social services available to them. How are these resources identified and cultivated? An examination of social networks, family ideology, and family functioning may offer some explanations about the agency of culture in protective processes and resiliency.

Family Ideology and Parenting. Communal parenting, where adults informally share parenting duties, is a common practice in most African traditions.[5] Co-parenting or fostering sometimes takes the form of sending one's children away to live with relatives without any monetary compensation for their maintenance or other expenses such as school fees. The parents trust that the host relatives will take good care of their children as if they were their own.

Family and School. These parenting norms and values are transferred to similar expectations of other adults involved in caring for their children. Comparable trust is extended to teachers during school hours, and parents expect that their children will show teachers the same discipline and respect as parents and other adults. The families we interviewed in Atlanta seem to perceive American schools as going beyond the traditional African expectations. In their eyes, the immunization requirement for school enrollment is tangible evidence that schools care for their children's welfare. Most study participants were unable to name the required immunizations, but they were confident that their children were properly immunized because of the requirement. Furthermore, the school system provides transportation and meals, sometimes free or at reduced costs. Both services are perceived as excellent opportunities, without consideration of potential disadvantages or health risks, especially associated with school meals. The parents we interviewed are not concerned with the quality of food their children eat at school. They seem to trust that the schools will make the right decisions about their children's nutrition, just as they do with immunizations.

Relatives and Friends. African immigrants participate in two other important types of social networks: friendly families and religious institutions. Study participants came to Atlanta by choice. Most had learned of Atlanta from a friend or relative, from the city's association with the Civil Rights Movement, or from its reputation as the host of the 1996 Olympic Games. One family who moved to Atlanta from New York said that the city presented a better environment for rearing children. A few families came directly from Africa as students, political exiles, or winners of the immigration lottery. When they first arrived, those who helped most were people they had known in Africa or former classmates. The relatives or friends who welcomed them provided hospitality, information about job opportunities, and financial assistance. In a few cases, support included sponsorship, or even payment of travel expenses for the individual or the family from Africa to the U.S.

Old friendships persist after the newcomers establish themselves, but the number of friends and acquaintances grows as they become more active in the African immigrant community. Most of their friends are from the same country or of the same ethnic group.[6]

A few are Africans from other countries. Some have Black and White American friends who are co-workers, former classmates, or individuals they knew from Africa. However, they interact more with their African friends, particularly those from the same country or same ethnic group. Friendly families visit each other, communicate often by telephone, and sometimes e-mail. Together, they celebrate family events such as births, baptism, and graduation. They mourn together and contribute money when one of them is bereaved. When visitors come from home, the other friendly families invite them for a special dinner. Friendly families observe parenting traditions. The children in one family call the parents in the other family *uncle* and *aunt*. When parents in one family have to be away from home without their children, they leave them in the care of their co-parents. Such practices further reinforce the parenting norms of child-centered family ideologies that depend on mutual trust and confidence that the children will be well cared for.

Study participants have also assisted other African newcomers with hospitality, money, and advice. Some still have other relatives living with them. All send money home to help relatives and they maintain communication by telephone with friends and relatives in Africa. These practices help to conserve other African norms and values that may be instrumental in adapting to the new setting.

Family and Church/Mosque. Spirituality is a salient value of the study participants and their religious organizations mean a lot to them. They also exhibit a strong belief in God, including respect for the power of communal and individual prayer. All participants regularly attend religious services in churches or mosques. These associations are the source of vital cultural resources that are cognitive, relational, and material.

Most participants are Christians. Some attend American churches. Others have their own small churches, with their own pastors, their own liturgy, and their own music, although often without their own church buildings. Participants reported that the church provides a family atmosphere that is embedded in fellowship, meeting people and exchanging views. It is a forum where faith grows, is strengthened and renewed. The church gives them a deeper understanding of life events and, in general, makes their lives more meaningful. They believe that prayers can alleviate the burden of life's hard-

ships. In the church, their children learn the essentials of moral and disciplined life. It is a setting that reinforces conformity to the regulations of life in society. In addition to being a context where cultural traditions are cultivated and passed on, the immigrant church is a resource to lean on in times of need.

Some immigrants receive substantial assistance from churches. For example, through an anonymous donor, a church paid transportation from Africa for one study participant's wife and children. Pastoral care is also available on a continuous basis. Personal interventions by the pastor or influential church members have been instrumental in securing employment. They write letters of recommendation and support for housing, business permits, or other administrative actions on behalf of their members. Usually, these are mainline denominations or international churches with headquarters and branches outside Georgia.Study participants also praised their churches for non-material benefits. A mother who converted from Islam to the Unification Church praises this church for freedom from restrictions she experienced in Islam relative to age or to the role of religion in life. She also commends the church for its education of the faithful through preaching. "You learn things that may help you change your heart and your life. Now, I understand many things, thanks to the church."

The Mosque and its international community are important to the Muslim families we interviewed. It provides a sense of identity, social anchorage, and participation. "I go to the Mosque on Fridays to pray if I am not working," declares a Muslim father who has lived in Atlanta for five years. "I pray at home. At the Mosque I feel like I am back in Africa," says the mother. "At the Mosque, you see people who dress like you, you exchange news, and you meet new people." Both appreciate the fact that their mosque is close to home. "When it is time for prayer you go without difficulty." The majority of the members are African Americans. In another family, he does not go to the mosque often. She prays at home. Nonetheless, the mosque means a lot to them. They were born and grew up in the Muslim tradition. The mosque helps them keep up with that tradition. People from all over the world attend their Mosque. In another family, the father attends prayers at the Mosque on Fridays. He practices Islam because his parents practice it. His Mosque is attended by

Indians, Arabs, Pakistanis, Africans, and African Americans, but not by Whites.

Patterns of Religious Affiliation. Study participants have strong religious convictions, but they are flexible in their affiliations. Three families are Muslims and have been Muslims since childhood. Three of the Christian families have always been Catholic and two have always been Presbyterians. The remaining families reported some change of religious affiliation. A family from West Africa has converted from Islam to the Unification Church. One participant is a former Protestant who has become Catholic. In one family, the father was Catholic and the mother was Muslim. Now they are both Catholic. In another, he was Catholic; she was Presbyterian; now they are both Catholic. In a family of a former Catholic man and a former Muslim woman, both now attend a Christian non-denominational church. Of three former Catholic families, one belongs to the Unification Church, one is Methodist, and the other is Pentecostal. Another Pentecostal family is headed by a father who was Presbyterian and a mother who was Catholic. None of the families declared any association with traditional African religions of their country.

The changing patterns of affiliation and instrumental approaches to religion are not surprising. Differences are more in the packaging than in the messages. Therefore, shifting between religious affiliations often denotes nothing more than a desire to make better sense of life circumstances, consolidate networks, or take advantage of material resources rather than a disturbance in profound religious beliefs (Ndeke 1994).

Cultural Resources and Resilience

We observed a success ethic that is common to all the study participants. It is characterized by willingness to work hard even in jobs that may not be commensurate with their level and type of education and training. Some participants are college graduates, including two with a doctorate in their fields of study. They have worked as produce stockers at the DeKalb Farmers Market, as dish cleaners in restaurants, and as security personnel in variety stores.

High achievement orientation, a determination to get ahead and do well despite barriers and limitations, is another major characteristic of the success ethic. An entrepreneurial spirit is also prominent, whether it is in business or other enterprises. For example, tech-

nical skills such as cooking, tailoring, hair braiding, retail trade, and ministering have been adapted to opportunities available in Atlanta. The most impressing example of entrepreneurship is a study participant who came from West Africa with only $100 in his pocket. All he needed to get started in the pursuit of his American dream was a place to buy small items that he could sell on the street. Later, he translated a love for cooking and an aptitude for culinary arts into his current job as chef in a restaurant chain.

Formal education is highly valued. A participant who was a cofounder and assistant pastor of a small church fulfilled his ambition to start his own church. While working for the church and as a computer technician, he took classes to upgrade his knowledge and performance. Now, he is negotiating the purchase of a large facility so his congregation will not have to rent space. His goal is to have a church of their own with ample space for community meetings, social events, and service delivery.

Acculturation. Adaptive cultural change fostered by prolonged contact with the dominant culture of the host society is inevitable. Incipient signs of acculturation are evident in the behaviors of the study families. Perhaps most apparent are food choices. An optimal African meal consists of a staple food, vegetables, and meat and or fish. In the absence of preferred vegetables or the traditional ingredients for making the staple, local substitutes are readily adopted. Thus, instant mashed potatoes and cream of wheat are used as substitutes for corn flour and cassava flour in the making of the staple *fufu*. Spinach substitutes for *lenga-lenga*, a green leaf vegetable that is rarely available. Likewise, what would be considered ordinary everyday food becomes a treat when available and special foods become ordinary. For example, in the countries represented, chickens are a highly valued food item. They are killed for food only on special occasions because of their economic value for eggs and breeding supplies. In Atlanta, chicken has become a common everyday food because it is cheap, abundant, and without broader economic value.

Acculturation is also apparent in the patterns of snack consumption. Processed American snacks, such as potato chips, cookies, crackers, popcorn, and candy are gradually overshadowing traditional African snacks such as cassava, corn on the cob, and peanuts. Families who reported the highest frequency of processed snack consumption are also those who are more economically stable. Par-

ents in these families have lived longer in the United States or in Europe. In contrast, families with more limited means do without processed snacks because they cost extra money that can be used for more essential foods. These families are also relatively new to America.

Children are more susceptible to acculturative influences than the parents are. Because of their age, they are naturally more open to leaning and they receive greater exposure to the host culture at school. Learning experiences in the classroom, sports, other extracurricular activities, riding the school bus, and eating in the school cafeteria, all contribute to integrating the children of immigrants into American culture. School cafeteria food, snacks, and refreshments in school vending machines are typically American. Children develop a taste for these foods and gradually come to prefer them over foods regularly served at family meals. For example, parents in the participating families often expressed their own preferences for cassava leaves and collard greens while the children prefer salads. Children prefer breads and sandwiches over rice, the parents' preference. Parents snack on peanuts, the children on potato chips. When the parents eat *fufu* for dinner, the children have boiled potatoes.

African values are conserved primarily through culturally homogeneous social networks. Friends and relatives in the U.S. and Africa along with religious institutions help immigrant families deal with the harsh conditions of life in the U.S., giving added importance to these networks. In addition to material support and cognitive resources of spirituality and identity, relational resources that are essential for social anchorage are available through religious institutions. African family ideology characteristic of the study population endorses child-centered parenting styles. In this context, the parents' attitudes toward the school as *co-parent* enhance the power of the school as an agent of acculturation and expedite the children's assimilation into American culture.

Concluding Observations

This study was designed to identify food consumption patterns, health practices, and social networks in families of immigrants from French-Speaking African nations and residing in metropolitan Atlanta. Special emphasis is on parental behaviors relating to children's health. Parental behaviors were assessed as potential resources for, or hindrances to children's good health.

Parental choices of food, although not guided by health considerations, appear to be conducive to good health. Most participating families follow a balanced regime consisting of home cooked staple foods, green vegetables and meat in moderation. They consume fresh fruits on a regular basis. Their daily consumption of water seems adequate. Water-based cooking is the most common. These food consumption patterns are generally associated with good health. With the exception of high-sugar-content non alcoholic beverages, most study families consume limited amounts of foods deemed risky for health. Processed canned foods, snacks and deserts, frozen foods, fast foods, carry outs from restaurants, and eating out in restaurants are minimal and sporadic.

Social networks of relatives and friends are the most active in the lives of African immigrants as providers of hospitality, information about job opportunities and financial assistance. Most friends are from the same country. Home visits, telephone calls, celebrations of family events, and sharing child care when needed are common practices.

Churches and mosques offer opportunities for greater networking and social and mental adjustment. Fellowship, a deeper understanding of life challenges, increased faith, teaching children good conduct and moral discipline, pastoral care, and material assistance are among the most appreciated benefits of belonging to a church or mosque. Participants perceive them as vital contributors to the family's overall well being. The observed resilience in these families is due in large part to these networks and the cultural continuity they promote.

Particularly important for children's health is family networking with the school. The school affects children's health by requiring annual immunizations for admission, providing meals, and requiring that parents keep sick children at home until they pose no risk of contaminating other students. As with relatives and friends, parents trust that school administrators and teachers will act in the best interest of their children and tend not to monitor the quality of food their children receive from the school cafeteria.

Parents are aware of their children's health needs and knowledgeable of the available health services and ready to take advantage of the benefits that health facilities provide. Community health cen-

ters provide child and maternal health care quite adequately. Access to heath care is more difficult for women's other health needs and especially for men. Lack of health insurance or inadequate insurance coverage is perceived as a major impediment to good health.

Directions For Further Research

This pilot calls for a more comprehensive study of health disparities that disproportionately affect people of African descent in the United States. It has revealed the presence of some conditions such as heart disease, hypertension, and diabetes among the participants. However, the fourteen-family study population is too small to make generalizations about other African immigrants in Atlanta. There is a need for a larger study of nutrition and health practices including an inventory of prevalent health conditions. The inclusion of immigrants from countries where English is spoken may yield additional insights, as some problems may be related to language proficiency.

The present study was concerned more with families' behaviors and practices than with their knowledge and perceptions. It did not include questions about participants' understanding of the nutritional value of the foods they eat and the potential health consequences of these foods. A larger study is needed to investigate nutrition health literacy relative to typical foods, common diseases, and their connection to diet and cooking styles.

The study of health disparities subsumes cultural differences among social groups both in food consumption patterns, susceptibility to certain diseases, and attitudes toward diseases. Environmental factors also differ in the ways they affect different groups and in the intensity with which they affect them. A comparative study of African immigrants and native African Americans in these respects can reveal the differential impact of culture and the social environment on the two groups in the same society.

We have conducted a study of diet and health practices similar to the present study with 11 families of Salvador, Bahia, Brazil. We have also conducted a study of nutrition and health literacy with 10 Afro-Mestizo families in El Ciruelo, Oaxaca, Mexico. A comparison of the findings from these two studies and Atlanta studies on African immigrants and native born African Americans will provide a base for a better understanding of nutrition-related health dispari-

ties among people of African descent in different geographic regions of the Diaspora.

Notes

1. *Fufu* is similar to a large dumpling. In the Congo, it is most often made from cassava flour and corn flour or either flour alone. In West Africa it is made with cassava, rice, and plantain.

2. They mentioned the following centers:

Fulton County Health Center in College Park	West End Medical Center
De Kalb Women and Children Health Services	Grady Health Center in East Point
Family Medical Center, Old National, College Park	Kaiser, Crescent Northlake Mall
Kaiser Clinic	Clifton Springs Community Center
Grady Memorial Hospital	Oakhurst Community Medical Center
De Kalb Medical Center	Eggleston at Gwinnett Medical Center
Southside Medical Center – Gresham/DeKalb Office	Chamblee-Dunwoody Health Clinic, at Indian Creek Trail

3. WIC serves to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk. The program provides vouchers for milk, juices, and nutritious foods to supplement diets, as well as information on healthy eating and referrals to health care. In Georgia, the Department of Human Resources (DHR) oversees the WIC program, which is administered through the county DFACS offices.

4. Title XXI of the Social Security Act provides states with the opportunity to create programs to increase access to affordable health insurance for children. In Georgia, this program is PeachCare for Kids. It provides

comprehensive health care to children through the age of 18 who do not qualify for Medicaid and live in households with incomes at or below 235% of the federal poverty level. Services include physicians visits, preventive services such as immunizations and regular check-ups, specialist care, dental care, vision care (including vision screenings and eyeglasses), hospitalization, emergency room services, prescription medications, and mental health care.

5. In typical African villages, practically all adults take on the responsibility to monitor children's behaviors, praising good conduct, reprimanding misbehavior, and reporting it to parents who apologize for the child"s misbehavior and correct it. Adults share meals not only with their own children but also with the children of neighbors and relatives.

6. Because of population movements in the pre-colonial era and the manner in which African nations were created during the colonial era, many African ethnic groups spread across contemporary national boundaries. In this study, the participants from Guinea and Senegal were of the same ethnic group.

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