**REVIEW ARTICLE**

# Health, Adjustment and Well-Being in the African Diaspora: Trends in Research December 2007 to June 2008

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Articles relating to health, adjustment and well-being in the African diaspora are relatively rare in Africanist journals. However, many articles on these topics are published elsewhere. This review summarizes articles relevant to these topics for the diaspora from sub-Saharan Africa. All the articles became available in scholarly journals between December 2007 and June 2008. The review encompasses people who were displaced within Africa and those who have settled as refugees, asylum seekers or immigrants in Western countries. Articles on people displaced within Africa are included because it is important to remember that the majority of people dispersed from their homelands remain within the continent and because such articles provide insight into the prior living conditions of Africans who become refugees and asylum seekers in countries of resettlement. Because these are vulnerable populations, and questions relating to health, well-being and adjustment are sensitive topics, it is important for ethical reasons, as well as for the quality of scholarship, for researchers, policy makers and practitioners with an interest in these topics to be aware of the research that already exists.

The review is organized in terms of common themes, the region of origin of participants, and the level of specificity in the description of participants.

## Articles that explicitly focus on East Africans

### Oral health

Some of the most topical subjects in research specific to immigrants and refugees from East African are practices that are viewed by Western dentistry as dental mutilation. Several traditional practices bring East African patients to the notice of dentists in countries of resettlement. One of these is "ebinyo", the surgical removal of the primary canine tooth follicles of infants.[1] This surgery is usually conducted by traditional healers and other village elders in the belief that the underlying tooth follicles, which are perceived to resemble worms, are the cause of high temperature, vomiting, loss of appetite and diarrhoea in infants. The practice is widespread in rural areas of East Africa. It risks immediate infection because the instruments are rarely sterilized and can cause a number of dental problems later in development.

[1] Edwards, Levering, Wetzel & Saini (2008).

Ritual dental extraction in the Sudan has been a particular focus. One study reported on Dinka and Nuer refugees to the US who had requested the replacement of missing anterior teeth (i.e., the six upper and six lower front teeth) that had been removed in ritual extractions during their childhood.[2] Many of the patients were missing a large number of teeth. The report focused on 36 Sudanese refugees, on whom a total of 238 extractions had been performed. Another study, conducted in Australia, reported on a case that illustrates one of the subsequent dental problems that can occur following ritual tooth extraction. The article described a rare type of benign tumour (an erupted compound odontoma) seen in a 15-year-old immigrant Sudanese boy who had undergone traditional extraction of his primary teeth earlier during his childhood.[3]

The oral health of Somalis living in the US has also been of interest.[4] A specialist clinic in a university dental school in Minnesota found that many Somali adults rated their oral health and access to dental care only as poor or fair.

**Mental health: Displaced children remaining in Africa**

Mental health issues have also been a focus of research. The mental health of displaced Sudanese children remaining in Africa was the topic of several studies. Morgos, Worden and Gupta reported on psychosocial distress amongst children from Southern Dafur.[5] They found that the children had been exposed to a very large number of war experiences. There was no difference in exposure to war experiences, including rape, between boys and girls. However, there were age differences in such exposure. Children aged 13-17 years had greater exposure to war experiences than children aged 6-12 years. High levels of psychological distress were found. Three out of four children met the diagnostic criteria for post-traumatic stress disorder, more than one in three showed clinical symptoms of depression and one in five showed clinically significant symptoms of grief. Increased exposure to war experiences was associated with higher levels of symptoms of traumatic stress, depression and grief. However, different war experiences were associated with the three different symptoms. Of the sixteen war experiences that were assessed, four (abduction, hiding to protect oneself, being raped, and being forced to kill or hurt family members) were most predictive of traumatic stress. An overlapping group of five experiences (being raped, seeing others raped, the death of a parent, being forced to fight, and having to hide to protect

[2] Willis, Harris & Hergenrader (2008).
[3] Amailuk & Grubor (2008).
[4] Okunseri, Hodges and Born, 2008).
[5] Morgos, Worden and Gupta (2007-2008).

oneself) were the strongest predictors of symptoms of depression. Abduction, death of one's parent/s, being forced to fight, and having to hide to protect oneself were the war experiences most strongly associated with grief. That is, the study identified the war-related traumatic events most frequently experienced by the children and showed their varying impact on the children's psychological well-being.

Chaiken also focused on children from Dafur.[6] She outlined a series of concerns surrounding these children, described how current strategies are failing, and proposed several public health nursing interventions.

A third study examined the mental health of young adults from Southern Sudan who were formerly traumatized as slaves or child soldiers.[7] It reported on the successes and failures of governmental and non-governmental rehabilitation programs and compared programs in Sudan to those in other parts of Africa (Angola, Ethiopia, Ghana, Liberia, Mozambique, Sierra Leone and Uganda) and in other regions (Afghanistan, India, Sri Lanka and the United Arab Emirates). The author attempted to identify pitfalls to be avoided and the best practices to be followed.

**Mental Health: Resettled in Western countries**

Issues surrounding mental health have also been explored for Africans resettled in Western countries. One Australian study compared accounts of depression by laypeople who were either Anglo-Australians or members of the Australian Ethiopian and Somali communities.[8] On the basis of focus groups and individual interviews, the study identified similarities and differences in understandings of depression between the two groups. Anglo-Australians tended to portray depression as an individual experience: depression was framed as a personal misfortune, and a condition that is socially isolating. In contrast, Somali and Ethiopian refugees living in Australia explained depression in terms of family and broader socio-political events and circumstances. They often framed depression as a condition that is both collectively derived and collectively experienced.

The mental health of Somali refugees was also the focus of several other studies. Ellis, MacDonald, Lincoln, and Cabral (2008) examined the association between four risk factors (trauma exposure, post-resettlement stressors, acculturative stressors and perceived discrimination) and mental health problems in Somali adolescent refugees resettled in the U.S.[9] They

[6] Chaiken (2008).
[7] Fegley (2008).
[8] Kokanovic, Dowrick, Butler, Herrman and Gunn ( 2008).
[9] Ellis, MacDonald, Lincoln, and Cabral (2008).

found that cumulative exposure to traumatic events prior to resettlement was associated with symptoms of both post-traumatic stress disorder and depression. However, the types of recent events that were associated with post-traumatic stress disorder and depression differed. Stressors that were experienced after resettlement, acculturative stressors, and perceived discrimination were also associated with greater symptoms of post-traumatic stress disorder. A smaller number of factors were associated depression: number of years since resettlement in the US and perceived discrimination.

Nilsson, Brown, Russell, and Khamphakdy-Brown examined the association between psychological distress and two factors, acculturation and domestic violence, among married female Somali refugees living in the US.[10] Women who reported greater ability to speak English reported more experiences of both psychological abuse and physical aggression by their partners. Greater experience of psychological abuse and physical aggression were associated with greater psychological distress.

Research has also focused on the mental health of Sudanese refugees. One study examined the relationship between psychological distress and functional health outcomes for the "Lost Boys" of Sudan who had been resettled in the US.[11] The participants were Sudanese refugee minors who were currently receiving foster care organized by the U.S. Unaccompanied Refugee Minors Program. They found that service use was high. Almost half the participants received counselling and three out of four had sought medical care for symptoms or problems often associated with behavioural and emotional problems. However, the association between service use and adjustment was unclear. Participants with post-traumatic stress disorder were no more likely to receive counselling than their peers without post-traumatic stress disorder. In addition, counselling was not associated with the functional health outcomes. Formal services were not the only source of support for the participants. As a result of services provided by the URMP, the participants received high levels of psychosocial support despite the absence of their biological parents.

**Physical health**

Other topics of research included vaccination and unusual medical conditions in East African refugees who have been resettled in Australia. One study assessed both self-reported vaccination status and pathology tests of immune status of adults resettled from East Africa.[12] The results showed a high level of vulnerability to potentially life-threatening infectious diseases. Four out of five participants had inadequate immunity against at least one of tetanus (67%),

[10] Nilsson, Brown, Russell, and Khamphakdy-Brown (in press, 2008).
[11] Geltman, Grant-Knight, Ellis & Landgraf (in press 2008).
[12] Skull, Ngeow, Hogg & Biggs (2008).

hepatitis B (41%), diphtheria (34%) or measles (3%). This was despite the participants having made many visits to services that could have provided vaccination since their arrival in Australia (median = 7 visits). In addition, about one in six patients tested positive to tuberculosis on a Mantoux test.

Daveson and Macdonald reported on a puzzling medical condition shown by a 37-year-old male Sudanese refugee in Queensland.[13] The man was diagnosed with periportal fibrosis. Fibrosis is the name given to scar tissue that results following persistent inflammation. Fibrosis in the liver is serious and can eventually lead to organ failure. The man's condition was characterized by lethargy, nausea, abdominal discomfort and bloating. He had chronic hepatitis B and a 2-year history of hazardous levels of alcohol consumption (90 g/day), which may have affected liver function. However, examination showed no evidence of chronic liver disease.

**Ethiopians in Israel**

Another focus of research has been the adjustment of Ethiopians who have settled in Israel. One study compared the self-concept of child and adolescent immigrants from Ethiopia with those of native-born Israelis.[14] Among children, self-concept was higher among native-born than Ethiopian immigrant children, while for adolescents the pattern was reversed. Ethiopian adolescents appeared to be more closely associated with their peer group, while younger children appeared to be more closely associated with their immediate family. Self-rated language proficiency appeared to be associated with several aspects of self-concept. It was noted that the gap between the host culture and refugees is often wider than that for voluntary migrants. The author made several recommendations related to language, family, and inter-group relations. Another study of Ethiopian adolescents in Israel examined the association between ethnicity, culture and adolescents' attitudes to filial responsibility toward aging parents.[15] The results support the role of culture as an important factor in shaping perceptions of filial responsibilities. Ethiopian immigrant students scored higher than local students on all dimensions of filial responsibility.

A third study focused on patterns of mourning in adults.[16] It found that bereaved Ethiopians living in Israel faced a "double" cultural discrepancy. One discrepancy related to differences in cultural and mourning practices of Jews in Ethiopia and Israel. The second discrepancy was between the professional team in a mental health centre and their Ethiopian patients. The authors

[13] Daveson and Macdonald (2008).
[14] Tannenbaum (2008).
[15] Sultany, Lavie & Haimov ( 2008).
[16] Grisaru, Malkinson and Witztum (2008).

identify a number of culturally sensitive factors relevant for professionals intervening with displaced and bereaved individuals and families.

**Somali identity**

A relatively large number of articles focused on Somalis living outside Somalia. Most of these have touched on issues of identity, either among Somalis displaced in Africa or those resettled in Western countries. Prouse de Montclos studied the ways in which experiences influence the construction of the identity of Somali refugees living in Kenya.[17] The author argues that new forms of forms of collective identification have emerged not only as a result of armed conflicts, massacres, and forced migrations but also as a result of international aid organizations' practice of gathering refugees together into camps. One of the results is the emergence of "communities of suffering." Bigelow examined the issues of race and religion faced by Muslim Somali adolescents resettled in Minnesota.[18] The author made a series of suggestions about how teachers can engage classes in discussions about race and religion in ways that will both make Muslim students feel more welcome, and help all students to understand racial and religious identity. Kleist studied the association between identity, transnational politics and development in Somali adults resettled in Western countries.[19] A transnational conference of Somalis was used as a case study to examine the tensions between affiliation to specific groups based on lineage and a broader identification with the region. The author analyses the patterns in transnational mobilization and loyalties among Somali communities and argues that the 'diaspora position' is linked to issues surrounding identity, the recognition of status, and "the enactment of proper and respectable masculinity". Other studies have focused on Somali women. Bassel examined the experience of Somali refugee women living in France.[20] The article uses Louis Althusser's concept of interpellation to examine models of citizenship. It is argued that such models serve to restrict the claims of refugees through the imposition of a dominant hierarchy of identities and needs.

An exception to this focus on identity was provided by Patel's examination of the equivocal attitude towards the social use of the drug known as khat in Western countries.[21] The scientific name for khat is Catha edulis. It is an evergreen shrub cultivated in the Horn of Africa. The leaves contain a stimulant that has long been used for social and recreational purposes. Recently, there has been an increase in use of "khat" by East African

[17] Prouse de Montclos (2008).
[18] Bigelow (2008).
[19] Kleist (2008).
[20] Bassel (2008).
[21] Patel (2008).

immigrants to the UK. The Somali community in the UK is divided in its attitude towards khat: some perceive its use to be harmful, others believe that it serves an important social function and increases the cohesiveness of the community. Currently, the UK government has not classified khat as a controlled substance. Therefore, its use remains legal. However, the Advisory Council for the Misuse of Drugs (ACMD) recommended that more information about the use of khat, and its risks, be provided to the healthcare professions and users of khat. It also recommended that ways should be found to make it easier for khat users who wished to do so to access treatment.

## Articles that explicitly focus on West Africans

During the review period fewer articles were published about the health, adjustment and well-being of West Africans.

### Well-being of children from Sierra Leone

The well-being of Sierra Leonean children was studied both in displacement within Africa and in countries of resettlement. Davies examined the needs of refugees from Sierra Leone in public schools in New York City.[22] The research involved interviews with teachers and students and observations at a school. It concluded that limited proficiency in English caused by interrupted schooling was the greatest barrier to the students' integration.

Gupta and Zimmer examined the effectiveness of an intervention to address educational needs and psychological distress among displaced children in Sierra Leone.[23] The Rapid-Ed intervention is a four-week program designed for children in post-conflict settings. It combines basic education with activities to heal trauma. Children who had been displaced by war were interviewed about their war experiences and reactions to the violence before and after participating in the intervention. After the intervention two symptoms of post-traumatic stress disorder (intrusive thoughts and high levels of arousal) decreased. The children also showed greater optimism. However, one symptom of post-traumatic stress disorder (avoidance) increased. The interpretation of this pattern of findings was hampered by the absence of a control group.

### Health in Australia

Nyagua and Harris explored the cultural background of one health practitioner from West Africa in order to highlight potential areas of misunderstanding

[22] Davies (2008).
[23] Gupta and Zimmer (2008).

between practitioners trained in West Africa and Australia. The example is used to explore culturally sensitive practice.[24]

## Studies of unspecified "Africans" or participants from several African countries

### Nutrition

Many studies did not identify the country of origin or ethnic background of African participants. Three such studies focused on diet. One study examined dietary acculturation among African refugees newly resettled in the US.[25] The authors presented a conceptual model to address the choice of diet and activity among Liberian and Somali Bantu refugees. This model shows how institutional support, peer support, and interactions between children and caretakers might offer useful points for intervention. An Australian study examined vitamin D deficiency in immigrants from Sub-Saharan Africa.[26] It found that there were lower vitamin D levels in participants with latent tuberculosis infection than in those with no tuberculosis infection, with tuberculosis, or past tuberculosis. The third study focused on a nutritional intervention in a Zambian refugee camp.[27] It studied the effect of introducing fortified maize meal to rations in the camp on vitamin A and iron status in children, adolescents, and women. A daily ration of 400 g per person of fortified maize meal led to a decrease in anaemia in children and a decrease in vitamin A deficiency in adolescents. The authors concluded that fortification of maize meal is a feasible and pertinent intervention in food aid even though it does not have a uniform effect for all recipients.

### HIV/AIDS

Another studied focused on HIV in countries of resettlement. Ndirangu and Evans (2008) reported on a qualitative study of the experiences of eight African immigrant women in the UK who were living with HIV.[28] The women's ability to live positively with HIV was found to be influenced by their migration history, their legal status, their experience of AIDS-related stigma and their Christian faith. In interviews, the women represented the health services they attended as safe social spaces that were highly valued as sources of advice and support.

[24] Nyagua and Harris (2008).
[25] Patil, Hadley & Nahayo (2008).
[26] Gibney, MacGregor, Leder, Torresi, Marshall, Ebling, & Biggs (2008).
[27] Seal, Kafwembe, Kassim, Hong, Wesley, Wood, Abdalla, & van den Briel (2008).
[28] Ndirangu and Evans (2008).

## Research focusing on both African and non-African groups

### Adjustment in Australia

A diverse array of studies included unspecified "African" participants along with other participant groups. Several of these focused on adjustment in Australian contexts. Among these were a study of job-finding and the development of social networks among skilled refugees from former Yugoslav, African and Middle Eastern backgrounds now living in Perth.[29] The paper explored refugees' perception and use of the "Job Network ", a group of employment service providers contracted by the Australian government. Data were collected through interviews with the employment service providers and other key informants. There was a mismatch between service providers' and refugees' perceptions and expectations of the employment services. Refugees perceived the Job Network services and especially the job training they provided as an opportunity to develop social networks rather than to learn specific skills relevant to seeking a job in Australia. The authors apply the concept of "linking social capital" (the capacity of individuals to leverage resources, ideas and information from institutions beyond their immediate communities) to labour market integration of refugees in Australia. Viewed from this perspective, even though Job Network failed to provide the services that refugees needed, their activities were useful for developing "linking social capital". A second study by the same research team examined the apparent paradox between the high levels of discrimination reported by humanitarian entrants to Australia both in the labour market and in everyday life, and these entrants' reports of positive well-being.[30] The study was based on quantitative and qualitative data from refugees from the former Yugoslavia, the Middle East, and Africa. Three possible explanations for their well-being were explored, "relative deprivation theory", resiliency factors and moderating factors, including personal and social supports. Negative experiences appear to be associated with low-level dissatisfaction and are expressed as directed or contained disappointment, rather than as serious dissatisfaction with life generally, negative orientation to Australia, or negative subjective well-being.

### Mental health

Several studies have examined the mental health of different groups of young refugees, including those from Africa. Hodes, Jagdev, Chandra and Cunniff compared the mental health of unaccompanied asylum-seeking adolescents and accompanied refugee adolescents in London.[31] The 13- to 18-year old unaccompanied adolescents were predominantly from the Balkans and Africa.

[29] Torezan, Colic-Peisker and Fozdar (2008).
[30] Fozdar & Torezani (2008).
[31] Hodes, Jagdev, Chandra and Cunniff (in press, 2008)

They had experienced high levels of loss and war trauma. Risk factors for posttraumatic stress symptoms included low-support living arrangements, being female, higher exposure to traumatic events, and older age. Risk factors for depression included being female, and region of origin.

Oppedal examined the role of risk and protective factors in explaining individual differences in internalizing mental health problems (such as depression and anxiety) among young immigrants from Somalia, Sri Lanka, Iran and Vietnam.[32] Results indicated that there were two groups with "healthy", low levels of internalizing problems (Somalis and Tamils) and two groups who were "vulnerable" (Iranians and Vietnamese). Profiles of risk and protective factors differed between the four groups. These profiles explained a significant amount of variance in internalizing symptoms in all four groups. Differences in three factors (school-related problems, self-efficacy and intergenerational conflict) contributed to the difference in internalizing symptoms between the healthy and vulnerable national groups. The author interpreted the findings in the context of culture-specific patterns of behaviour and patterns of interaction in families.

**Health and nutrition**

Another study examined the intersection between physical and mental health. It explored the prevalence of two serious medical conditions, diabetes and hypertension, among psychiatric patients with a refugee background who had been resettled in the US.[33] The refugees were from Somalia, Vietnam, Cambodia and Bosnia. The prevalence of both conditions was higher than in a representative US sample. In addition, both conditions were more prevalent in groups that had experienced high levels of trauma than in those who had experienced low levels of trauma.

Piwowarczyk, Keane and Lincoln examined challenges faced by refugees and asylum seekers after arriving in the US. The data were collected during a needs assessment by a program that served survivors of torture and trauma.[34] Asylum seekers were more likely than refugees to be from Africa, to need family reunification, to move from place to place because they did not a have permanent place to live, to have gone to bed hungry in the previous two weeks and to be unable to contribute to rent. Refugees were more likely to be eating more food now than before fleeing, whereas asylum seekers were more likely to be eating less food now than before fleeing. Asylum seekers were almost four times more likely to suffer from food insecurity than refugees, and more than five times more likely to have no work authorization. Torture survivors

[32] Oppedal (2008).
[33] Kinze, Riley, McFarland, Hayes, Boehnien, Leung and Adams (2008)
[34] Piwowarczyk, Keane and Lincoln (2008)

were more than ten times more likely to suffer from hunger than peers who had not experienced torture.

## Australian research on refugees that includes Africans

In some cases, research pools a large number of refugee groups, among whom participants from Africa are mentioned. Two of these are reports of projects for young refugees that included refugees from Africa. One of these reports describes the Changing Cultures Project in Victoria. This project involved young people from the Horn of Africa as well as many other regions.[35] The project ran for three years and used a mental health promotion framework to explore models of appropriate and accessible education and training for refugee and other newly arrived young people. The project involved partnerships between the education, health and settlement sectors. The programs within the project met a broad range of needs as well as providing language, literacy and basic education to newly arrived young people.

Ramirez & Matthews (2008) reported on the Narrating Our World (NOW) project in Queensland.[36] This arts-based project also examined the educational experiences of young refugees, including those from Africa. The project attempted to create a flexible and open space for activities and discussions, with the topics chosen by the participants. The authors found that young refugees rarely expressed negative experiences. Rather, they focused on their hopes for the future.

Another article that mentioned Africans provided an overview of issues for social workers working with young refugees.[37] The authors note the pressure that social workers are often under to defer to psychiatric discourse. Instead, they argue for the strengths of a social work perspective on the challenges refugees face during settlement. They recommend "a reflexive, deconstructive and dialogical approach within a broadly ecological model". The authors argue that settlement tasks are mediated through a variety of discourses (including language, values, constructs, social practices) that are constructed in the young person's own community and the host country.

## Conclusion

During the review period there has been considerable research interest in the health, adjustment and well-being of Africans who have been displaced within Africa or who have settled in Western countries. A relatively large number of

[35] Bond, Giddens, Cosentino, Cook, Hoban, Haynes, Scaffidi, Dimovski, Cini, and Glover (2007).
[36] Ramirez & Matthews (2008).
[37] Ingamells & Westoby (2008).

the journal articles on these topics that have become available since December 2007 relate to the Australian context. Concern over the mental health of young refugees from Africa who have resettled in Western countries dominated the field, but a wide variety of academic disciplines and perspectives were represented.

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