EXPLORING CULTURAL PERSPECTIVES OF PHYSICAL ACTIVITY AMONG TRANSNATIONAL
AFRICAN IMMIGRANTS

BY

KELECHI IBE-LAMBERTS

DISSERTATION

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Doctoral Committee:

      Assistant Professor Andiara Schwingel, Chair
      Professor Reginald Alston
      Professor Kim Graber
      Assistant Professor Juliet Iwelunmor

Abstract

Background: The overall foreign born population is increasing significantly in the US. The African-born population represent fastest rising immigrant group in the US since the 2000s. Transnational African Immigrants (TAIs) are a subset of African immigrants with a unique ability to sustain multi-national ties. African Americans (AAs) and African Immigrants possess two distinct historical backgrounds that affect their respective cultural practices, yet African immigrants are often grouped into the same category in health research, not taking into account their different ethos and cultural identities. Their ethos and their cultural identities also influence the health behavior choices that they make such as participation in physical activity. Physical activity has the potential to improve health and well-being, and prevent or delay the onset of chronic disease and disabilities. Studies have shown that different factors can facilitate and/or to prevent physical activity in different population and age groups. However, there is a dearth in information regarding physical activity and its determinants within the Transnational African Immigrant population.

Purpose: The objectives of this study were to explore: (1) TAIs understanding of the concept of PA; (2) TAIs interpretation of the socio-cultural contexts in which they chose (or chose not) to be physically active, and; (3) their visualization of PA opportunities and barriers in their respective communities.

Methods: The study utilized the PEN-3 cultural model to support an inductive approach. A qualitative research design was conducted that involved a two-pronged interview process after completion of a demographic questionnaire. Semi-structured interviews were conducted with 24 Transnational African Immigrants (11 males, 13 females), discussing physical activity

followed by a photo-elicitation process where participants were presented photographs related to physical activity in order to evoke richer information. Questions were asked pertaining to their perceptions of their cultural beliefs and attitudes towards physical activity.

Results: Three themes emerged from the analysis of photos and in-depth interviews: (1) We are not the same; (2) Physical activity is good, but…; (3) A culture of physical inactivity. Participants reported perceived factors such as cultural differences, lack of education, employment and transnational responsibilities that influence their choices in regards to physical activity participation. Participants also highlighted activities intertwined with their culture such as dancing as a form of physical activity that they prefer to engage in and find satisfying. Participants call for culturally tailored approaches to their community.

Discussion: The findings of this study revealed the following: 1) The concept of transnational responsibilities factoring into time constraints for PA participation; 2) The socio-cultural differences between TAIs and AAs; 3) The importance of dancing within the TAI culture; and 4) The possible misconception of the causes of chronic diseases within the TAI community. Results of the study increase our understanding, and also add to the literature on African Immigrant health for the reason that it highlights the impact of transnational activities towards potential health choices. It can contribute in future developments and implementation of culturally competent initiatives to improve promotion of physical activity in this respective community. This study also elicits important information regarding the socio-cultural factors influencing physical activity behavior within the TAI community and how it can inform intra-

racial interactions within the overall Black population, further proving that there is not a one-size-fit all approach to addressing health disparities within the Black population.

Dedicated to my sister Adure (in memoriam), the first and very best friend that I've ever known. Although you have long passed among us, I know that you are watching and proud of my accomplishments. To my Momsi, Adenike Jaji-Balogun. This is for you. You are my inspiration and my hero always.

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CHAPTER 1
INTRODUCTION

African-Americans (AAs) -- descendants of slaves brought to America in the 1700s and freed in 1865-- and African immigrants, foreign born immigrants from Africa arriving in the United States (US) since 1965 to present day-- share two separate histories of migration to the US that influence the construction of cultural identity, attitudes and daily life activities of both groups (Kent, 2007). AAs represent the second largest minority group in the US, approximately 14.7% of the population (41.7 million people). The overall population of foreign-born people in the US is increasing at an exponential rate (Passel & Cohn, 2008). The US census reports that the African-born population increased exponentially in size from 881,300 in 2000 to 1.6 million in 2010. The most populous country in the African continent is Nigeria (located in West Africa), with approximately 178.5 million people (World Population Review, 2015). Nigeria also represents the largest group of African immigrants in the US with an estimated 299,310 people; (US census, 2013). Despite this increase in the African immigrant population in the US, there still remains a scarcity of research on the health and wellbeing of African immigrants (Venters & Gany, 2011). Although immigrants often arrive into the receiving country in better health than the non-immigrant population and compared to counterparts from country of origin (Migration selectivity hypothesis, (Palloni & Morenoff, 2001), research shows that health begins to decline over time (Mohamed, Hassan, Weis, Sia & Wieland, 2014). This could be attributed to acculturation to the host country's lifestyle that leads to an increase of developing chronic diseases and conditions.

An emerging characteristic that distinguishes many modern immigrants, such as African immigrants, is the ability to maintain close contact with their country of origin (Guarnizo, Portes & Haller, 2003). These transnational migrants have the ability to maintain unprecedented levels of multi-national ties that influence their activities and beliefs -- they are able to maintain strong ties to their native customs while also acculturating to their current land of establishment. Because of their sustained cultural practices Transnational African Immigrants (TAIs) represent a group of immigrants with unique practices and beliefs. Figure 1 illustrates the complex dynamics of the Black population in the US.
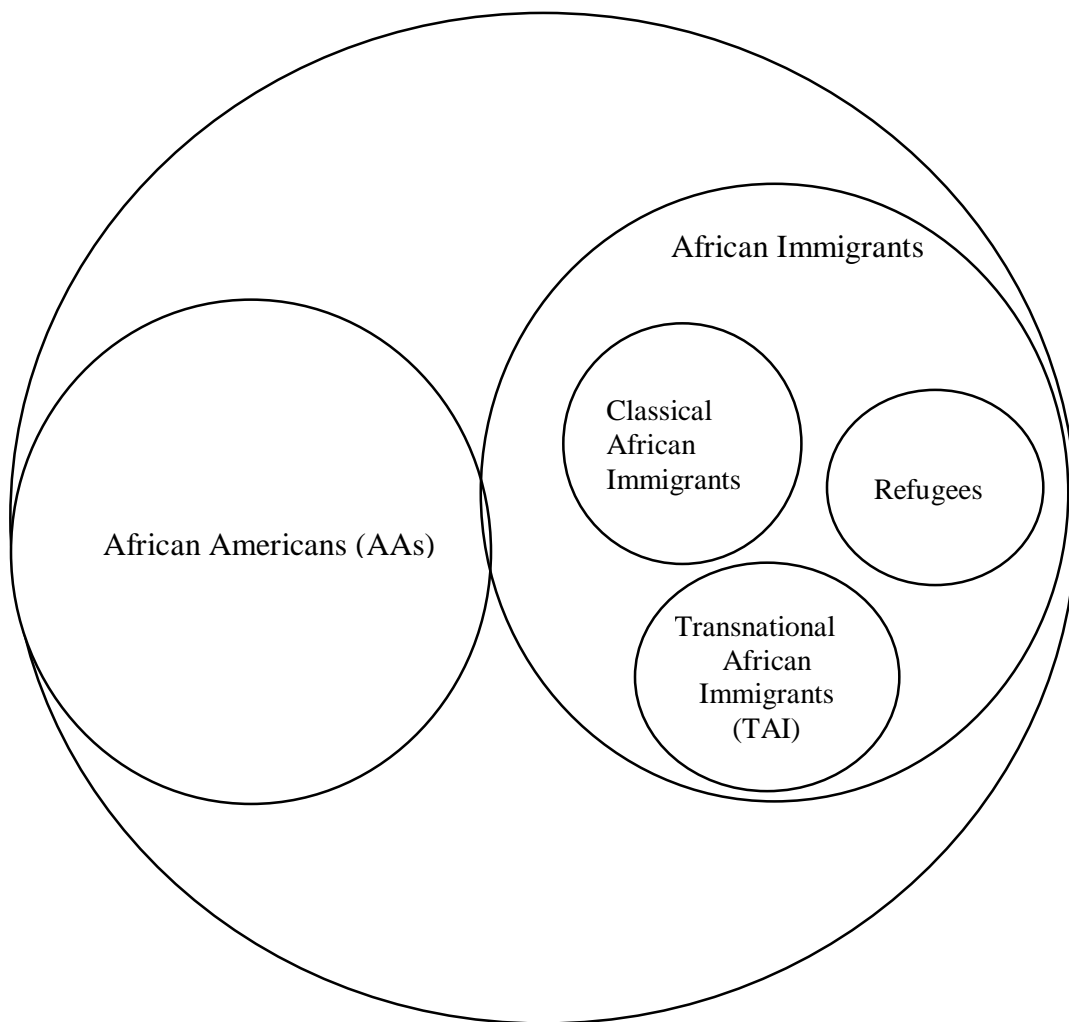
Figure 1. US Black Population

Transnationalism is an emerging global phenomenon of maintaining cross-national ties between one's native country and current country of establishment. It can be identified as a sustained long distance, border-crossing connections that can be manifested in several ways including communication networks, social movements or even criminal/terrorist groups (Schiller et al., 2005). Transnational immigrants live their lives across international borders. Guarnizo, Portes & Haller (2003) suggest that such persons are best identified as "transmigrants". These border crossing activities include occasional trips back to native homeland, sending of remittances (financial contributions) and an involvement in political and current affairs in the home country. Research indicates that many modern immigrants engage in activities that link them to family members or significant others who may reside in the native land from which the migrant is from (Vertovec, 2004). Research has yet to explore how these cross border connections may influence health behavior and health outcomes of these immigrants (Ilunga Tshikwaka & Ibe-Lamberts, 2014).

With the increasing diversification of the population, public/global health has attempted to better understand health disparities, not just in the US, but across the globe (Almeida-Filho, Kawachi, Filho, & Dachs, 2003; Woolf, Johnson, Fryer, Rust, & Satcher, 2004). A focus on disparities in health is paramount because it can influence the way in which health care is delivered and funded. Reducing health disparities has been a US public health goal in recent years and is continually evolving its scope and focus (DeSalvo, O'Carroll, Koo, Auerbach & Monroe, 2016; DHHS, 2000). DeSalvo et al. (2016) states that public health is shifting its focus to understanding the social determinants of health and how it impacts confronting health disparities. Health disparities in the US are well documented in minority populations. Compared

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to Whites, minority groups (e.g. AAs and Latinos) experience a higher incidence of chronic

diseases and disabilities, higher premature mortality rates, and overall poorer health outcomes

(Ford, Giles, & Dietz, 2002; Thom et al., 2006). Current research work on race and health shows

that the racial groups that have been historically marginalized and labeled as "minorities" have

noticeably poorer health outcomes when compared to the majority White population (Takeuchi

& Williams, 2011). Health research reports ongoing disparities in morbidity and mortality

among AAs, Latinos and other minority groups (OMHD, 2007). Moreover, adult AAs and Latinos

are reported to have twice the risk as Whites of developing diabetes and also have higher rates

of cardiovascular disease (Black, 2002; Mensah, Mokdad, Ford, Greenlund, & Croft, 2005).

Obesity is a risk factor that is frequently found in the Black population (Kelley-Moore & Ferraro,

2004).

Overall, African immigrants in the US are underserved and under-researched (Venters &

Gany, 2011). When conducting health research on African immigrants, there is a propensity for

researchers to combine both AAs and African immigrants under the same category of "Blacks"

without taking into consideration differences in lifestyles, beliefs and culture between the two

groups (Ilunga Tshiswaka & Ibe-Lamberts, 2014; Turk, Fapohunda & Zoucha, 2014). What

further complicates the matter is that TAIs are a subset of African immigrants, a group as

aforementioned that is already overlooked within the Black population (Ilunga Tshiswaka & Ibe-

Lamberts, 2014). Some systematic reviews in health research reveal that the collective grouping

of African immigrants with the overall Black population, AAs included, misses important

variations within the African immigrant population that are vital to determining the ethos of

distinguishing health disparities within this specific group from the overall group (Venters &

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Gany 2011; Turk, Fapohunda & Zoucha, 2014). This creates a dearth in literature that specifically accounts for the prevalence of chronic diseases with first-generation African immigrants who arrive from the African continent. To date, there have been limited studies conducted in order to explore the dynamics of African Immigrant health (Read, Emerson & Tarlov, 2005). This issue of oversight with African Immigrant health is not only limited to the US; researchers in Europe also face the same challenges of African immigrants being an unexamined population, but rather a group combined into the overall Black population (Agyeman et al., 2013). This verifies that the overlooking of African immigrants extends beyond the US and is also an issue across other countries. In the US, limited reports on foreign Black immigrants reveal that they have better health statuses than US born AAs, displaying lower prevalence rates in strokes, obesity, hypertension and high cholesterol compared to their AA counterparts (Hyman et al. 2000). However, there is no evidence of the sustainability of this health status over the course of time; there is not enough data on chronic diseases within this group to make an accurate statement on the effects of acculturation to African immigrants on a longitudinal scale (Singh, 2004; Venters & Gany, 2011). Some recent studies on African immigrants suggest that there is a closing of the gap between both African immigrants and AAs due to the current influence of Western culture on Africans and implementation of some Western practices to some African communities (Ukegbu et al, 2011; Okwuosa & Williams, 2012).

Researchers in this field have to refer to African immigrant studies in other countries, particularly in Europe, to serve as a point of comparison for African immigrants who are in the US. There has also been insufficient evidence to establish causal factors of the health

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differences between African immigrants and their US born counterparts (Hummer et al., 2009;

Venters & Gany, 2011). Determining the root of these differences has important health

implications for research, intervention, and policy. There is an emergence of research that

concentrates on exploring the different health behavior and habits within different ethnic

groups. This can be achieved when examining a group's cultural identity and practices. Culture

is something that is learned, shared, reflected in a group's values, beliefs and norms and can be

transmitted inter-generationally (Betancourt & Lopez, 1993; Herskovits, 1948; Hughes,

Seidman, & Williams, 1993; Orlandi, Landers, Weston, & Haley, 1990; Rohner, 1984; Triandis,

1980). Studies show that culture can play a salient role as a determinant of health in immigrant

groups and in the prevention and management of chronic disease (Shaw et al., 2009).

Generally, immigrants arrive in the US bringing their cultural and traditional practices along

with themselves. Some of these cultural practices and remedies may not comply with the

standard norms and prescribed practices of the native land, but these cultural disparities can

impact potential communication of health and interactions between US based healthcare

providers and immigrants residing in the US (Kreps, 2006). These particular behaviors or culture

vary among different ethnic groups but are important to explore as they serve as potential

contributors to health and health equity (Satia, 2009).

Chronic diseases are prevalent and pervasive across the globe and minority populations

are disproportionately affected by it (Lloyd-Jones et al., 2010). Reports show that minority

groups experience a higher incidence of chronic diseases, higher mortality, and poorer health

outcomes in comparisons to the majority group (Ford, Giles, & Dietz, 2002; Thom et al., 2006).

Diseases such as cardiovascular diseases, diabetes and obesity are the more common forms of

chronic diseases. Cardiovascular disease is the leading causes of death in the US and especially in the mortality rates of Blacks in the US; AA deaths are much higher than Whites (Lloyd-Jones et al., 2010). In addition, hypertension is one of the more commonly diagnosed cardiovascular ailments in the US, specifically among minority groups. Diabetes is also proven to be one of the most prevalent chronic ailments among minorities (Okwuosa & Williams, 2012). Public health officials worldwide also acknowledge that obesity is an emerging global epidemic in recent years (Kohl et al., 2012). In order to reduce mortality and morbidity from these ailments, there needs to be preventative measures taken. According to Chodzko-Zajko et al. (2009) there is an increased call for the prevention of chronic disease through lifestyle interventions due to the epidemiological transition—a developmental phase witnessed by the sudden growth in population due to medical innovations in disease and sickness treatment-- that has occurred over the past century. The use of behavior change interventions such as the inclusion of PA and/or healthy eating has been encouraged for the prevention and treatment of a myriad of chronic diseases and conditions (Blair et al., 1996; Swinburn, Caterson, Seidell, & James, 2004; Thompson et al., 2003; Vuori, 2001).

In regards to physical activity (PA), Kohl et al. (2012) state that physical inactivity is a global pandemic that public health needs to address. The same study iterates that physical inactivity is a critical risk factor associated with premature death and loss of quality of life worldwide. Research shows that physical inactivity leads to an increased risk to several chronic diseases such as diabetes, cardiovascular ailments and obesity (Lee et al., 2012). According to Lee et al. close to 6-10% of deaths by chronic diseases are attributed in some form to physical inactivity. Despite the benefits of PA, approximately 30% of the world's population still does not

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obtain the recommended amount of it, which is 150 minutes of moderate-to-vigorous intensity PA weekly (Hallal et al., 2012). Researchers understand that promoting PA is a necessary action by public health and it is most effective when non-government and government agencies collaborate with community based organizations. PA is highly recommended for people all ages regardless of chronic disease or any other conditions. Sallis, Owen & Fisher (2008) state that PA is predicated on three important factors: personal (biological), social (family) and environmental (policy and resources available). Interventions to increase PA in large populations are trying to become more visible, whether it is through community based informational, social, policy and environmental approaches (Powell & Paffenbarger, 1985; Pate et al, 1995; Heath et al, 2012). The recently revised National Physical Activity Plan (NPAP) continues its emphasis on the socio-ecological approach to health behaviors through its continual stress on the significance of change at a personal, institutional, community and policy levels; calling for a more comprehensive incorporation of PA principles in healthcare provider education and training (National Coalition for Promoting Physical Activity, 2016). In addition, the concept of culture is also being recognized as a critical factor for influencing PA, especially within minority groups (Gordon, 2004). According to Gordon (2004), the determinants of PA participation in any community are present within the cultural environment. Every cultural group is unique and multi-dimensional, which suggests that a "one-size fits all" approach in designing PA programs and interventions will most likely be ineffective.

There have been some studies that have explored PA within the AA community (Bopp et al, 2006; Bopp et al, 2007; Matthews et al, 2014), but the majority of studies on PA have been conducted in White populations (Bell et al., 2013). This lack of literature pertaining to this group

has spurred the calls for more community based programs. The emergent issue with the community based programs is that the effectiveness of these community based participatory programs is limited due to the lack of understanding the factors that influence adopting PA (Macera et al, 1995). Bopp et al. (2006) suggests further research requires a deeper understanding of the AA culture in order to improve the designing of culturally sensitive PA community based intervention programs for this group. Research also suggests that AAs may comprehend the concept of PA differently than other groups, which may impact overall perceptions and knowledge of PA (Affuso et al., 2011).

Because of their unique ability to sustain cultural practices- along with representing a vastly different cultural group- it cannot be assumed that the same intervention approach that works on AAs can work effectively on TAIs. This initiates the argument that TAIs are an overlooked US population and need to be further explored. Concerning with the lack of supporting research examining TAIs, this study examined the cultural perspective of TAIs in regards to PA and compare with the overarching literature on PA among AAs. This study also aimed to further add to the school of thought on cultural perspectives TAIs have towards PA and how it impacts their PA participation. The objectives of this study were to explore (1) TAIs understanding of the concept of PA; (2) TAIs interpretation of the socio-cultural contexts in which they chose (or chose not) to be physically active, and; (3) their visualization of PA opportunities and barriers in their respective communities. The study used the following guided research question and subsidiary questions:

What are the Relationship and Expectations of TAIs towards physical activity

behavior?

- What factors influence the perceptions and knowledge of PA among TAIs?

- How do TAIs daily activities affect health behaviors and their beliefs towards PA?

- What socio-cultural factors serve as motivators or inhibitors for PA among TAIs?

- What factors and relationships nurture PA behavior?

A qualitative design was employed. In-depth individual interviews were conducted followed by using the participatory approach known as photo elicitation (Harper, 2002). A Photo elicitation process was conducted by gathering visuals (Appendix C) to present and had the participants discuss images of things germane to their daily lives in regards to PA. This procedure combined with the in-depth interview enabled us to better comprehend their understanding of PA.

This study was guided by PEN-3 (Airhihenbuwa, 1989), a theoretical model that served as a map for understanding TAIs perceptions towards PA in relation to their environment or their interactions with their peers and families. This model has been successfully used for capturing cultural dimensions that interfere with health education and intervention in migrant communities (Airhihenbuwa, 1994; James, 2004; Melancon, Oomen-Early, & del Rincon, 2009; Yick & Oomen-Early, 2009). The framework suggests that health behavior and attitudes are influenced by several complex factors that are broken down into three dimensions. These three dimensions are interrelated and interdependent: (1) Cultural Identity, (2) Relationship and

Expectations, and (3) Cultural Empowerment. This model was used in this study to assess how culture impacts the perceptions and influences on the attitudes of TAIs towards PA. This theoretical model was used to explore in depth the influences on the perception, attitudes and behavior that one's surroundings and culture may have. In this study, the PEN 3 model illuminated how social norms, culture and community may impact an individual's attitude towards PA.

CHAPTER 2
LITERATURE REVIEW

This study explored the influences of understanding PA for TAI (and African immigrants) along with the factors that contribute to their decision to be physically active or sedentary. In order to fully grasp the distinguishing attributes of TAIs, it is very vital to also discuss issues in the larger AA communities to serve as a form of context. The review of the literature is composed of five sections below. Each section elaborates on topics that are very relevant to both African immigrants and AAs such as: (1) the origin and ethos of both groups; (2) Understanding the phenomena of transnationalism and its association with modern African immigrants; (3) Health disparities that exists within both groups; (4) Physical activity (PA): Its benefits, influencing factors and perceptions towards PA in relation to both groups; and (5) Cultural influences on health and PA participation. This literature review illustrates the ongoing conversation in research regarding these topics and each group's unique attributes and challenges respectively.

2.1 Immigration History

While developing the discussion of African immigration to the US and the contemporary welfare of AAs in the US, it is very critical to put to the forefront the history of how both similar, yet different populations arrived in the US. AAs and African immigrants pose different perspectives that are rooted in the history of their immigration to the US.

The first set of Africans that immigrated to US arrived forcefully as a product of the trans-Atlantic slave trade in the 1600s. This practice of forced immigration to Colonial America

occurred between 1700 and 1840, with the majority of the Africans being taken into slavery

(Eltis & Richardson, 1997). Historically, slavery was abolished in 1865 but the descendant of the

former slaves, later to be identified as AAs, faced a history of inequality, racism, segregation

and oppression of rights throughout the course of US history until the civil rights movement in

the 1960s, which produced equal citizens' rights and opportunities for AAs in the US (Levy,

1998). According to the US Census, there are currently 41.7 million people who are identified

AAs, making up 14.7% of the US population. The US Census also projects that by 2060, AAs will

make up 17.6% of the US population with a projected number of 74.5 million people

approximately (US Census, 2013).

After the end of slavery in 1865, the number of African immigrants reduced through the

1950s with the US government setting quotas on immigrants from the African continent below

2000 people a year (Venters & Gany, 2009). The US faced major changes in immigration after

the Hart-Celler Act in 1965. This act was viewed as a product of the civil rights movements by

pan-African advocates. It established criteria for admissions to the US based on professional

skills, as well as family and other relationships to the US (Riemers, 1992). Other important

changes in African migration after the passage of the Refugee Act in 1980, which offered

permanent residence over the year; the Immigration Reform and Control Act in 1986 which

legalized the status of over 30,000 Africans living in the US at the time; and the introduction of

the Diversity Visa Lottery in 1990 which offered visas to Africans (and others) from

underrepresented countries (Coutin, 2007).

Venters & Gany (2009) report that between 1990 and 2000, the total number of African

immigrants increased by 166%. This outstanding surge apparently outpaces the rate of African

immigrants that were arriving since 1965. Compared to African immigrants of the past who were forced to immigrate, these contemporary immigrants arrive with hopes of improving their professional standings, business opportunities or strengthening their transnational networks (Ogundele, 2004, Reynolds, 2002). From 1960 till temporary time, most immigrants tend to arrive from predominantly West African countries like Nigeria or Ghana; regionally West Africans represent 35% of the immigrants arriving in the US (Singh & Miller, 2004). According to the US census Nigerians represent the largest group of African immigrants in the US with an estimated 299,310 people (US census, 2013). Fig 2 displays the steep rate of African-born foreigners that reside in the US since 1970.

Figure 1.
The Foreign-Born Population From Africa: 1970 to 2008–2012
(Data based on sample. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see *www.census.gov/acs/www*)
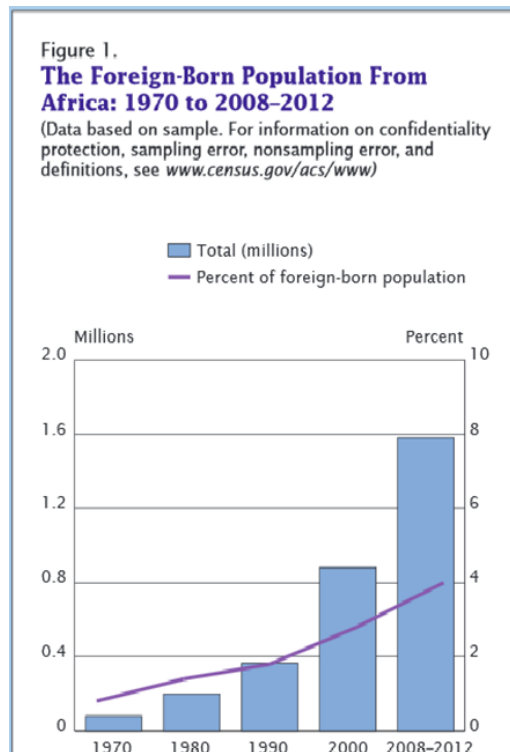
Figure 2.The Increase of African Immigrants in America

2.2 Transnationalism and African Immigrants

    2.2.1 What is transnationalism?

The maintained tie by migrants to their native homelands is described by researchers as "transnationalism." The term, however, has yet to be strictly defined and has been used loosely by researchers introduced to this recently developed term (Schiller et al., 2006). This idea of "transnationalism" can be identified as a sustained long distance, border-crossing connections that can be found in several ways including communication networks, social movements or even criminal/terrorist groups (Schiller et al., 2005). It has become a multi-disciplinarily term that provides an advantageous range of perspectives to the study of global migration (Vertovec, 2009). Research indicates that many contemporary migrants engage in activities and engagements that link them to family members or significant others who may reside in the native land from which the migrant is from, but may not be residing in (Vertovec, 2004). The literature focuses on the key practices taken upon by transnational migrants that help maintain strong ties back to their homelands such as remittances—sending money back—or telephoning or the development of hometown associations.

One literature argues that the use of transnational indicates the broader phenomena of globalization (Schiller et al., 1995). The concept of "transnationalism" creates a time period of strengthening nation-state building processes. Today migrants encounter a society that is much more diverse and contains a stronger transnational connection compared to a time period where assimilation was demanded (Levitt et al., 2003). Debate about when and how the word "transnational" should be utilized is still ongoing; however recognition is growing in observing the objective dimensions of transnational practices (Koehn, 2006; Levitt et al., 2003).

When the concept was first developed, the initial tendency of most people aware with the term of transnationalism was to assume that it involved the movement of people. Research indicates that often the term transnationalism becomes confused with the term "transmigration" (Lee, 2011). The author claims in that "movement is not a prerequisite for engaging in transnational activities". The movement of a population may not necessarily indicate the movement or the creation of transnational engagement (Harney & Baldassar, 2007). Both studies indicate that there needs to be some form of clarity in determining the correlations between transnationalism and transmigrancy. The discussion of both subjects created a question fundamental to all researchers in migration studies: can a transnational be someone who does not physically move from host and origin country often? The research work of Harney and Baldassar (2007) derived a confounding factor to the analysis of transnationalism and transmigration: mobility. Eckenwiler, Straehle and Chung (2012) in their study believe that this form of mobility also affects workers. They believe that a person must first be able to identify themselves as interdependent in order to truly migrate, particularly as a worker. The notion of mobility plays a role as a catalyst for interpreting the process of migration, but researchers question whether mobility should be quantified or measured in order for it to be relevant with transnationalism.

The concept on transnationalism, though very versatile, is a concept that is still in the works. All the literatures mentioned above have a common consensus that transnationalism is the act of maintaining some form of tie between a nation of origin and the host nation. However, none of the researchers can truly solidify a definition of what transnationalism is; there are no limits to the applications of the definition. Vertovec (2004) was able to define the

practicum within the concept of transnationalism that help define the concept's characteristics, yet the author's study was limited due to a lack of clarity of the extent of the engagement of these transnational activities. Lee (2011) decided to take on that task by taking the perspective from the common study of first generation immigrants and study their children; the second generation. She was able to delineate the depth of how transnational activity can be passed on generationally, how it can be maintained from generation to generation, which helped clarify the possible extents the practice of transnationalism can reach.

2.2.2 Transnationalism within Nigerian immigrants

Nigerian immigrants have developed a network that contrast from any of the other immigrant networks (Reynolds, 2002). Compared to most transnational immigrants who come as farm workers or have little education, many Nigerian immigrants have immense educational accomplishments, professional experiences and backgrounds, and have experiences living in large sized cities, with large social contacts with various ethnic groups and classes (Reynolds, 2002). Transnational Nigerian immigrants use the prospects to obtain higher education and professional practice as a motivating factor to immigrate to the US compared to political freedom or poverty (Reynolds, 2002). Nigerians' perception of immigration is based on the fact that one's best bet to enter the country is with a visa for education compared to Europeans, who have access to tourist visas, or Filipinos who have direct political ties with the US or Mexican immigrants who can simply cross a border (Reynolds, 2002). Also unlike most immigrant affairs, Nigerian immigrants arrive with the mindset of returning home after their education or professional achievement in order to help their young nation (Ogundele, 2004).

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Transnational practices such as ethnic hometown associations are also formed in order to develop better transitional networks amongst immigrating Nigerians. Nigerian immigrants tend to search for an association as quickly as possible when they immigrate to the US in order to find job leads and business associates. It is important to remember that some of these Nigerians have previous professional or pre-professional experiences from their homeland as merchants, entrepreneurs, scientists or engineers and establishing themselves is in the new homeland is not a hard transition, especially with the help of their hometown associations. Transnational Nigerian immigrants are very fluent in English, withstanding an accent (Ogundele, 2004) and would much rather to live in areas based on professional affiliation compared to ethnic affiliations, rather relying on their hometown association meetings as a time to interconnect amongst similar ethnicities (Reynolds, 2002). Transnational Nigerians often engage in the remittance of money to their native lands for reasons such as: a) Family provision b) Investment for future retirement in Nigeria c) Commercial or business ventures that they wish to engage in or are already involved in (Ogundele, 2004). These actions are the best ways for them to maintain the strength of the ties to their native lands.

2.3. Health Disparities and Chronic Diseases

2.3.1 Among African Americans

Health disparities are described as negative health differences endured by underserved populations resulting from multiple factors, such as poverty, environmental threats and unequal access to care, individual and behavioral factors, and educational inequalities (CDC, 2013, DHHS, 2010). Overviews on the current research on race and health continue to

document that racial groups have been historically marginalized and labeled as minorities have noticeably poorer health outcomes compared to the dominant white population (Takeuchi & Williams, 2011). Health disparities are well documented in minority populations with research showing that minority groups, in comparison to Whites, experience higher incidence of chronic diseases, mortality and poor health outcomes (Thom et al., 2006). The Office of Minority Health and Health Disparities reports that there are ongoing disparities in the problem of morbidity and mortality suffered by AAs, Latinos and other minority groups (OMHD, 2007). Researchers maintain that extended exposure to these disparities thru structural and material difficulties can lead to chronic diseases and decline of health (Geronimus et al, 2001).There is empirical evidence that the overall health and wellness has improved and the life expectancy gap between Blacks and Whites has decreased by almost five years (Miniño et al, 2009). However, the Healthy People 2020 objective of reducing health disparities between the population's subgroups has yet to be reached (Hummer & Chinn, 2011). There is still a pressing need for scholars to continue to pay attention to the racial/ethnic disparities in health in the US.

Mortality rates are specifically high in the AAs communities (Adler & Newman, 2002; Kelley-Moore & Ferraro, 2004). Although the overall life expectancy gap has reduced as aforementioned, Blacks still have the lowest life expectancy rate. The 2005 National Vital Statistics report shows that the life expectancy for AA males and females are 68.5 and 75.5 years respectively in comparison to White males and females with a rate of 75 and 80.2 years (Natl Vit Stat rep, 2005). An examination by Sloan et al. (2010) on American males from 1900-1914 and 1992-2006 revealed that the gap between Black and White mortality rates has not changed much. Death within the AA population due to disparity is nothing novel. The report by

the 1985 Task force on Black and Minority Health revealed that over 60,000 excess deaths were

occurring annually because of health disparities (Satcher et al., 2005; Heckler, 1985). According

to Satcher et al. (2005), that number has increased to over 83,000 excess deaths.

Chronic conditions (hypertension, diabetes, cardiovascular disease and stroke) are more

prevalent among Blacks than among Whites (Ferraro, Farmer & Wybraniec, 1997). Among all

causes of mortality, cardiovascular disease is the most prominent killer of AAs, regardless of

violence and HIV/AIDS rates within this group (Lloyd-Jones et al, 2010). Other diseases like

obesity, hypertension and diabetes also excessively affect AAs (Adler & Newman, 2002). In

most cases, when mortality from specific diseases is analyzed, AAs typically have the worse

statistics in most of the major categories (Fiscella & Williams, 2004). In fact, researchers have

conducted several analyses to further pronounce these extreme statistics on this specific group.

Mensah et al. (2005), using data from the national surveys, analyzed the cardiovascular disease

risk factor prevalence, morbidity, mortality and overall quality of life for adults 18 years and

older based on race/ethnicity, socioeconomic (SES) status, sex, geographic displacement and

education. The authors concluded that hypertension prevalence was higher among Blacks

(39.8%) regardless of sex or education level. Hospitalization rates for stroke and heart failure

was highest with Blacks. Ostchega et al. (2007) also observed a gap in the rates of hypertension

between Blacks and Whites. They reported that approximately 70% of adults in the US ages 60

years and older have hypertension and both AA men and women had high prevalence rates.

Obesity is a common risk factor that serves as opening segue for other chronic diseases

and also in itself a problem eminent in the Black population (Kelley-Moore & Ferraro, 2004).

Research shows that AAs across the US have higher prevalence rates in obesity in comparison

to Whites (Denney, Krueger, Rogers & Boardman, 2004). Flegal et al (2012) examined the prevalence of obesity and trends in distribution of body mass index among US adults using the NHANES data from 1999-2008. The authors observed that an initial difference of 38.8% among Black men in comparison to 36.2% among white men; 58.5% among Black women compared to 32.2% among white women. The results of this study raises concerns not just on the severity on Blacks but specifically on Black women, with this group showing an alarming rate of prevalence in obesity (Flegal et al., 2012).

2.3.2 Among African Immigrants

The increase of foreign Blacks in the US has increased by more than double the amount in the past 20 years (Read, Emerson & Tarlov, 2005). African immigrants represent the fastest growing Black immigrant groups in the US (Venters & Gany, 2009; US Census, 2010). Venters & Gany (2009) highlight that in the study of African migrant health disparities; public health shows a propensity to focus more so on infectious diseases such as HIV, AIDS than on chronic diseases such as cardiovascular diseases, diabetes and hypertension. With the increase of long-term African immigrants that stay in the US, the authors suggest that it is imperative for public health to have a more heightened sense of screenings, prevention and treatment services that are available and tailored to this population.

There have been limited studies that have been conducted in order to explore the dynamics of Black immigrant health, so researchers often use studies of other immigrant groups as a basis for hypothesizing the different variations of health in African immigrants (Read, Emerson & Tarlov, 2005). These studies reveal the impact of the "healthy immigrant

effect" in analysis of African immigrant health outcomes in comparisons to other groups. On average, foreign Black immigrants have better health statuses than US born Blacks, displaying lower prevalence rates in strokes, obesity, hypertension and high cholesterol compared to their AA counter parts (Collins & David, 1997; Lanska, 1997; Hyman et al., 2000; Singh & Miller, 2004). Some researchers suggest that this disparity within the overall Black population can be attributed to a combination of factors such as: selective migration of healthy immigrants; cultural buffering that includes a strong support network and reduces risky behavior; and healthier lifestyles in native countries (Hummer et al., 2009). Read et al. (2005) stated the importance of acknowledging selective migration as a primary argument for the differential health between foreign born and native born Blacks; these immigrants have the ability and resources to transition to healthier habits in the US.

Previous studies on immigrant health show that although foreign-born people initially display healthier advantages and better health statuses than the native-born people, increased duration and acculturation to American society diminish these advantages over time (Marmot & Syme, 1976; Singh, 2004). Findings by Singh (2006) indicate that the recent surge in African immigrants is also beginning to impact demographic changes; more immigrants are likely to be in poverty and unemployed, which can potentially impact health outcomes projections in the future. Ukegbu et al (2011) also suggests that lifestyle changes and adoption of "Western" lifestyle in African countries are also impacting the depletion of the gap in Africans migrant health status in the US after immigration. The depth of acculturation and adoption of new lifestyles without intervention is projected to put African immigrants at risk for chronic diseases (Kaplan, Huguet, Newsom, & McFarland, 2004). Studies in African immigrant communities also

expose the lack of awareness and knowledge about diseases, while revealing high rates of stigma (Rosental et al, 2003). This highlights the cultural-specific barriers that exist in these communities.

Scholars furthermore argue that there is a dearth of overall data on chronic diseases among African immigrants. US national data systems typically used to surveillance health, mortality, and disease patterns do not identify Africans in the US as a separate ethnic group, and fail to routinely account for and analyze health data by immigrant status (Singh & Hiatt, 2006). The limited mortality data that is available reveals low prevalence by African immigrants in all-cause mortality, but mortality rates paint merely a blurry, incomplete picture (Venters & Gany, 2011). According to national data, diabetes rates for African immigrants are limited and not widely reported, leading researchers to utilize data from prospective studies on African immigrants in different countries like the Israel and the Virgin islands (Medalie, Papier, Goldbourt & Herman, 1975; Tull, Ambrose & Chambers, 2003). These respective studies reveal higher incidence rates of diabetes in association to acculturation to the host country.

A study conducted by Beune et al (2006) on attitudes on hypertension by Ghanaian immigrants in the Netherlands showed a lack of understanding by African immigrants on hypertension as an independent component of stress and revealed the impact social stigma has on the participant's response to hypertension diagnosis. Researchers in this concentration collectively agree that the health needs and practices of African immigrants in the US continue to remain poorly characterized and poorly understood (Venter & Gany, 2009; Okwusa & Williams, 2012; Read, Emerson & Tarlov, 2005; Singh et al, 2004). Africans in the US remain one of the least studied groups in health research.

2.4 Physical Activity

2.4.1 Physical activity and its health benefits

Physical inactivity is becoming increasingly pervasive across the US within the past 50

years in the guise of daily sedentary (sitting or reclining) behavior (Brownson, Boehmer & Luke,

2005). According to the CDC, fewer than 50% of adults reach the US PA guidelines (CDC, 2009).

Physical inactivity has shown to be a modifiable risk factor for obesity and other chronic

diseases that persist in the US (Brownson et al, 2009). Researchers have acknowledged that

increasing the appeal of PA promotion strategies because of its association with a myriad of

health benefits, particularly longevity in life (Stamatakis, Hamer & Dunstan 2011).The

Department of Health and Human services recommends that every adult should engage in a

minimum of 150 minutes per week of moderate to vigorous levels of PA to achieve its health

benefits (DHHS, 2008). Amid the benefits of PA are promoting health and well-being,

preventing the onset of chronic disease and disability, and reducing mortality (Chodzko-Zajko et

al., 2009; Hubert et al., 2002; Warburton et al., 2006). These benefits may occur in healthy

people, people at risk of chronic disease or people already with disabilities and chronic

conditions (Nelson et al, 2007)**.**

Regardless of its health benefits, there is a common misconception of PA with the

complementary behavior of exercising. According to Caspersen et al. (1985) PA has been

defined as any bodily movement produced by the skeletal muscles that result in increased

energy expenditure. Exercise can be described as a form of PA, an action that is repetitive,

structured and planned by an individual geared to improve their health and fitness (Chodzko-

Zajko et al., 2009; Hubert et al., 2002; Warburton et al., 2006). Exercise and PA are often used

interchangeably under the misconception that both are one in the same. It is vital to understand that all exercise is PA, but not all PA is exercise. Researchers have examined the role of PA within different underrepresented populations, specifically Hispanic and AAs, and how it serves as a factor for different chronic health outcomes and mortalities (DHHS, 2010).

2.4.2 African Americans & Physical Activity

The majority of the studies on the effect of PA have actively been conducted in primarily white population (Bell et al., 2013). AAs display some of the lowest rates of PA participation in the US (BRFSS, 2011). Bell et al. (2013) delineates that although the relationship between PA and all-cause mortality rates is proven, there isn't substantial amount of research conducted in low SES urban communities that is mostly occupied with AAs. Crespo et al. (2000) conducted a review of the national cross-sectional survey study (NHANES III and National Exam Survey) conducted from 1988-1994 to explore race/ethnicity and social class in relation to leisure time physical inactivity. Their results, based on the age-adjusted prevalence (per 100), revealed that AAs have the second highest percentage of leisure time physical inactivity (35%) next to Mexican-Americans (40%). The authors, however, conclude that social class does not serve as a strong enough indicator for determining PA and other potential constructs that may influence leisure time physical inactivity need to be explored, specifically in the AA population (Crespo et al., 2000).

Community based participatory research studies have been employed in order to explore the prevalence of PA in AA populations, however, Marcera et al. (1995) report that the effectiveness of these community based participatory programs are limited due to the lack of

understanding the factors that influence adopting PA within this group. Other forms of health promotion include using different avenues such as healthcare facilities, schools, community centers, workplaces and even churches. Recent research suggests that it is important in incorporating religiosity in the designing of culturally tailored intervention programs for AA participants (Krueter, Ludwago & Bucholtz, 2003; Resniscow et al., 2002). In a study exploring the understanding of PA of members of an African American church, Bopp et al. (2006) state that there is a need for more culturally tailored intervention for AAs people in order to increase their participation in PA during leisure time; highlighting the notion that the church, social connections and spirituality are integral factors to be taken into consideration when attempting to improve PA within the AA population.

2.4.3 African Immigrants & Physical Activity

Though there is some research on PA trends in African countries (Guthold et al., 2011) there is a miniscule amount of work that focuses on PA trends with African immigrants in the US (Turk, Fapohunda & Zoucha, 2014). One study on PA on immigrants in the US conveys that 79% of African immigrants claim to be physically inactive (Koya & Egede, 2007). In most studies regarding PA, factors such as weight and diet are usually associated interactively with PA as contributors to health. However, there is little known evidence that focuses on the perceptions and attitudes of PA in African migrant populations (Turk, Fapohunda & Zoucha, 2014).

Although some studies show that the traditional diets of immigrants are healthier in comparison to non-traditional diets (Delisle, 2010; Okafor, Carter-Pokras & Zhan, 2014) these migrants are susceptible to facing barriers that may hinder the maintenance of traditional diets

and healthy PA habits in their new countries. Using an analysis by the National Health Interview Survey, the study by Koya & Egede (2009) showed that 58.4% of adult African immigrants were either overweight or obese in 2002 after residing in the US for 15 or more years (Koya & Egede, 2007). However, it is vital to explore the cultural perspectives that may influence this rate; in some parts of Africa, being overweight is embraced and considered associated to affluence and prestige (Holdsworth, Gartner, Landais, Maire, & Delpeuch, 2004.)

A recent study by Turk et al. (2014) explored the eating and PA of Nigerian immigrants in the US Their findings discovered that these groups of African immigrants faced barriers to PA with their busy lifestyles (employment demands, schools etc.) and limited time to engage in PA. These participants, instead, resorted to meditation, prayer and quiet time as their preferred "healthy" activity during their leisure time. They perceived PA as perfunctory actions that are incorporated in their daily life activities such as household chores or walking around at their workplace (Turk, Fapohunda & Zoucha, 2014). Another study by Mohamed et al. (2014) explores PA among Somali immigrant men in Minnesota. The research findings express that PA was viewed as secondary to more primary things such as employment and school and the pursuit of a better livelihood (Mohamed, Hassan, Weis, Sia & Wieland, 2014). Both studies seem to agree the effort to meet the demands of the fast-paced lifestyle of the US supersedes the effort to engage in PA.

2.5 Factors influencing Physical Activity

PA is a complex and dynamic process involving an interconnected series of behaviors and, the identification of the variables affecting PA adherence is often difficult (Schutzer & Graves, 2004). It is well documented that studies on PA concentrate on the profiling its determinants and developing potential interventions that can successfully promote PA (Seefeldt, Malina & Clark, 2012). There are several factors that can challenge, prohibit or even facilitate individuals from being physically active (Jones, 2003). Understanding what influences PA participation is essential for designing targeted and tailored interventions (Bopp et al., 2005)

Because the incentives to start and sustain a physically active lifestyle may differ among individuals and populations, it is a very cumbersome task to identify the determinants of a sustained active lifestyle (Seefeldt, Malina & Clark, 2012). Research identifies some demographic variables such as being male, younger, a nonsmoker, leaner, more educated, Caucasian, and healthier (self-reported) as positively associated with PA (Trost et al. 2002). Research also identifies several social and environmental factors such as social support from friends, family, and healthcare providers (Giles-Corti & Donovan, 2003; Owen, Leslie, Salmon, Fotheringham, 2000); perceived and actual access to PA and recreational facilities (Holman, Donavan & Corti, 1996); neighborhood safety (Humpel, Owen & Leslie, 2002); and more "walkable" neighborhoods (Berrigan& Troiano, 2002) as vital determinants of PA.

Research exploring PA participation and the clarifying limitations of PA among culturally diverse minority groups has increased over time. These studies report that significant barriers exist that either prevent or make it difficult for AAs to engage in PA. These limitations include: limited income or financial confines (Richter, Wilcox, Greaney, Henderson, & Ainsworth, 2002),

a lack of PA-related health education resources(Nies, Vollman, & Cook, 1999), limited space and

neighborhood safety issues (Richter et al., 2002; Wilbur, Chandler, Dancy, & Lee, 2003).

Research on AA women specifically revealed barriers such as larger family size (James, Hudson

&Campbell, 2003); ideal body image (Yancey et al., 2006), and hair maintenance (Malpede et

al., 2007). A study by Bopp et al. (2006) explored the factors on PA with AA men and women.

The authors recommend that there needs to be more gender-tailored interventions for physical

inactivity between both groups because each groups faces its own unique challenges and

barriers (Bopp et al., 2006).

2.6 Perceptions and Attitudes towards Physical Activity

AAs are a vulnerable group within terms of susceptibility for physical inactivity. Previous

studies on the perceptions of PA among older AA underscore that AAs may comprehend the

concept of PA differently, which can make them less responsive to public health messages

(Affuso et al., 2011). A study by Wilcox et al. (2002) conducted focus groups on AA women to

explore their perception of PA. The authors' findings suggest that AA women perceived PA

potentially as a producer of undesirable outcomes such as appearing too masculine. Their

findings also revealed that the participants also associated being "active" synonymously with

being "fit", believing that incorporating PA into their daily routines was sufficient (Wilcox et al,

2002). Other related studies show that different facets of people's social and physical

environment are related with people's levels of PA, obesity, and self-rated health (Poortinga,

2006). Very few studies have aimed to understanding the perception of PA on AA men and have

been mainly focused on AA women (Bopp et al., 2007).

Recent studies also delineate a consistent trend of confusion when attempting to understand PA by AAs. Another study conducted by Wilcox et al. (2005) reported that their AA women participants were confused with the term "moderate intensity" of PA. Likewise, another study by Lavizzo-Mourey et al. (2001) explored the inconsistencies in the concept of exercise in a study conducted within urban older AAs by functioning abilities. The findings indicated that physical functionality levels also affected the comprehension of the concepts of exercise (Lavizzo-Mourey et al., 2001).

2.6.1 Culture, Health and Physical Activity

Culture is something that is learned, shared, reflected in a group's value, beliefs and norms and can be transmitted inter-generationally (Betancourt & Lopez, 1993; Herskovits, 1948; Hughes, Seidman, & Williams, 1993; Orlandi, Landers, Weston, & Haley, 1990; Rohner, 1984; Triandis et al., 1980). Culture is fluid and dynamic; ever changing (Becker, Gates and Newsom, 2004) Immigrants that come to the US tend to bring their cultural and traditional practices along with them. Some of these cultural practices and remedies may not comply with the status quo and prescribed practices and ideologies presented by health care professionals in the host country. Shaw et al (2009) acknowledge that the concept of cultural differences is very salient in health care today and especially the management of chronic ailments. The authors also acknowledge that expanded access and the development of more refugee health programs have brought increasing numbers of cultural and ethnic minorities into the US health care system, especially the public health system (Shaw et al., 2009).

In regards to the management of chronic disease, culture plays an essential role because it reflects how a group deals with ailments over a longitudinal scale and integrates treatment into their daily life activities. According to Shaw et al. (2009), lifestyle, diet and stress are areas in human behavior that are delineated by cultural differences. Cultural differences also influence health communication between provider and patients from ethnic-minority background. Kreps (2006) focused on health communication and how it is affected by racial health disparities. Though focusing particularly on cancer care and how it is communicated, he analyzed that there is a high rate amongst minority groups in risk factors to chronic illnesses like cancer, particularly AAs. The researcher indicates that there is a low amount of participation in cancer screening and a large amount of resistance to engage in preventative behaviors such as dieting and exercise amongst the AA community due to the lack of intercultural communication transmitted by health professionals. He highlighted that public health communication campaigns need to be strategically developed in order to address the targeted minority groups. His review of several literatures highlighted that "sensitive, adaptive and strategic health communication programs and policies can help break down the barriers that contribute to health disparities" (p.765).

Perloff, Bonder, Ray, G. B., Ray, E. B., & Siminoff (2006) explored both the theoretical and empirical perspectives of the cultural barriers between patient-physician communications. The researchers delve into understanding the physicians' expectation and attitudes toward the patients from a culturally sensitive standpoint and vice versa with the patients' expectation and attitudes. Their findings identify that different cultural experiences may determine how the patient may interpret a medical visit, especially if it is an interracial dialogue. They write, ". . .

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during interracial conversation, Blacks (AAs) sometimes feel they are being interrogated by Whites who are pursuing categorical talk and seeking information perceived by Blacks to be of a more personal and private nature" (p. 841). Barriers such as self-identification may impact the conversations that may occur during a medical consultation. The important factor mentioned that highlights another cultural barrier is the concept of trust. The researchers believe that if health providers can provide cultural competent communication, then they can gain the trust of patients which would improve the patients' believability and compliance to treatment; breaking the barrier.

Research implies that due to the diversity in culture, there needs to be development of more culturally sensitive and competent care and services provided within the US health system. Rosenberg (2008) examines and comments on the lack of diversity and cultural competency in the healthcare delivery systems, particularly for mental health services the author highlights through referencing national sources like the US Census, that there is a lack of cultural competency in the current healthcare systems in the US and with that at the helm, she correlates the lack of diversity in the leadership ranks to the prospective lack of cultural competent healthcare that will be provided to an increasingly diverse population in all facets of healthcare services, not mental health alone.

In respect to the aforementioned statements on culture, it is very important when studying culture and health to recognize that all research must specify salient differences among groups in order to prevent one group's cultural perspective to appear as the dominant or monolithic entity (Lambert & Sevak, 1996; Shaw et al., 2009). The authors state that this can lead to confusion when conducting cross-cultural research that creates generalizations within

one sub-group within a population that may be despised by another sub-group within that population. This example can be apparent in generalizations applied to "Latinos" that may represent several countries across the globe that have their own subset of beliefs/traditions within a single country.

Regarding PA, research also indicates that culture is a vital component for the motivation for PA (Fontayne, Sarrazin, & Famose, 2001; Gill & Williams, 2008; Kim & Gill, 1997). The authors suggest that cultural differences can influence the personal and situation factors for PA within different groups. Gordon (2004) submits that because every cultural group is multi-dimensional, a standard "one size fits all" approach will fail; using one program designed for one particular group on another group is destined to fail. The author recommends understanding the characteristics and barriers spaced by each specific community in order to tailor a culturally sensitive program encouraging PA participation. Understanding these cultural influences on PA participation is integral to determining other barriers such as gender roles) or even religious expectations (Hoebeke, 2008; Mansfield, 2009; Caperchione et al., 2009) A report by Seefeldt, Malina & Clark (2002) states:

> "…the contextual variables of sociopolitical forces, issues of gender embedded in a particular culture/society and the values and attitudes regarding the place of women and PA in specific cultures should be considered whenever PA is assessed or interventions to decrease sedentary habits are initiated." (pg. 145).

Even though cultural diversity is something that is rarely studied in respective fields such as sports and exercise psychology (Gill, 2007), these cultural differences can potentially influence a person's PA behavior.

2.7 Health Behavior Theory

2.7.1 PEN-3 Cultural Model

Public Health is a multidisciplinary field that has historically been a vital force for reflective and collective action on population health and well-being (Frenk, 1993). This set of actions includes a systematic approach when solving problems. This approach helps determine the gradations, severity and existence of an issue by using models and theories to serve as guides when developing the rationale behind an intervention. There are numerous theories and models that are functional in the health sciences that aim to understand health behaviors.

The PEN-3 model is a framework utilized for health promotion and assessment that targets cultural sensitivity and appropriateness in health program development on both a macro (government, international, policy) and micro level (community, individual, family) (Arihihenbuwa, 1995). An important characteristic of this model is its versatility and inclusivity of culture into a variety of other health behavior theories. With respect to more prominent theoretical frameworks that is used in understanding and predicting health beliefs and health behavior in health such as the Health Belief Model, Theory of Reasoned Action and the PRECEDE/PROCEED MODEL, the models aim to create a culture-centric model that can be used to assess health education and health beliefs in hopes of developing culturally relevant method of promoting health for diverse and multicultural groups. The framework is composed of three dimensions that are interrelated and interdependent: Cultural Identity, Relationship and Expectations, and Cultural Empowerment. Each dimension consists of three categories that all align with the acronym PEN. Figure 3 shows the interactions of the different dimensions of this model.

THE PEN-3 MODEL

CULTURAL IDENTITY

RELATIONSHIPS
& EXPECTATIONS

Person
Extended Family
Neighborhood

Perceptions
Enablers
Nurturers

Positive
Existential
Negative

CULTURAL EMPOWERMENT
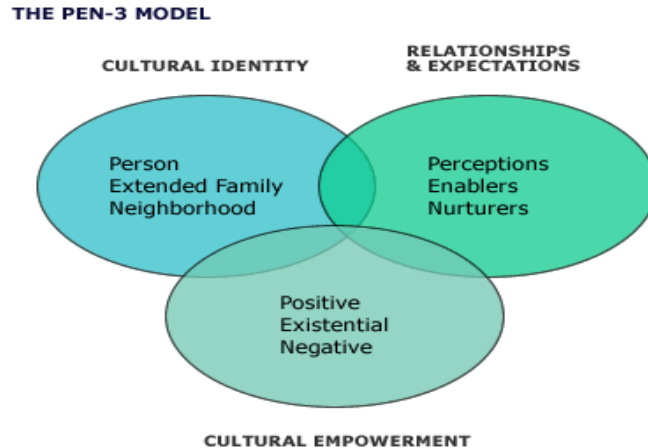
Figure 3.Representation of the PEN-3 Model.

2.8 Photo-elicitation in Qualitative Studies

Photo elicitation is a research technique that invites participants to take or use photographs of salient features and relate it to things that are both personally meaningful and possess significant explanatory power. Harper (2002) defines photo-elicitation as a research technique based on the premise of simply adding a photograph into an interview. The authors suggest that the difference between interviews that use visual images (e.g. Photography) and text, in comparison to interviews that use words alone can impact the ways that people respond to these two forms of representation. According to Harper, the parts of the brain that process visual information are evolutionarily older than the parts that process verbal information. This allows for images to evoke deeper elements of the human consciousness that words cannot reach; the interview is guided by these images. These may be some of the rationale that make photo elicitation interviews seem like not a typical interview process that elicits more information but rather a type of interview that evokes a different type of

information, providing more meaningful information. Elicitation interviews connect "core definitions of the self" to society, culture and history (Harper, 2002).

Researchers have used photo-elicitation in a variety of ways. One of the more common methods is allowing the participants to take or gather photos that are assumed to be meaningful to the participant (Lapenta, 2011; Harper, 2002; Harper, 1987). However, there are also approaches in which the images are taken and collected by the researcher in order to stimulate the thoughts and responses of the interviewee (Lapenta, 2011). Matteucci (2013) states that there are four approaches of photo-elicitation that are frequently used in social research: 1) when the images are produced by the researcher; 2) when the images are gathered by the researcher; 3) when the images are produced by the participant; and 4) when the images are gathered by the research participant.

Photo elicitation techniques have recently been successfully employed in several PA studies in order to explore attitudes, beliefs, and preferences around PA topics (Fleury et al., 2009) and for other different purpose, such as understanding physical barriers (Sebastiao, Ibe-Lamberts, Schwingel & Chodzko-Zajko, 2014) or even food choices (Johnson, Sharkey, McIntosh, & Dean, 2010). For example, Sebastiao et al. (2014) conducted a participatory research approach in order to explore the perception of PA among older AA women. After interviewing 7 women through the photo-elicitation process, the study revealed a low level of PA by the participants, a lack of knowledge of the importance of PA and also the personal, social and environmental facilitators and barriers that exist in their lives that were revealed by the photographs that they produced. The study by Turk et al. (2014) similarly used photo voice to explore the perception of eating and PA in Nigerian immigrant communities. The study

revealed that the photographs were valuable in exploring the different vantage points and

perspectives on diet and PA by this group. The participants also expressed the photograph as an

easy facilitator of discussion and deriving rich information about healthy and unhealthy

Nigerian habits and adaptation to the US lifestyles.

CHAPTER 3
METHODS

The aim of this study was to explore the cultural perceptions of PA in TAIs. The study

design investigated the perceptions, attitudes and cultural values about PA with members of

this particular group. This study consisted primarily of qualitative data collection and took on an

inductive approach. When researchers take an inductive approach, they start with a set of

observations and then they move from those particular experiences to a more general set of

propositions about those experiences (Patton, 2014). In other words, they move from data to

theory or from the specific to the general. This research utilized a two-pronged qualitative

approach to explore the topic of perceptions of PA: individual interviews supplemented with

photo-elicitation. Interviews allows for the researcher to generate an understanding based on

rather sensitive topics (Patton, 2014) such as the participant's experience with assimilation and

acculturation, barriers in health behaviors and also existential behaviors that dissect the

uniqueness of their cultural practices. In addition, to further dig deeper into the relationships

between both the person and the broader community and how it influences the choices that

are made by the individuals towards physical activity, this study also utilized a research

technique known as photo elicitation (Harper, 2002). Both these approaches allowed for the

most insightful of details to be shared by the participants. It allowed for the researcher to

generate an understanding based on the sensitive topics such as the participant's experience

with assimilation and acculturation, barriers in health behaviors and existential behaviors that

dissect the uniqueness of TAI's cultural practices.

3.1 Study Participants

In the Chicago area, the Nigerian community is by far the largest represented African community with approximately 30,000 people residing in the Chicago area (Encyclopedia of Chicago, 2005). Participants in this study were primarily recruited in areas and communities in Chicago where African immigrants resided. Participants were recruited mostly from the Uptown area in the Northside of Chicago or the Chatham community area on the Southside of Chicago. Figure 4 displays a map and the recruitment location of the participants. Participants were recruited in community centers, hometown associations/ethnic group community meetings and churches in the Chicago area through flyers and through email. Organizations and community centers were contacted inquiring for permission to recruit participants for the study.

Figure 4: Map of targeted population recruitment in Chicago area

In order to join the study participants needed to meet the following inclusion criteria: be of the ages 30-65 years (adults/non-elderly), men and women self-identified as TAIs, Nigerian, and be of any occupation or unemployed. The exclusion criteria were: being from a country of origin other than Nigeria; length of stay in the US is shorter than 5 years; unable to comprehend and speak English.

A snowball sampling method was used in this study because it allowed for recruiting participants who are conveniently available and can create opportunities for access to more participants with similar profiles that fit into the design of the study. Qualitative studies often reach theoretical saturation with a relatively small number of participants (Patton, 2014; Suri, 2011). Snowball sampling in an interview may lead to the referral from one participant to interview someone else (Beirnacki & Waldorf, 1981), which may lead to another one, until it reaches saturation (when same information keeps recurring and nothing new is revealed). A total of 24 TAIs, 11 men and 13 women, participated in the study.

3.2 Instruments

Firstly, a brief, standard questionnaire (Appendix B) was used to collect descriptive information on the targeted population. The questionnaire asks for information on age range, marital status, country of origin, religion, length of stay in the US, years of completed education, and frequency of communication with native homeland (Nigeria) and method of maintaining ties to Nigeria.

Individual interviews in the health field typically allow for the interviewer to accrue and assess the individual's views on health beliefs and attitudes towards the subject of interest

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(Patton, 2014), PA in this case. Individual interviews were used because delineating TAI culture

in relation to PA is a phenomenon that can solely be described through the words, recollections

and the rhetoric values shared by those who have engaged in those practices; awareness is

created through the details. Photo elicitation is a research technique based on using

photographs to stimulate discussion during a structured research interview (Harper, 2002).

Photographs (Appendix C) were provided by the interviewer during the second phase of the

interviews in order to allow participants to further illustrate potential motivating factors or

barriers to PA with the intention of hopefully pinpointing potential areas of needs and

interventions for the group that they represent.

In order to help place the findings of the study within a broad theoretical framework,

the study interview questions and data analysis were guided by the PEN-3 Cultural model

(Airhihenbuwa, 1995).

3.3 Procedure (Overview)

Prior to the commencement of the study, the research study protocol was approved by

the Institutional Review Board of the University of Illinois at Urbana-Champaign on September

23rd, 2015. After approval, a pilot phase of the picture selection process began (more on Section

3.3.1). After selecting the pictures, the recruitment phase initiated. Recruited participants met

with the research team to receive a comprehensive explanation of the research study and were

asked to provide informed consent in order to further proceed with the data collection.

Consent forms were administered and reviewed with participants; participants were explained

in detail, the objective, the expectations and their rights as participants of this study. After the

consent process, the participants were given a standard questionnaire to complete. Participants

filled out the questionnaire that asked for general socio-demographic information. After

completion of the questionnaire, the interview process then began.

3.3.1 Selection of Pictures

There are four different approaches to photo-elicitation that are employed in social

research: 1) when the images are produced by the researcher; 2) when the images are gathered

by the researcher; 3) when the images are produced by the participant; and 4) when the images

are gathered by the research participant (Matteucci, 2013). For this study, the pictures were

gathered by the researcher.

In order to reduce researcher's bias, a pilot process was implemented for the selection

of pictures. The process went as follows:

- 10 visuals representing PA collected from various sources (internet, health

  magazines & journals)

- 2 community members (non-participants of the study), one from both sexes

  were recruited and asked to select 5 out of 10 presented pictures that they

  believed were germane to their experiences in regards to PA within their

  community. These people selected are people who can relate with the

  perspectives and thoughts of the targeted population due to their similar

  backgrounds, experiences and attributes. These 2 community members were

  invited solely for the pilot photo selection process. These 5 pictures they were

  asked select should assist in prompting questions about PA in relation to the

individual's (a) Cultural identification, (b) family & friends, (c) daily life routines and (d) community/environment. The participants were first contacted and screened to determine if they fit the profile of the priority population. Then they were invited to select pictures.

- The selected pictures that appear to be redundant among each participant were chosen and the researcher used these pictures for the data collection process. These pictures are displayed in Appendix C.

3.3.2 Individual interviews

All Individuals interviews were conducted from December 18th, 2015 through January 4th, 2016 and then from May 18th, 2016 through May 31st 2016. Recruited participants were contacted via telephone in order to set up a meeting time for the interviews. Interviews took places within the homes of the participants. Upon completion of the consent forms and demographic questionnaire, the two part interview process was conducted. The interview times lasted between 30-90 minutes. All interviews were audio recorded and conducted by the researcher (Kelechi Ibe-Lamberts). Both the structured interview and photo elicitation process occurred in one sitting. The phases of the interview are outlined below (Figure 5).

Part I
Structured interview process

Part II
Distribution and discussion of pictures
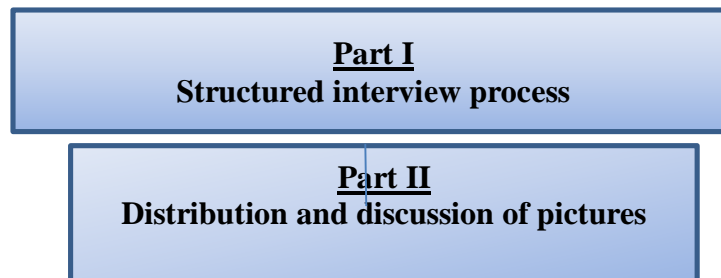
Figure 5: Interview phases

Part 1. Participants partook in an individual structured interview. The researcher asked questions guided by the PEN 3 theoretical model (Appendix A) to explore in detail participants attitudes and values of PA, along with PA opportunities in their local environment. Within asking the questions, it was anticipated that the cultural constructs and values of each participant would emerge organically within the individual's response.

Part 2. The researcher then presented pictures that were selected from the aforementioned pilot process. These selected pictured represented things assumed to be important to the participant's culture and cultural identity intertwined with PA. In this phase, the researcher asked general questions about these pictures to the participant to provoke the participant's perceptions and thoughts through their personal experiences in relation to PA. Participants were asked the following questions in order to initiate a discussion regarding the shared photographs:

- What do you think about this picture?
- How does it relate to your lifestyle?
- Do you see yourself doing something like this?
  - Why?
  - If no, why not?

Throughout the interviews the method of member-checking (Lincoln & Guba, 1981) was utilized where the researcher would repeat back or restate what the participant said to determine if that was what s/he intended or if had additional information to add.

3.4 Data Analysis

The descriptive data from the socio-demographic questionnaire was developed using quantitative analysis software (SPSS 11).

The qualitative data was analyzed by using inductive reasoning. NVIVO11 was used to organize the qualitative data that was collected. The initial set of 12 interview transcripts were independently coded then triangulated by a total of three researchers in order to determine credibility under the following steps:

1) A sample of transcripts were distributed among three total researchers to analyze and code individually

2) The researchers then reconvene to discuss individual initial codes. The codes were only then considered as final codes if there was a consensus reached among the researchers regarding which final codes emerged from the participant interviews. Codes that were not agreed upon with a consensus were discarded.

3) After the consensus was reached, a codebook was then created using the final codes that were agreed on by all three researchers. Another small selection of interviews was chosen to be coded completely by two researchers to be certain the coding was being used consistently and to ensure the credibility of the codebook.

4) Following this process, minor clarifications were made to the codebook and the researcher proceeded with coding all 24 interviews using NVivo 11 as an organizer. The data was then categorized and emerging themes were identified.

The emerging themes were developed through studying of the coded transcripts and careful consideration of possible meanings and how these meanings fit within the developed themes.

A framework is then used to organize these developed themes. The arrangement of the themes in the results section was assisted by the PEN-3 model's framework; the three dimensions of the PEN-3 model are typically used to categorize the emergent themes evolving out of the qualitative section. For this particular study, the Relationship & Expectations dimension was the primary dimension utilized.

3.5 Authenticity and Reliability

It is critical when conducting this study to be briefly discuss the importance of verifying its authenticity and reliability. An increased amount of attention must be paid to the reliability and validity of qualitative research in order for it to not lose its rigor (Morse et al, 2008). When deprived reliability and validity, research simply becomes fiction and useless to those it comes across (Lincoln & Guba, 1981). Lincoln and Guba (1981) indicated that the nature of knowledge within a specific research must depict a difference between the rationalistic (quantitative) or naturalistic (qualitative) paradigms. The authors developed the notion that each paradigm must have paradigm specific criteria in order to verify its "rigor". They suggested that the criteria in the qualitative model to ensure "trustworthiness" (in place of reliability and validity) are credibility, fittingness, auditability, and confirmability (Guba& Lincoln, 1981). Credibility alludes to the case of equivalence between participants' perspectives and the researchers' representation of them (Schwandt, 2001). Transferability focuses on the generalizability of study. This is strictly about case to case transfers in qualitative studies which is different in comparison to the notion of external validity in quantitative research (Tobin & Begley, 2004).

Dependability will be measured by a process of inspecting and reviewing. It is significant to make sure that all research procedures are rational, traceable, and clearly documented (Schwandt, 2001; Tobin & Begley, 2004). Lastly, confirmability assesses the prominence of findings clearly resulting from the data rather than results conceived from researchers' imagination or biases (Tobin & Begley, 2004).

To establish credibility the researcher utilized triangulation in my data collection methods as well as in the analysis of the data by multiple individuals. Also, during interviews the researcher used a form of member-checking in which he would regurgitate answers back to the interviewees in order to confirm that he had comprehended their answer and to explore for any supplemental information or interpretation of their responses.

To address transferability, the researcher included the data collection questionnaires instruments in Appendices and has provided rich detail on the methodology and the data analysis so that it provides other researchers the opportunity to repeat the procedures of this study.

To address the any issues of dependability the researcher used triangulation to assure the consistency of coding and theming of the data. The researcher used an in-depth process of independent coding along with two other peers as well as group sessions where they thoroughly discussed the data and coding at length and created coding only once there was a consensus. Additionally, once the code book was complete, the group once again engaged in independent coding of a sample of interviews to ascertain that they were coding consistently. The group reunited, clarified and updated the code book, and then the rest of interview transcripts were coded using the new code book.

To address confirmability, the researcher utilized the assistance of his doctoral advisor and two of my committee advisors to assist throughout the process. The researcher met regularly with his advisor and also met committee member to discuss the study and the findings. The researcher also utilized a third advisor when encountering additional questions about methods or how the results were developing and to explore the influence he may have had on the results as a researcher.

This study encompassed the suggested approaches to improving the authenticity of qualitative studies: (1) triangulation and (2) rich data-intensive interview and constant comparison method will allow the researcher to collect a "rich" amount of data. It is also very important for the researcher to engage in reflexivity- a critical self-reflection of potential biases and predispositions by the investigator (Johnson, 1997). Johnson claims that researchers could become more self-aware and control their biases through reflexivity. In qualitative research it is commonly thought that a researcher's values, beliefs and assumptions can influence research and this notion is likely an inevitable aspect of qualitative research but it does not essentially mean it is a weakness (Patton, 2014). Judiciously documented procedures, the usage of multiple data sources, triangulation, and other techniques are all ways in which high-quality, trustworthy data can be fashioned. The researcher utilized many of these techniques in his study in order to avoid any possible sources of error while also establishing an atmosphere of trust so that participants felt comfortable. This aided in minimizing the influence I could possibly have had over their responses. Additionally, the researcher was open to any information, good or bad, that would provide insight in regards to their cultural perceptions on PA.

CHAPTER 4
RESULTS

This study evoked rich data about several factors that influence the culturally driven

perspectives of PA among TAIs. In the following paragraphs, descriptive data will be shared to

better profile the participants of this study. In sequence, results induced by the qualitative

interviews will also be shared in detail.

4.1 Descriptive Data and Demographics

A simple demographic questionnaire was delivered to the participants from whom the

descriptive data was derived. Of the 24 participants in this study, 13 were females and 11 were

males. Table 1 shows further information about the descriptive information of the participants.

All 24 participants were born in Nigeria and maintain ties with their native homeland (Nigeria).

Of those interviewed, 17 (71%) reported they were married; 21 (87%) had children; 9 of the 24

participants (38%) reported to be within the ages of 51-60 years of age. Of the 24 participants,

20 (83%) reported themselves as "employed", 1 as "unemployed" and 3 (13%) reported

themselves as "Retired". Participants in this study reported an average length of stay in the US

of 23 years. Most of participants reported that their frequency in communications with their

ties in Nigeria was "everyday" (38%) or "often" (46%).

Table 1. Participants demographic

	WOMEN (n=13)	MEN (n=11)	TOTAL (n=24)
AGE RANGE N (%)			
20-30	2(15)	0(0)	2(9)
31-40	0(0)	4 (36)	4 (17)
41-50	2 (15)	2 (18)	4 (17)
Table 1 (cont.)			
51-60	6 (46)	3 (28)	9 (38)
Over 60yrs	3 (23)	2 (18)	5 (21)
LENGTH OF STAY Mean (SD)	23.6 (11.1)	22.5 (14.1)	23.1 (12.3)
MARRIED N (%)			
Yes	8 (62)	9 (82)	17 (71)
No	5(38)	2(18)	7(29)
WITH CHILDREN N (%)			
Yes	11 (85)	10 (91)	21 (87)
No	2(15)	1(9)	3(13)
EMPLOYMENT N (%)			
Employed	11 (85)	9 (82)	20 (83)
Unemployed	1 (7)	0(0)	1 (4)
Retired	1 (7)	2 (18)	3 (13)
FREQUENCY OF COMMUNICATION W/ TIES N (%)			
Everyday	5 (38)	3 (27)	9 (38)
Quite often	2 (14)	1 (9)	3 (13)
Often	6 (46)	5 (45)	11 (46)
Moderately	0 (0)	2 (18)	2 (8)
Never	0 (0)	0 (0)	0 (0)

4.2 Identifying Themes

The interview transcripts from the 24 interviews were coded, analyzed and developed

into major themes. To ascertain the reliability and validity of the emergent themes, a

triangulated analytical process was utilized in order to reach a consensus about the themes that

developed from participants' stories between the primary researcher and two other researchers. The themes were then categorized under one of the tenets of the PEN-3's *Relationship and Expectation* dimension' framework: **Perceptions**, which is related to the individually held knowledge, attitudes, values or beliefs stated by participants that assist or inhibit their personal motivation and decisions to maintain or change physical activities practices or beliefs;

After analysis of the information from the in-depth interviews and photographs presentation, the following themes emerged that focused on the participants' perceptions of themselves, their cultural and their environmental factors in regards to PA participation. The following themes are: 1) We are not the same, 2) Physical activity is good but… and 3) A culture of physical inactivity.

4.3 We are not the same (Perceptions of self and knowledge towards PA)

This theme alludes to the responses of the participants that were related to their perceptions of themselves, their environment and their attitudes towards PA. The participants expressed thoughts that portrayed their cultural values and perceptions and how it differentiates them from the status quo. Due to the complexity of the content within this theme, it was extended into 3 subthemes 1) Cultural Identity, 2) Acculturation and PA knowledge and 3) Visualizing physical activity.

4.3.1 Cultural Identity

An objective of this study is to explore not merely the cultural perspective of TAI's but also to understand how their identity as Black people in the US correlates with their cultural perspectives. How TAIs identify themselves can be an influencing factor to potential health behavior choices they might make. One of the main ideas shared by the participants was that they view themselves and their social networks to be significantly different from the AA communities despite living in the same areas or having the same skin color. This identity discrepancy is grounded by their connections to their African culture and their sustenance of it in the US. The following quotes illustrate issues around social identity:

"..Most Africans still follow the culture they brought over here. (Even) the older adults. They relate more based on the culture, You understand what I'm saying?, More to the culture than the African-Americans. It's difficult for Africans to assimilate… to assimilate with the general culture here…The reason is because Africans tend to draw towards other Africans. And also what they've learned from the beginning. So it's already ingrained. So for them to just discard it, it's very difficult for them. I'm talking about myself. Even though I relate a lot with African-Americans and other ethnic groups, but still I do things based on the culture." (Mrs. A)

"Because I have roots! I can go back (to Nigeria) and leave here…. I have a home here (In America) too. The land acquired that I chose to be in. I wasn't brought here by force. I came on my own and I can leave on my own…African-Americans don't have that. You understand? And do they really want to have it? I don't think so." (Mr. I)

TAIs believe that their transnational connection with Nigeria make them unique and distinguishes them from AAs. It also aids as an inhibitor for fulling assimilating because they can interact with people of similar characteristics. Their perceptions in identical differences also extend to factors such as social networks and demeanor/manners-- how they behave towards other people and who they decide to be friends with. The following quotes shed light on how TAIs feel about their social networks within the overall Black community:

"I don't have African-American friends. It doesn't mean I don't greet them." (Mr. I)

"Well…when you look at it culture-wise, you feel you are so different from them here…when you look at the cultural differences... like the way that you cook your own food, the activities you do back home, or the culture of the where you come from that uh…you know...like a respect. That we don't really get here. Because back home there's a lot of respect from the way they brought everybody up, compared with here that they (AAs) don't respect anybody."(Mrs. D)

This notion is not something that was solely developed by one group towards the other but instead, according to one participant, is a part of a societal construct in America. He states:

"I now understand that African-Americans believe that 'African-Americans' are people that are (natives) here whereby not just ones that migrated here, it is already set up by society. If I call myself that (African-American) people will tell me no that I am not and

that I am just African so that is just me fitting into what society has already set down."

(Mr. S)

The participant acknowledges that their identity discrepancies are in concert with society's

norms of classifying people. Another participant especially credited the discrepancies to an

historical grudge held by AAs towards African immigrants:

"...but the people here they try to differentiate you so once they see you the hatred is

there. Oh he's from Africa they sold us to the white. They try to do that to you especially

the Black ones." (Mrs. O)

There were some participants however, who did not necessarily agree with the feudal

relationship between TAIs and AAs and rather would identify themselves in other fashions. A

few participants mentioned:

"I am a Yoruba because Yoruba is in brazil, Puerto Rico, Ghana, Nigeria and everywhere

so if I alien myself with that because it is universal and if you're talking about African

American group I say I am black because the work African American was given to us by

Jessie Jackson so if I say African America I am saying African in the Americas." (Mr. M)

"I am me...I am who I am and I relate with you, I incorporate everything that I've gone

through in my life. So I can't say that I'm just Nigerian because I've lived a lot of my life

in the US but I cannot discount that I am a Nigerian because that is where I was born and

that is the culture that I practice." (Mrs. TA)

This quote highlights a definite distinction in regards to identity, along with a possible tension that might exist within the Black community that can create a divide between both TAIs and AAs, but there are also a few who may not have the same views in regards to the cultural identities. These findings indicate that the participants definitely do not perceive themselves the same as the AAs despite the fact that they reside in the same areas and have the same skin color. Their identity differences affect their cultural perceptions of their social environment and their interactions with it. This perhaps may serve as significant determinant for how certain health behaviors are developed within this population and not necessary across all Blacks.

4.3.2 Acculturation and PA Knowledge

Participants also discussed in detail a transition in knowledge level of PA due to their change in experience from their native homeland and migration and assimilation to the US Participants display a high level of awareness of knowledge in regards to PA and its benefits for physical health. The following quotes illustrate the participants' overall knowledge about PA:

"Because I know that when you...when you (get) involved in physical activities you can see the difference between not moving and more sitting. Your body...your body...you can see the difference there because I do exercise." (Mrs. D)

"It's (physical activity) good. It's good for your health and everything. For your body for you know." (Mr.R)

The participants show that they have a high level of awareness about PA. This level of knowledge about PA is ingrained in them because they mention that it is something that was

intertwined with their lifestyles while living in their native homeland of Nigeria. Two participants explain this in the following quotes:

> "Let me tell you something about Nigerians, Nigerian people don't really need this exercise because you walk a lot in Nigeria. It's not like here that you are okay if you are going somewhere now and to get to downtown there's a bus stop. Here you can go to your bus in a few seconds, a few minutes, but like… like…in Nigeria you walk a lot …People walk a long distance okay and the daily activities there I think it's harder than here." (Mr. I)

> "You know back home there wasn't much stuff about physical activity, because everybody gets that one daily, so I wasn't like this back home, as big as I am now, but everyone gets their workout one way or the other, because even if you're driving and you park, you will still have to walk at least 30 mins to one hour, so I think that one is good thing back home." (Mrs. B)

Despite their predisposed knowledge of PA, the participants testify within the following quotes that acculturating to the US allowed them to become more educated about PA as a health tool:

> "We know that it's (PA) very, very important. We know the importance. You know with the exposure that we have here and we see what is going on in, in this country…we're able to know that it's (physical activity) very important." (Mrs. A)

"I've been in America for a long time now. I know that when you…after you eat and you

sat down, you know, you're not doing your body a favor. So that's how it is…. I make

sure that I'm up on my feet, doing things before at least an hour or two before I go to

bed." (Mrs. J)

They recognize the importance of PA and what it does for physical fitness but that appears to

be extent of their knowledge content. Findings also highlight the perception and belief that

there is still an overall lack of understanding of causes of chronic diseases in the TAI community

and how PA is a tool for it. One participant mentioned:

"Yeah you see, physical activity…people (Nigerians) see it as uhh …it's not of health.

Most people see it as "I want to be skinny". Even though underneath it goes with health,

you know." (Mr. O)

Another participant mentioned:

"Here (in the US) we understand health risk so even though you see yourself getting big

you control it yourself. Which is why for someone like me, I'm on the healthy side and I'm

working very hard to lose weight… which is unbearable to some of my people. When I

talk to my Nigerian friends and I tell them I'm going to the gym they ask me "what is the

problem?" It is a culture thing." (Mr.BA)

The participants state that PA is not utilized for health reasons but rather it is used as a tool for

the intentions to change or maintain body image. In addition, the use of the facilities and other

resources may appear strange to others if they appear to look healthy and in shape. Another

participant in particular shared an interesting thought, mentioning that knowledge about the cause of chronic diseases within the African immigrant population is at times attributed to cultural belief in supernatural causes:

"A lot of Nigerians die because they don't know what is killing them…before they know it, heart attack! Because they are driving cab and they don't care…. Then the next day the person just drops dead, they say "Oh he just eaten some poison. The person drop dead and someone will say "they" cursed you. They just had a heart attack my friend. He didn't take care of himself." (Mr. I)

He continues to elaborate:

"Because our people always blame our neighbors for our mischief. ' He is the reason why. The reason I'm not progressing…I went to the Oracle, They say he is the one that is doing it.' When you start having that though, you are finished, everybody is witches and wizards." (Mr. I)

This statement denotes an element of rationale pertaining to the type of knowledge that accompanies some Nigerians prior to migration and acculturation; the idea that there is some form of supernatural reasoning behind the ailments they may face. There were some participants who refute the aforementioned quotes and believe that mentality is of the past and health awareness is increasing. For instance, one participant mentioned:

"Nigerians come here and have that mentality, but that belief gradually sinks because it is a different environment. The people you meet have different beliefs, you find out that those factors that make you think that way are no longer there, if those factors are

based on neighbors and family you don't see that here so it does fade and you find out

that those people that had those beliefs, they no longer think that way. They even go

home and give advice so the change of environment makes a huge difference"

Another interesting finding was that the participants acknowledged the presence of health

promotion materials and resources here in the US, but aren't consumers of promotional

material such as billboard or TV ads:

"Uhh let's just say physical activity is one of the biggest business ventures in America.

You see medication advertisements, there's some that are even lying so much and

people still bargain for them. Like the statistics said, I think 65% or 70% of Americans are

obese. And based on that, it's a good marketing area...You see a lot of different

treadmills coming out every day, and they have lot of medications.... It is good business.

If you go to downtown nearly every house is, every...have a gym and everything. But are

people really using it? People are paying for it but are they using it? If they are using it,

their weight should have reduced more." (Mr. O)

Another participant mentioned:

"Okay I'll tell you this. I've seen all of them (promotion materials). When I look at it, I just

laugh." (Mr. I)

Participants appear to be skeptical about the promotional message they receive, believing that it has some ulterior agenda behind it. Despite the amount of skepticism expressed, some participants in the following quotes still called for more culturally-tailored educative materials regarding PA and chronic diseases in their respective communities:

"I think if we start from the community, where there are African people trying to educate them, and just make them see the importance of doing it (PA). They don't need a lot of time to make a difference… maybe that will help some… no matter what we say it might not go well but some will accept and from that point we might be increasing, but we need the workshop, the education, the "how to" to do this. To teach all the importance of it and the benefit of it." (Mrs. F)

"Yeah, we can use our own language, you know, and our culture to teach. To teach our people to learn and understand (PA), you know, actually breaking it down for them so that they would understand it…. Like prevention basically you know… We can talk to them in our own way and use our cultural stuff to educate them you know." (Mrs. B)

Participants appear to be calling for a culturally sensitive approach for them by using their own languages and other cultural methods relatable to them in order to promote PA in their communities. In summary, interview findings suggest that members of this population may have an imbedded experience about the benefits of PA as a product of their past lifestyles when in their homeland. However, upon their arrival and assimilation to the US, there is still a

dearth in education and knowledge tailored in a way they can learn about the benefits of PA as a way to prevent chronic diseases and not just a way to stay fit and to sustain physique.

4.3.3 Visualizing physical activity

In the second part of the interviews participants were asked to view some images of PA and describe their relations to these pictures within their daily lives. This photo elicitation process evoked some interesting findings regarding how the participants visualize the practice of PA.

Some participants mentioned not engaging in some forms activities as a part of the ethos of their respective cultural groups. For example when discussing **Image 1** a participant mentioned:

Image 1

(Image retrieved from Google)

"I haven't seen any Africans running like this to be coming here and jogging I've never seen any Africans jogging. I see them strolling (walking) but that's different. Maybe they are doing it but I've never seen them." (Mr. I)

"We don't believe in all these marathons… culturally we just don't see it like that; we just wonder why people are running around like that. I see the white people doing that but not even African American people. One of my goals is actually to do a marathon and I will train for it. A lot of people just don't do that." (Mr. S)

Participants quip that they do not relate to **Image 1** because that behavior is not something they associate to their own imaginations of engaging in PA. However, participants did express that they see themselves engaging in a similar form of PA if they did not do it alone: For example, a participant states:

"It is different when you have people that want to do it with you. That is not much motivation if no one wants to do it with you. If my friends will do it with me it I will be more motivated to do it and make it competitive between my friends and I. This thing is something that is foreign to us." (Mrs. O)

"I don't really see this with our culture because we kind of believe in this buddy system type of thing, I see this with the younger generation but not the older people because even me I would need a…I would need a push from someone." (Ms. L)

The aforementioned quotes dictate that the sense of engaging in PA individually is not one that appealed to the participants much; they would rather have someone to engage in PA with. One form of PA that all participants strongly expressed is a major part in their lives is dancing; particularly their cultural dances (**Image 2**). For example:

Image 2

(Image retrieved from Google)

"The time we do physical activities was when we go to parties. You can be on the floor for 8 hrs. and dance. And sometimes I used to tell them this is my exercise for the week... So that is what I feel that the joy of Nigerians." (Mrs. T)

"It's dancing. Nigerians love to dance....Like on Saturdays, if they are out there in their local associations events, they always make sure that there's music and they dance. Then, on Sundays when they go to church, it's more of dancing by praising God. So two days in a week I would say they do that." (Mrs. A)

"Dancing to me makes more sense to me than the family taking walks" (Mr. S)

Dancing seems to be an activity that is incorporated in their cultural activities such as parties and religious practices. Participants also mentioned how they use dancing as a transnational tool to sustain their cultural ties:

"This is cool, I like to dance and I don't want to lose my touch so I practice my own moves so that I can do them at parties… the shoki (a form of dance) that I am talking about now is a dance coming from home (Nigeria) and if there is another dance tomorrow I will want to know the dance." (Mr. S)

The participant expresses that dancing is a way for him to keep up with what is going on back in Nigeria and uses dancing as a way to keep up with new practices over there. However, one participant did not necessarily feel as strongly about dancing as the rest. She mentioned:

"I don't think that it (dancing) is as effective because dancing is good only if you do it on a regular basis and not just when you go to parties, this picture doesn't even look they are doing any exercise to me, it looks like some kind of show." (Ms.L)

Another participant felt so strongly about dancing that she called for some form of culturally tailored dance program. She says:

"I would say like a Zumba type of thing, but with the African music…. People would jump at it…. because it relates to them…their upbringing…especially if it's the African music that is incorporated into it. Then people will do it. I would do it." (Mrs. A)

"A class is better, a video might work but African music with dance steps will make people workout more without even knowing it." (Mrs. TA)

In short, the findings indicate that dancing is something that the participants believe is engrained with their cultural practices and experiences. It is facilitated in their personal spaces or enclaves they utilize to not only sustain their cultural identity (for example hometown associations), but also used to engage in PA whether it be voluntary or involuntarily.

Participants also shared their perceptions of other activities such as yoga (**Image 3**). The participants did not relate well to this as a form of PA that was culturally relevant to them or as something that they would choose to participate in. For example:

Image 3

(Image retrieved from Google)

"We think that it is Hindu even though some of the practices relate to Islam and exercising is something the prophet Mohammed talked about so yoga is good but it is not something we do." (Mr. J)

"I saw a friend of mine on Facebook doing yoga and I nearly called her to see if she was okay because it doesn't even look appealing to me. It (yoga) looks like someone that is trying to worship something. If you find out the background of yoga you will see that's it's a spiritual thing."(Mr. BA)

The participants do not perceive this particular form of PA as something culturally relevant to them because it is perceived as something associated to spirituality that could interfere with their personal spiritual beliefs and religiosity. PA appears to be something that TAIs want to incorporate indirectly through cultural events and daily movements.

This theme along with its sub-themes alludes to participants' cultural perceptions and attitudes towards PA and the practice of it. It is reflective of how their cultural views of themselves and their surroundings; their transnational experience of acculturating (while yet maintaining native ties) impacts their knowledge and belief towards PA behavior. These individual determinants have significant potential to influence the volition to engage in positive or negative behaviors.

4.4. Physical activity is good, but… (Perceptions of enablers and barriers)

This section alludes to the participants responses related to the participants' thoughts on PA and the particular societal or structural factors that they perceive to facilitate or inhibit them from engaging in PA. Although there is a high level of understanding about PA and its health benefits, interview findings indicate that there are some particular challenges the participant described that they face. Therefore, this theme was divided into 3 subthemes 1) Safety, Weather & Neighborhood 2) Nigerian parties and 3) Time and Values

4.4.1 Safety, Weather & Neighborhood

There are several personal, social and environmental factors that can impact engagement in PA negatively even if there are resources that may be available to facilitate PA.

The following quotes revealed that participants viewed factors such as safety, weather and even the neighborhood play a role as a determinant for them to be physically active despite the fact that there are some resources around. For example one participant mentioned:

"There are parks, you know we have trails, you have the recreation centers across the street. But do I go? No…so many things are going on right now, like everybody is just like scared or trying to protect themselves or because you never know, you Black, you Africa you never know you never know what is going on people running up by themselves… because anything can happen." (Mrs. B)

"Uhhhh, I don't go to the park, first of all. My area before is uh is not really, well at least to me, is not really safe. I have one right almost in front of my house. But there's always gang banging people there, the boys always hanging around and uhhh few incidents have happened where police chasing and all that stuff. So I don't often go to the park." (Mr. O)

"There is one park here, but I don't have no business going there… What am I doing in the park??" (Mrs. O)

"Safety is going to be a big issue because it depends on where each person lives. If it's not very safe, it will be difficult to do the walking in the neighborhood." (Mrs. A)

This reflects that safety appears to be an impeding factor to PA participation for our participants. However, not all the participants registered complaints about the safety in neighborhood and furthermore praised some the environmental resources or facilitators that are available, one participant mentions:

> *"Oh yeah! I mean I tell you... I love the community and the environment. Why? Nobody bothers me… because this area is working area people. In the afternoon the only people you see are the cops...so I don't need those alarm people (home security companies)." (Mr. I)*

> *"Yea they have a lot of parks around us here so we can do a lot of activities that we want… We have the best of them (resources) all… this area down the street, Howard area community, they call then Howard area community, you walk in there and they give you a lot of information. You need help, you need this, and they provide you with it." (Mrs. T)*

When given the opportunity, it appears that some participants recognize and do take advantage of the resources that are available to them. Nevertheless, another environmental barrier that participants face is the weather. Participants, coming from a warm climate country such as Nigeria, complained about the impact of the cold weather on their willingness to engage in PA regardless of how long they've been here. For example:

"Do some exercise? Not in winter time, no. When it is uh, cold, no you don't go. You

won't find Nigerians exercising, you know, running. Maybe in their house, if they care."

(Mr. B)

"Yea sometimes that one is part of it, because like summer time sometimes, during

summer time I walk. During summer time, but when it starts getting cold you shut

down. Until it starts getting warm again, so yes weather has something to do with it, the

month of the winter is kind of too long." (Mrs. B)

"Chicago is so funny. We only have 3 or four months of summer. The rest is cold. Nobody

wants to go to the park. So give or take, if you remove 3 or 4 months from 12 months,

the rest is indoors." (Mr. O)

"Weather is another one that is another important one. If it is winter, I don't want to be

taking a walk in the snow and in the summer if there is violence I don't want to be

outside also so that tends to keep me inside. That is a restrain on me having the

opportunity to do my workout outside." (Mr. S)

It seems that the participants view the constant seasonal change that occurs in Chicago as a

determinant of PA participation. In short, weather and safety are impacting factors that

negatively affect the participants' willingness to engage in PA, even if there are good resources

that are present in their communities.

4.4.2 Nigerian parties

Although acculturated into the US, our participants sustain their transnational identities through maintaining cultural practices with fellow Nigerians who share the same characteristics. One form of this is the socialized practice of having parties. These parties are coordinated in similar fashion to events thrown in Nigeria, with similar dishes, attire and music reminiscent of their native land. Participants mention that this enables them to participate in dancing--their most common and natural form of PA. The following quote states:

"It's just a (place) to let loose…like we joke around and say, Nigerians don't go on vacation but when they come to Nigerian party, that's their own relaxation. We joke about that." (Mrs. F)

"Saturday I went to one Nigerian party. I mean we are there til…you know Nigerians…they love their parties (laughs). We were there till 4 in the morning and we were on the dance floor all the time dancing. Yeah. It's ah…it's really good, I mean, you see me sweating, it's good. Like I said that's good (laughs) because there's lots of sweat coming out (laughs)." (Mrs. D)

"When I'm at the party, I don't sit down. I don't sit down. I dance and I dance!" (Mrs. J)

Nigerian parties appear to facilitate an atmosphere that enables the participants to be highly active with dancing. However, the findings may suggest that Nigerian parties may also serve as an avenue for unhealthy, sedentary behavior, dependent on the individual. A few participants discuss their thoughts on this, as follows:

> *"If you go to the typical Nigerian party where you're just sitting down, eating…you probably won't lose any weight." (Mr. O)*

> *"The male most of time are drinking in most of the parties, the women, when it comes to the dancing… it's mostly women…I don't know why. If men are there dancing they move so slow as if they're letting the women dance around them. Party's good, but most of the time we (men) use it for drinking and eating." (Mr. I)*

In short, Nigerian parties are a societal and cultural construct that is viewed as an opportunity where TAIs can be active, sustain their cultural ties and enjoy themselves. However, it can also be a place where behaviors that can be counterproductive to being active can also take place. The utilization of these spaces is truly up to the volition and motivation of the individuals that attend and it is only captured in a small capsule of time.

4.4.3 The value of Time and Transnationality

Along with the environmental and community structure that facilitate and inhibit PA practices, throughout the interviewing process participants were all in consensus that the biggest barrier preventing them from engaging in PA is the notion of time. Findings from the

narratives revealed that the participants believe that the creation of time, along with other personal values or priorities, factor significantly into their motivation to engage in PA. For example:

"Over here it's a different thing you have to create time, there is no time if you have to take care of your family working one job working two jobs, physical activity is something that is not common, it's not common, it's something that we are supposed to be doing for ourselves but it's a little bit difficult." (Mrs. B)

"Not enough time (for PA) because most Nigerians that I come across they work sixteen hours in a day. If you see anybody not working sixteen hours in a day, they'll eight hours and then go to school. So by the time they get home, it's difficult for them to exercise. They're focus is on job, school, job, school, or school, job. So that's going to be a big challenge."(Mrs. A)

"There's no time to do any physical activity. And a lot of Nigerians...we Nigerians can work 24 hours. We go from one job to another. From one job to another." (Mrs. O)

"That's right, I know about it (being active) but when I set my priorities the money comes first." (Mr. S)

The participants expressed that they do not feel that they have the time to engage in PA. Furthermore, participants feel that PA is not a priority, but rather the pursuit of affluence and

money is because of responsibilities not just for their household in the US, but also their

transnational responsibilities for their family members back home in Nigerian that they send

remittances to. These quotes capture those thoughts:

"You have to create time for everything. Do you know how many Nigerians have

collapsed on the steering wheel? Driving cabs… because they don't have time. And I

don't blame them. Do you know how many people calling (from Nigeria) saying they

haven't eating since yesterday?" (Mr. I)

"I can't compare myself to others, but I do know majority of them is about the finance

because they have to take care of their families members back home…Because when you

think about it, if you send $50 to your family members at home, you really…you really

helped that family, you really do. And this $50 when we go to grocery store its nothing,

but when you send that to a family member in Nigeria, it's something…because those

are the ones…we think about first before us. You're gonna find that in our culture. We

don't buy clothes for ourselves. We don't think we really have to spend that money on us

because we have a brother, a sister, or a mother. That extended family cultural

cohesiveness." (Mrs. J)

Because of their transnational connections, participants admitted to having a sense of duty and

accountability for their family members overseas that factor into their decision makings.

Findings indicate that the participants believe that their purpose of coming to the US

supersedes any notion of creating time for PA. Even if it's for a popular concept

aforementioned such as dancing:

"Yeah dancing at parties sometimes is part of losing weight. But like I said we're not here

to party, we're here to work and make money." (Mr. O)

"Everything you have to create time for it. Our people here, they don't have time for it.

They believe they come to America to come to work and make money." (Mr. I)

"Work! Work and earn money…a Nigerian man comes (to America) and wants to prove

that he is a man that can take care of his family." (Mr. R)

In some cases however, some participants also simply attributed their lack of PA participation

to not wanting to do it and/or exhaustion:

"I don't think there anything that you can really do, a lot of people that are more

concerned about their health or fitness I feel like they will engage more in PA but some

people just really don't care and some people are just too lazy and some people know

that they should do it but they are just too lazy and tired at the end of the day" (Ms._)

"Because of laziness! I watch my diet but it is simply laziness. I used to play football even

at the college level for 2 years but after that I have not been doing much. It comes from

just being lazy. The gym that I have a membership is only a 10 minute walk, but I do not

go because I am lazy and tired." (Mr._)

In summary, the pursuit of wealth significantly impacts TAIs from engaging in PA, more so than the typical person with occupation obligations because of the transnational responsibilities they take on such as sending money, clothes, shoes, medicine and other necessities they feel their family members overseas may need. The findings indicated that TAI's put the well-being of family, domestic or internationally, and their financial security above everything else including their health and finding time for PA.

This second theme relates to the enablers and barriers that TAIs perceived that they encounter in regards to PA behaviors. The findings show that there are more societal and environmental barriers that exist in comparison to facilitators. The sole facilitator, Nigerian parties, serves a construct that is deeply intertwined within the ethos of their community and will always be existential. The values and purpose of immigrating to America is a far more challenging barrier to PA behavior and heavily outweighs any motivation to find time to engage in PA.

4.5 A Culture of Physical Inactivity (Perceptions of family and community influence)

This section of findings discusses the participants' perspectives pertaining to the perceived influences that they may receive from significant others and their respective community groups that could be either discouraging or supportive to PA behavior. The influence of family members or loved ones can serve as a significant factor for nurturing practices that can be considered positive or negative determinants maintaining PA behaviors. This section consists of 2 sub-themes: 1) Family & Friends and 2) Hometown Associations.

4.5.1 Family & Friends

Interview findings demonstrate that most of the participants do have discussions on the topic of engaging in PA with their family members and friends. However, the participants disclosed that the majority of there are about losing weight or body image. For example:

"Uhh like my children want me to shed a lot weight, they want me to keep fit. My wife worried. Unfortunately, both me and my wife are big people so it doesn't bother us, you know. We joke about it. We joke with each other like 'You need to shed some weight' or 'You need to trim your stomach down', so we joke about it...uhm, we actually registered into some uh...fitness centers. But, unfortunately we don't keep to...we don't go down there all the time."(Mr. O)

"They (family members) do care. Everybody is concerned because you don't look too good when you are overweight so you are conscious about it, we all joke about it, we say 'your tummy is looking big that doesn't look too good'. " (Mr. S)

"When we (family members) meet (at home), we may talk about exercising. We tease ourselves about it." (Mrs. A)

The discussion of PA participation seems to be in forms of banter and jokes among family members, but it doesn't appear to extend beyond that. Participants' responses also revealed that their level of PA with family members is dependent on the age level of the children they have. Participants who have older children reported higher level of participation in the past

when their children were younger, but presently do not participate because of isolation and other priorities. This is supported by the following quotes:

"Hmmm. I'll say ummm when my children were growing up, we played games together. You know, we might go outside to the park and walk. We visited so many places. That helped, but now I'm the only one in the house. So I can't really say that I would do that very often, you know." (Mrs. O)

"Oh yeah. Moving a lot. Like doing things around the house with the kids. When the kids were younger, it wasn't much TV. There's always something to do around the house. There's always something. You'll move around. (But) now they're grown now…they're even more independent…we don't go do things together like we used to." (Mrs. J)

Those with older children expressed that they're not as active anymore because their children are grown. This point did not hold true for participants with younger children. They reported more engagement in PA in the household or outside, as mentioned in these quotes:

"My kids are still little and they need me so I want to get fit. I promised myself that when my kids graduate I want to be there! I don't want to be in a wheel chair or on a sick bed so that is my motivation." (Mrs. T)

"Well I try to encourage them to get active like, you know, when I see that they're staying too long behind the computer I have to get up and give them chores to do, you

know I do that. We talk about it as well…I make them understand the important of

staying (active). You know." (Mrs. F)

Those with younger children tended to find something active to do in order to stay engaged with their children. There were some cases in which participants mentioned not having discussions with family member because it is unorthodox. One participant mentioned:

"That is not a regular conversation people have, we would rather sit and talk about the

Kardashians than talk about exercise. I think that it is just the society, it is something

that should be part of their daily life but they do not think about it." (Ms. K)

"It's not something that you discuss as a topic it is just not typical in our culture to just

talk about it. But it's in our culture to address laziness…like just sitting down not doing

anything for the whole day someone will walk by and tell you that you are lazy, it a part

of the culture to be active so with my family and kids if I see someone is not physically

engaged then I will say something" (Mr. BA)

But contrary to the aforementioned statement, when discussing leisure time activity, the participants had expressed that during their leisure time, they typically engage in sedentary behavior with their family and friends. This is supported by these quotes:

"We watch TV a lot…" (Mr. S)

"…But most times, we sit down and watch TV to be truthful." (Mrs. A)

"Um.. we watch TV, we argue and we debate about what's on TV." (Mr. O)

The watching of television seems to be the common activity shared by the participants and their family members.

In regards to the involvement of friends and PA participation, the participants make known that they do not discuss PA with their friends and at times when it is discussed, it is short-lived. For example, a few participants said:

"We normally talk about family, talking about work, talking about what happened since we've seen each other last, so.. just like different topics, but the physical activity one is not part of the topic." (Mrs. B)

"So if I'm explaining to them (friends) how I take care of myself, they say 'ahhhhh...I don't think I have time for that.' So I just leave the topic." (Mrs. J)

In short, interview findings reveal that family and friends are not nurturers to positive behaviors regarding PA. Family members address the need for PA via discussion but may not support in the participation of it.

4.5.2 Hometown Associations

Hometown associations are organizations or social groups formed in order to develop better transitional networks amongst immigrating Nigerians. Nigerians use hometown associations as a tool where they can interact with people from the same ethnic background or

hometown region in Nigeria; to sustain the cultural practices that they collectively share; and to assist with alleviating challenges to acculturation. The following quotes show that the participants who mentioned having an affiliation with a hometown association perceive it in regards to the promotion of PA engagement or even discussion. For example:

"We never discuss that in our meeting, but as you mention it now it's something that I'll bring up to them. We don't discuss it that much… We talk about what is affecting us. If somebody is going through a difficult time here, how we can assist such people. How we can…really we're looking at ways of getting ourselves used to the system here. So we're not thinking about the health issue. We're thinking about blending with the culture here. Okay, you need to go to school. You need to get a job. So those are the things we discuss more." (Mrs. A)

"Yeah sometimes uh…you know when we go there we talk about how the association can help. In case we having problem with uh moving around or anything like that. So it is really helpful to just go and socialize." (Mrs. D)

"Those groups are faji (fun) groups, they don't believe in exercise. Just to eat and drink." (Mrs. T)

PA promotion appears to not be a priority for members of these hometown associations but instead falls behind other objectives such as assisting with acculturation and creating a space

for socializing. One participant however, believed that awareness can be spread through these spaces. He states:

"The best way is to pursue our people, go through these home organizations, the mosques and the churches and to go where our people congregate to educate them. When you understand your people language you can help them." (Mr. M)

"Going into the community and even the churches, we are very religious and to the mosque and when they have their picnic for the fourth of July you can have your health fair when people are having fun but at the same time they can have things like their vital signs and then they can talk to their physician but I think that is the only way you can catch people" (Mrs. SM)

Hometown associations appear to primarily assist in sustaining transnational identities and activities. In short, these hometown associations, despite their benefits from a transnational standpoint, have not been perceived to pose any form of influence to positive behaviors regarding PA, nor has it been used as a platform to initiate discussions about health behaviors related to PA. However, there are some that believe it can serve as a possible channel for possible change

This third theme along with its sub-themes focused on the perception of factors that may serve as nurturers to particular behaviors that TAIs may show. The interview findings reveal that family and friends, elements of one's interpersonal network, have no positive influence to sustaining PA and in fact may actually assist in nurturing more sedentary behaviors.

Hometown associations, another element in a TAI's social network also were mentioned in an ineffectual context in terms of being a supporting tool to promote any form of PA behaviors. Because of its influence in social interactions or acculturating standpoint, hometown associations still stand as a potential space for health promotion to members of a hard to reach, complex population. It simply has not been used as such. In sum, participants' responses reveal that there is no support for them to sustain any positive PA behavior.

In conclusion, the interview with TAI's revealed much about their cultural perspectives about PA and factors that influence the engagement of PA. Findings reveal that TAIs cultural identity and perspectives affect knowledge regarding PA and preventing chronic diseases and also affect the forms of PA they choose to engage in. Despite having some knowledge or experience about PA, TAI's have transnational and environmental factors that serve as barriers for engaging in PA. They also appear to express a lack in support from families or organizations for sustaining PA behavior even if they were to develop one.

CHAPTER 5
DISCUSSION

5.1 Discussion

The primary objective of this study was to explore the cultural perceptions and the understanding of PA among TAIs and how these factors contribute to their decisions to be physically active or not. This study employed an inductive approach guided by the PEN-3 theoretical framework and dimensions (Airhihenbuwa, 1995). A qualitative research design consisting of a semi-structured interview and photo-elicitation were conducted with 24 Nigerian participants living in Chicago. TAIs have the unique ability to sustain ties, so it is important to explore how these multi-national ties affect health behavior and long-term health outcomes.

The vast majority of African immigrants live symbiotically within the AA population, a population that already faces a disparate burden of chronic diseases compared to other racial groups. Furthermore, AAs already report the lowest rates of PA participation, which adds more to the risk of negative long term health outcomes associated with physical inactivity (Lee et al., 2012). TAIs, despite similarity in skin color, represent a group of people who possess different cultural beliefs, traditions and practices different from the AA population so it cannot be assumed that the same approaches to health interventions for AAs can be applicable to TAIs (Ilunga Tshiswaka & Ibe-Lamberts). There are no proposed solutions for how to take care of the TAI population, especially for those who have acculturated and have resided in the US for a long time and may be at risk for adverse health outcomes (Singh, 2004). Studies have shown that there are socio-cultural and environmental factors that can impact PA in a positive or negative way in different populations (K. S. Hall & McAuley, 2010). However, there isn't much attention

that focuses on how TAI culture and behaviors, such as transnational practices and/or partial acculturation, impact PA participation. A principal goal of this study was to explore the cultural perceptions, attitudes and values about PA of TAIs and how it's incorporated in their daily life activities.

Although guided by the PEN-3 model, not all the findings fit the tenets of the "Relationship & Expectations" dimensions completely. Many of the emerged themes primarily fell under the tenet of "Perceptions" since the findings highlighted the personal perspectives of the participants toward PA while taking their cultural practices into consideration. The "Enablers" and "Nurturers" tenets were not truly addressed because the participants solely expressed their perceptions of factors that are enabling or nurturing but it was solely their own perceived notions towards these factors and how they impact their participation of PA or lack thereof. The first theme that emerged from the interviews was "We are not the same". The sum and substance of these findings indicate that there is a distinction in how African immigrants identify themselves and how their socio-cultural identification impacts their perceptions, which influence their behavioral choices and interactions with other groups that they may resemble or coexist with. It is paramount to understand that this concept of perception does not solely speak to how they identify themselves in comparison to AAs but furthermore how their knowledge of PA and visons of PA also differ. Nevertheless, these identity differences revealed were crucial in understanding why TAIs may behave differently than what may be typically expected from a Black person in the US. It was revealed by the participants that while they considered themselves Black, they do not view themselves the same as the AA's. Participants effusively spoke to how their cultural and transnational ties, their

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beliefs and practices distinguish them from their native counterparts. It was clear that there is a

chasm driven by tension between both groups. This is consistent with the small amount of

research that is available that explores the intra-racial relations in the Black populations.

Studies in this arena show that TAIs typically display higher levels of educational achievement

(Logan, 2007; Thomas, 2012) and overall health status (Wheeler, Brooks, & Brown, 2011). The

findings from this study are also consistent with the studies that show that African immigrants

(and TAIs) purposely segregate themselves from their native counterparts despite the facts that

the societal structures force them to live in the same inner-city ghettoes as AAs (Abdi, 2012);

African immigrants to some extent feel they are superior to their native counterparts

(Takougang, 2003). The findings also show that the participants believe the tension is caused

because of a lack of acceptance from the AA community. This is consistent with Takougang's

claim that native Blacks (AA's) feel negatively towards African immigrants and direct blame to

that group as the cause of historical transgressions and atrocities that happened to their

ancestors; primarily the Trans-Atlantic Slave trade. AA's also view African immigrants as a

threat to their socio-economic mobility; their taking away of potential jobs and opportunities as

they all fight for limited job pools and other avenues for prosperity (education, entrepreneurial

outlets etc.) (Waters, Kasinitz & Asad, 2014). AAs also consider African immigrants to be the

perceived as "model minority", favored by the Whites and more likely to be selected and

treated better by Whites. This "model minority theory" submits that minority groups can

overcome obstacles based on not only their immigrant status, but also their race because of

their positive cultural and behavioral values (Dodoo, F, 1997).

African immigrants are actually described as "invisible immigrants" because they are not compared to other immigrant groups, but are instead compared to the native Blacks, which become a detriment to AA (Bryce-Laporte, 1972; Waters 1994). Conversely, despite the voluntary attempt to distance themselves, research has also shown that African immigrants are still subjected to the same form of racial discrimination and injustice as the AA's counterparts (Benson, 2006; Brettell, 2011). The author denotes that the more foreign-born Blacks begin to identify themselves more with AAs, the more likely they encounter discrimination. This is congruent to health research findings that discuss African immigrants becoming at high risks for chronic diseases the longer they stay and acculturate (or assimilate) to the US (Mohamed, Hassan, Weis, Sia & Wieland, 2014). However, the research findings from Benson (2006) conclude that both groups interpret racial encounters differently. According to the author, African immigrants tend to not fight against racial injustice or discrimination, nor attribute their positions as Black in the US; African immigrants tend to attribute the AA negative position on the individual rather than on societal structure. This is consistent with some of the testimonies of the participants of this study. One participant in particular described that African immigrants have more "tolerance" than AAs, alluding to their reactions to certain cases of adversity or conflict that they may face in the US. For instance, the US has a unique classification system centered on race and African immigrants tend to come from structures where discrimination is not based on skin color and more on factors such as SES, language and culture (Cornell and Hartmann, 1998; Landale and Oropesa, 2002; Rodriguez, 2000; Waters, 1999). African immigrants tend to avoid conflict and do not want to create uproar and are more likely to be compliant. This is evident in findings by Nielsen & Martinez (2011) that show that foreign-born

Blacks have lower rates of arrest than US-born Blacks. With these differences taken into account, the focus now needs to be on how these differences impact health behaviors such as PA activity in the TAI community. If TAIs are distancing themselves from AA's, it can also be concluded that TAIs do not necessarily want to engage in behaviors that AA's are engaging in to improve PA participation. This can also be inclusive to other health behaviors as well. This is an area that Public Health needs to do more work in order to further understand the intra-racial relationships between AAs and African immigrants and how it also is a determinant of health behavior choices. There is paucity in literature in that area.

Subsequently, the findings under the theme "We are not the same" also attest to the concept of acculturation and assimilation and its impact on PA knowledge. The findings show that African immigrants are lacking an understanding of PA as a tool for chronic disease prevention. Despite PA being a part of their lifestyle in their native homeland Nigeria, it was not something they were educated on as a tool for primary preventive health. Their knowledge of PA extends to its broad benefits in regards to achieving physical fitness and body shaping. Upon arriving and acculturating to the US the participants become exposed to more information about chronic diseases, but overall do not typically see the connection between lifestyle behaviors and chronic diseases such as CVD, diabetes, cancer. The findings from this study briefly touch on the notion that some African immigrants may attribute chronic disease to supernatural or spiritual causes. This finding is consistent with the idea suggested by Kamya (1997) noting that African immigrant cultural beliefs and practices tend to defer to spirituality and supernatural beliefs, possessing a strong sense of religiosity. The findings also display that although they have a high awareness of PA, African immigrants tend to engage in PA activities

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that relate to their cultural and self-identity. When visualizing PA, concepts such as participating in walking or jogging, or yoga by themselves were things that they did not identify with. This alludes more to the African immigrant community's interdependent nature compared to their preconceived assumptions of the individualistic ethos of the western world that they reside in. Berry & Annis (1974) study on acculturation state that the immigrant must face and answer two important questions: 1) is the cultural identity of value to be retained? and 2) are the positive relations with the dominant culture worth seeking? The scarce research on TAIs show that their unique connection to their native homelands permits them to do both. They can acculturate to the dominant culture for the purpose of gaining access to resources that can be beneficial to themselves and their native land ties, but can also sustain their indigenous culture for the benefit of sustaining self-identity in their new land (Itzigsohon & Saucedo 2002). Studies on PA show that although people may have a high understanding of PA, it may not necessarily create behavior change (Dishman, 1982). The findings in this study also touched on the skepticism in regards to health promotion. Participants also didn't find the messages related to them and their cultural identity and furthermore were perceived as a way to simply spend money. This is consistent with research findings from Sebastião (2015) on older African American women and PA, which submitted that AA women did not feel public health messaging related to them due to cultural factors and did not relate to their reality. Research shows that perceived expressions of understanding and satisfaction combined with knowledge lead to higher participation and sustenance (King, Taylor, Haskell, & Debusk, 1988). This idea is supported within this study as our participants spoke fervently about dancing as the primary form of PA that they engage in. It is incorporated into their culture and their daily life activities and their social/transnational

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networks. Studies report that dancing has both psychological and physiological benefits for both the old and the young (Hui, Chui & Woo, 2009; Jain & Brown, 2013). Whitehorse et al. (1999) implemented a community intervention trial geared toward the Hispanic population utilizing mainly salsa aerobic dancing. The results from this finding proved that community-based dance intervention programs have proven to be an effective way for health promotion programs that are group specific and tailored for under-served populations (Whitehorse, 1999; Jain & Brown, 2013). Participants in this study called for similar programming that is tailored to their fashion of music and cultural dancing. Future studies in African immigrant health should consider interventions centered on African dance. All together the findings signal that intra-racial cultural influences for PA within the Black population need to be explored because African immigrants perceive PA differently because of their cultural identity.

The second theme developed from the responses of the participants is labeled "Physical Activity is good, but...". This theme focused on the perceptions of the environmental and societal structures that may serves as enabling or inhibiting factors for engaging in PA. The findings suggest that TAIs face environmental barriers to PA. Participants mentioned neighborhood safety (in terms of fear of crime and violence) and weather as a factor that negatively impacts their participation in PA. The FBI Violent Crime Statistics of 2015 listed Chicago as the number one rated violent cities in America among America's largest cities. Crimes rates are at a high in neighborhoods that are occupied by minorities, within the inner city ghetto (Sampson, 2012). The illustration (Figure 6) tells that there are high crime rates all over the city of Chicago. With gang violence and shooting occurring frequently in these areas,

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this becomes a major concerns for residents and could most likely discourage them from

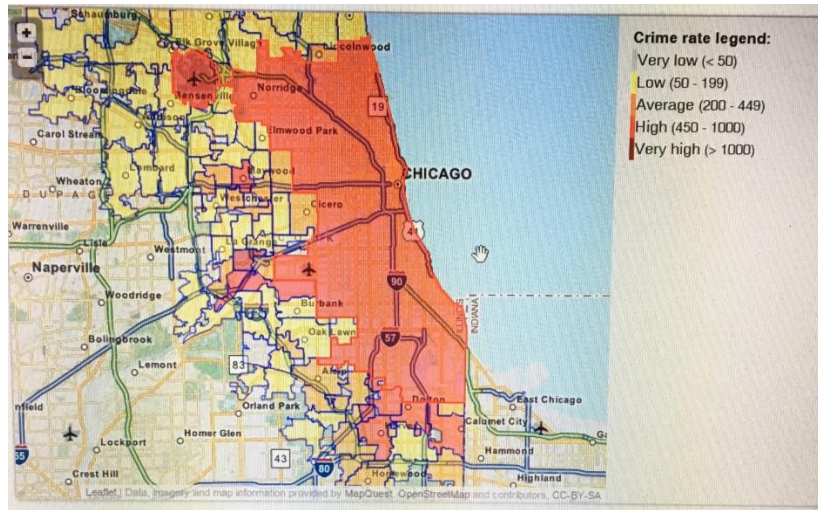participating in PA if the opportunity were to present itself.

Figure 6. **Crime rates in Chicago, Illinois (IL): murders, rapes, robberies, assaults, burglaries,**

thefts, auto thefts, arson, law enforcement employees, police officers, crime map

Research also acknowledges that cold weather and precipitation can play a role as a deterring

factor for PA (Tucker & Gilliland, 2007; King et al., 2000; Wilcox, Castro, King, Houseman, &

Brownson, 2000). Chicago, located close to Lake Michigan, is a city that experiences extremely

cold winters. TAIs from Nigeria come from climates that are primarily humid and do not

experience winter, so regardless of length of stay our participants report that the winter season

primarily, discourages their want to participate in PA.

These barriers are not unique to members of other minority groups and are consistent

with research findings on environmental determinants of PA participation. People of AA

communities and other racial groups also face similar barriers that may discourage them from

participating in PA. Efforts to reduce gang violence and gun violence in Chicago have been an arduous task and an ongoing battle in communities mostly occupied by minorities, especially the Black and Latino communities. There have been several anti-violent organizations developed in recent years such as CeaseFire Illinois and the Chicago Area Project, geared to reduce the violence in these areas through education promotion and rallies, community organizing and other forms of activism. In order to reduce these barriers to PA, there needs to a continual growth within these organizations and substantial support from this organization to protect areas where PA primarily can take place, such as the neighborhood parks and community centers. In order for PA to increase in the aforementioned neighborhood, community safety initiatives need to be continually supported and maintained.

The Physical Activity Guidelines for Americans recommends that adults should accumulate at least 150 minutes of moderate intensity PA a week for active adults (DHHS, 2008). One of the most important barriers for out participants was time constraints due to employment demands and financial responsibilities. These employment demands are also entwined with the motivation of coming to the US by TAIs. TAIs feel responsible for not just themselves but their families back in their native lands and are more committed to working for the pursuit of affluence and wealth compared to making time for PA. This is consistent with the findings by Horst (2004) on remittances by Somalians in Minnesota. The transnational responsibility proves to be critical because there is a level of expectation and dependency bestowed upon the TAI by family members and even friends that may be in need; TAIs don't make decisions simply based on local factors but transnational as well. The assumption held by these dependents is that their provider is in a better state of living and should have enough

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resources to send remittances; not taking into account that TAIs may face in terms of

acculturating and occupational demands. These TAIs feel the pressure to live up to these

expectations and take on whatever form of employment (2 or 3 jobs) in order to maintain this

false image of achievement (Wong, 2006). This holds true for males as they perceive

themselves as the provider in the family and bear the responsibility of securing the financial

stability of his family in the host land and his native land. This concept is not far behind with

women either. Wong's (2006) study of transnational remittances on Ghanaian families shows

that gender roles and responsibilities are structured by transnational connections. The author's

findings stand to most resemble the picture our participants in this study attempted to paint. In

addition, research shows that African immigrant women play a vital role as contributors in the

workforce in the US compared to their experience in the native homeland, where they served

more as dependents (Daff, 2002; Takougang, 2003). A study on older Latina women reported

that along with financial responsibilities, women also allocate their time to other household

responsibilities that might be intertwined with their culture (i.e. child rearing, cooking, cleaning,

etc.) (Juarbe, Turok, Perez-Stable, 2002). This concept is vital because it demonstrates that TAIs

will choose work over PA every time if given the opportunity to make a choice. The desire to

attain enough wealth to take care of their family on a local and transnational level supersedes

any other goals they may consider setting for themselves pertaining to PA and this applies to

both men and women. Because of the demands of their transnational responsibilities, a TAI is

forced to go above and beyond simply to maintain a false image to their family members

overseas that they have acquired the affluence that one is imagined to attain by simply living in

the US. Family members in Nigeria cannot relate or understand the challenges TAIs may go

through in the US. Failure to uphold their transnational responsibilities can create the sense

that he/she is not fulfilling the purpose of what they came to the US for; to achieve enough

wealth for the betterment of their family "over here" (in US) and "over there"(Nigeria). The

shared belief from the interviews was that there is simply not enough spare time to commit to

PA and PA is not important enough to adjust their priorities and values. It is far more important

to send remittances than to be physically active.

When taken all things into consideration, the barriers that TAIs face are very similar to

what AAs face in regards to employment demands. Living in low SES areas, AAs are forced to

work multiple jobs in order to make some sort of living. Financial costs were also founded to be

a barrier to PA in the AA community (Matthews et al., 2014). Studies express that economic

issues due to life conditions have been reported as a barrier to PA (Gobbi et al., 2012). Research

on AAs demonstrates that AA men and women face time constraints with PA due to gender

roles and responsibilities (Diemer, 2002; Griffith, Gunther & Allen, 2011). The chief difference is

that AAs do not have the transnational responsibilities of AAs and are more likely to be

subjected to psychosocial stress due to economic struggle and also factors such as segregation

and racism (Kawachi, Daniels & Robinson, 2005) compared to their immigrant counterparts.

The third theme emerged from our participants was labeled "A culture of physical

activity". This theme describes the perspectives of the participants in regard to the support or

influence that TAIs may receive from significant others that can be encouraging or discouraging

to the sustenance of PA behavior. The findings show that family support was not a powerful

factor for nurturing healthy PA behaviors. Dialogue with family and friends about PA extended

to topics about physical fitness and body image and not about preventing negative health

outcomes. The findings in fact reveal that family and friends are inadvertently more nurturing

of sedentary behavior patterns. In addition the findings can also connote the idea that family

members, such as their children, tend to have different schedules and may pursue various

forms of PA independently at their own discretion. This appears contradictory to the call for

more interdependent activities and social support by researchers in minority health (Ayler et

al., 1999). It is a longstanding notion that that family support is important (Rakowski, 1988).

Individuals are more likely to engage in PA if they know they have the support of their family

members and friends and they engage in these activities together (King et al., 1992; Dishman &

Sallis, 1994: Ayler et al., 1999). The findings also observed that hometown associations are

currently not being utilized as tools for health promotion. Hometown associations can

potentially be an influential outlet for health promotion because it is a hub for community

gathering and community activities, such as collective sending of remittances or fundraising or

the social activities that involve the sustenance of cultural practices (parties, weddings,

religious events) (Orozco & Zanello, 2009). Hometown associations create a powerful support

network for TAIs, regardless of length of stay or acculturation (Caglar, 2006; Mercer, Page &

Evans, 2009) but have been under-utilized as a platform for the promotion of health education

materials. The primary objective of these organizations so far has been to maintain a

transnational social network geared towards maintaining cultural identity, assisting with

acculturation while staying involved in all aspects of affairs going on in their native homeland. It

has been shown in research that community factors can serve as facilitators and barriers for PA

(Siddiqi et al., 2011; Sebastião, 2015). Bopp et al.(2007) study on AA churches and PA show that

individuals would be more motivated to engage in PA if its implemented in communities

intertwined with the culture and which they value most in such as their church and supported by their community leaders (pastors for example). Hometown associations have a similar impact and still remain a space that is optimal for sharing health information. Centered on the African immigrant's belief in interdependency and social support systems, Hometown associations create access to a population that may be hard to reach and also serve as prime avenues for intervention planning and the filtering of salient health information. Programs that include cultural education and activities such as dancing can be encouraged through their channels. In sum, utilizing hometown associations is the key to improvement of health behavior within the TAI community.

With all themes taken into consideration, the underlying point prompted from this present study is that while TAIs perceive themselves as culturally different and voluntarily distance themselves from AAs, they have very similar needs and face similar challenges in regards to PA. An intelligent, productive discussion about African immigrants (and TAIs) cannot be had without involving AAs as the larger context because African immigrants are the minority group in comparison to AAs; a minority within a minority. In comparisons to the research work in the AA community, studies shows that AAs face challenges to PA in terms of knowledge and beliefs; environmental and physical barriers such as safety and neighborhood structures; and factors pertaining to social support and financial and/or employment demands. AAs may not have hometown associations but they do have similar unifying organizations and/or communities such as the religious based institutions like the AA churches or mosques; and social organizations such as fraternities and sororities that provide powerful community support and a strong influence. AAs are subjected to the same if not worse circumstances

because of psychosocial stressors caused by discrimination, racial injustices (Gaskin, Headen, & White-Means, 2005) and an accumulated cultural mistrust in the health system (Boulware et al., 2003) which should be taken into account when planning an intervention for this particular community. AAs also display a lack of understanding and relatability to the public health messages that promote PA (Sebastião, 2015). AAs still remain an understudied population in regards to influences of PA for different genders in this population; one example is the deficiency in literature that discuss PA factors for male AA community. Both populations remain under-researched in this field and their nuances and the magnitude of their disparities need to be further explored in the future. TAIs have unique cultural practices and attributes that distance them from their AA counterparts, however the question becomes whether this is beneficial for posterity? While research shows that length of stay and acculturation factors make TAIs susceptible to the same challenges that AAs face (Singh, 2004), it also shows that second and third generation Black immigrants are more likely to identify more with the native AAs (Waters, 1999; Owens & Lynch, 2012; Imoagene, 2015). This begs the question as to whether the transnational identity and practices passed on by their predecessors have some form of impact on lifestyle behavior choices. Second generation transnational immigrants tend to struggle in identity formation and the need to choose whether to identify with the ties of their parents or simply identify with the dominant culture they are born into (Gowricharn, 2009; Lee, 2011) referred to sometimes as the "Americanization process" (Griffith et al., 2011; Sakamoto, Woo & Kim, 2010). The challenge for Public health becomes determining to what extent should future cultural competent initiatives be considered when creating separate materials for two communities that are different but encounter resembling issues?

Nevertheless, the findings of this study still suggest that public health research must take into account the cultural differences between African immigrants and AAs and how these cultural idiosyncrasies impact health attitudes and beliefs, despite facing similar challenges now and in the future. Activities such as cultural dances are aspects that can potentially motivate both groups to increase PA activity participation; however, African immigrants and AAs have their own respective dances and music sewn within their ethos. There is not a "one-size-fit all" approach when attempting to address issues in a population as complicated as the "Black" communities. Public health needs to be aware at this stage in its fight against health disparities to know that there is diversity in the Black race in the US. This highlights the importance of utilizing the PEN-3 model in this study because even though it possesses the main features of other health behavior models, it makes the concept of culture its center (Airhihenbuwa, 1995). It is still paramount to identify the needs of the current first generation African immigrants (and TAIs) as they begin to merge with the current aging population, yet there are no approaches or programs in development driven to identify how to address the needs of these people in a way that is respectful to their cultural beliefs and practices. These belief systems or cultural practices are considered by research a powerful filter from which information can be shared and received (Thomas et al, 2004; Sebastião, 2015). It underlines how critical the development of culturally sensitive interventions towards PA and other lifestyle health behaviors in order to reduce health inequalities and enhance quality of life within the overarching Black population.

5.2 Implications

The findings of the present study devise important information for public health practice. This study is one of the few studies on this topic that focuses on a population that is hard to reach and hard to distinguish. The following findings of this study may be helpful for understanding how to promote PA among TAIs: 1) The concept of transnational responsibilities factoring into time constraints for PA participation; 2) The socio-cultural differences between TAIs and AAs; 3) The importance of dancing within the TAI culture; and 4) The possible misconception of the causes of chronic diseases within the TAI community. Taken into account these findings, public health officials can develop a better understanding on how to approach this community for health promotion programs. Studies of this nature are important because the foreign population in the US is increasing significantly and African immigrants represent a large portion of those rates. TAIs are arriving at the US, acculturating and staying for a long period of time. There are no studies that focus on how to approach this population and explore how their transnational connections impact health attitudes and practices. TAIs have the ability to create a connection to two different worlds which creates an ability to negotiate the extent on which to make acculturation and assimilation decisions.

The findings of this study are also geared towards encouraging further exploration on the intra-racial relations within the overarching Black population, its impact on health behavior and how it can be utilized to create better health programs culturally tailored for each group. Discussions on the impact of these differences are present in other fields (e.g. Education, Anthropology sociology), but deficient in the health field. Different racial group like the Latino and Asian population have already made progress in this arena while the Black population is

still trailing behind. There are several other subsets within the Black population that was not taken into account in this study that need to be explored as well (Afro-Caribbean, Afro-Latino) and how transnational activities may impact lifestyle behaviors and long term outcomes. AAs and African immigrants have two historical backgrounds, yet live symbiotically in the same spaces while facing many of the same obstacles. However in many cases their cultural differences affect how they perceive and address these challenges. The assumption should no longer be made that all Black people are the same because it would be apocryphal. Public health practices, already moving towards a more culturally competent agenda, needs to take into account the diversity of the Black population and discover a way to reach underserved groups within an underserved population and address the ongoing disparities that are already present. All groups need to be attended to.

5.3 Strengths and Limitations

The present study employed a qualitative approach involving photo-elicitation that complemented an in-depth interview process in order to enhance the viewpoints of PA among Nigerian TAIs. In addition to the uniqueness of this study and the targeted characteristics of the participants, this study was enhanced by the photo-elicitation process. This technique helped in evoking a deeper conversation between the investigator and participant and allowed for the participant to elaborate in further details their perspective of PA. It allowed for the participants to see the significance for why people like them need to be studies and why their needs should be addressed. The technique better informed the triangulation process and also provided deeper insights into the results.

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The utilization of the qualitative design is beneficial in order to understand in-depth a complex phenomenon like "transnationalism". It also allows for deep understanding of the culture of TAIs in order to unpack research problems that may exist but be hard to understand due to lack of access to this community. Qualitative studies have the benefit of understanding attitudes, beliefs and values germane to health behaviors. However, the findings of this study are subject to limitations and must be comprehended with practicality. Qualitative studies typically have limitations that include challenges in generalizability of the findings to a larger, reference population. The sampling process in qualitative studies allow for the sample size to be purposely collected in order to provide the rich data needed to examine a particular phenomenon. This study was subjected to a small convenient, snowball sampling method and was not randomized, which begs the question as to whether the patterns that emerged would be different if an alternate approach was exercised. Furthermore, social desirability should be taken into account. The participants may respond in ways that may make them appear more favorable to society's eyes and not necessarily how they genuinely feel. Those are critical elements that should be taken into consideration.

Also the geographic displacement of the participants should be taken into consideration; TAIs that may live in areas that are consistently warm like Houston or Atlanta may have different perspectives and environmental barriers than our participants who live in a mixed climate location like Chicago. The study took place in the winter time, which could also affect their perspectives towards PA compared to doing it during a warmer time period. The study also takes into account that there are several different types of TAIs who represent different countries in a large continent such as Africa. This study focused on TAIs from an Anglophonic)

country such as Nigeria, which is an advantage when acculturating to an English speaking

country like the US. This study did not take into account African immigrants that are non-

Anglophonic (for example Lingala, Francophonic) and are not from countries where English is

spoken.

5.4 Future Studies Suggestion

There is a growing interest in examining factors that influence PA among minority

groups. However, little is known about underserved populations such as the AA community, so

it can be assumed that very little is known about the TAI community due to the constant

grouping of both groups by researchers. Because this study is fairly novel in its development

there are several avenues in which future studies can take. Examining cross-cultural differences

between the AAs and TAIs is an area that needs deeper understanding. Future studies should

consider utilizing a qualitative method, such as focus groups for example, in order to explore

similarities and differences in perception of PA of members of both groups who reside in the

same areas. This study provides new and valid information that may help in the development of

culturally sensitive interventions. For example Schwingel et al. (2014) developed a culturally-

sensitive lifestyle behavioral program called Abuelas en Accion (AEA) which displayed a

collaborative effort with faith-based organizations and community leaders to develop and

implement a curriculum for behavior change in nutrition and PA activity for Latinas ages 50 and

older (Schwingel et al., 2014).

Applying this intervention model to AAs and/or TAIs can prove to provide interesting

findings regarding both groups. Future studies should try and duplicate these findings utilizing a

sample size that represents different socio-linguistic barriers (French speaking vs English speaking African immigrants). Future studies should also explore the impact of acculturation and length of stay on health behaviors such as PA. Studies exploring the variations in perspective between 1st, 1.5 and 2nd generation TAIs could provide impactful results that can be utilized in developing sustainable health programs and health education materials.

5.5 Conclusion

The objective of this study was to explore the cultural perspectives of TAIs on PA and factors that may serve as determinants to their decisions to be physically active or not. In addition, due to the lack of studies in the TAI population on health behavior and chronic diseases, the study insidiously explored the socio-cultural differences that distinguish AAs and TAIs. TAIs have the ability to maintain transnational ties at their own discretion. Three major themes emerged: 1) We are not the same, 2) Physical activity is good, but… and 3) A culture of physical inactivity. The factors that emerged in regards to facilitators and barriers were very similar to the literature relative to AA and PA. An important finding from this study relates to the cultural perception of chronic diseases and health behaviors. TAIs do not have a full grasps on the connection between health behavior and chronic diseases due to their peculiar cultural beliefs. Another critical discovery is the notion that cultural dancing is highly utilized as a primary form of PA in this community.

These findings inform us that TAIs face similar challenges consistent in the literature relative to AAs; however their transnational attributes provide a unique barrier to PA. Their transnational identities allow them to distance themselves from PA practices that may be

considered normal in the US (i.e. individuals running by themselves). Their willingness to take

on heavy occupational loads in order to fulfill transnational demands from family members

overseas makes it difficult to make time for PA because that time would rather be committed

to work in order to acquire items or money to send as remittances. These transnational

obligations impact their decision making and should subsequently affect ways in which they

should be approached when planning programs or interventions. There is also a need for

culturally sensitive materials to be developed specific to their cultural characteristics. Utilizing

avenues such as hometown associations could serve as avenues for potential impact and

dissemination of health promotion materials. The findings of this study have multiple

underlying agendas: 1) It contributes to our understanding PA among TAIs and also attempts to

instigate a conversation in public health research about the intra-racial relations between AAs

and African immigrants; 2) It aims to shed light on a topic that displays a lack in research

literature. 3) this study also serves as an igniter for future exploration of transnationals and

their health behaviors; 4) The study aims to serve as a pioneer study, calling on the

improvement of culturally competent health programs that can assist in the preservation of

cultural behaviors that are deemed to positively influence health outcomes in the Black

community and 5) the study serves to point out a targeted topic in which scholars and health

professional can learn of new ways of developing cross-cultural relevant programs or ideologies

in the Black community.

This study found that TAIs have similar needs and face unique challenges as their Black

counterparts due to their ongoing acculturation process, but because of their cultural

differences and transnational activities, there needs to be a way for public health agendas to

concoct health information that can be appealing to them and their culture. The overarching

Black population is very complicated and diverse. PA is complicated and diverse. To effectively

promote PA in this population, the nuances of this population needs to be explored further and

pilot programs need to be developed in order to address their needs on a local and

transnational level.

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Appendix A

Interview Guide (Guided by PEN-3 model)

Cultural identity (person, extended family, neighborhood)

- When you think of physical activity, what comes to mind?

- Who or what influenced you to have those thoughts?

- Have you and your family discussed physical activity?

- If not, why not?

- If yes, what do some of your family members think of physical activity?

- What do you and people your household like to do during your free time?

- Who do you go to when you have questions about being physically active?

- How can the community encourage people to be more physically active?

Relationships and expectations (perceptions, enablers, nurturers)

- When was the last time you received information on physical activity?

    o Where did you receive this information?

    o What did you think about this information?

- What do your friends/peers think of physical activity?

- What factors do you think influence those thoughts on physical activity?

- What is your impression of health facilities in the communities where you live?

- Do you talk to your doctor/health provider about being physically active?

- What do you think health facilities in your communities should do to encourage physical activity?

- What information on physical activity would be helpful for men and women in your community?

Cultural empowerment (positive, existential, negative)

- What do you think about the government's effort to encourage physical activity nationwide?

    o What appeals to you and what doesn't?

- What things, good or bad will influence your decision to participate in these type of initiatives?

- Does being a member of ethnic organization impact why you are physically active or not?

- What can your hometown association do to encourage members to be more physically active?

Part 2 (Photo presentation)

- What do you think about this picture?
- How does it relate to your lifestyle?
- Do you see yourself doing something like this?
    - Why?
    - If no, why not?
- Repeat these questions for each photo

Participant Demographics Questionnaire

Date: _____   **Time**: _____   **Place**: _____

Please respond to the following demographic questions:

1. **What is your occupation? _____**

2. **Are you married? Yes or No (Please circle one)**

3. **Do you have any children? Yes or No (Please circle one)**

4. **What is your country of origin/ birth place? (If not born in U.S.)**
   _____

5. **Do you still have ties to your native homeland? Yes or No (Please circle one)**

6. **How often do you communicate with your ties back home?**

   O Everyday
   O Often
   O Quite Often
   O Moderately
   O Never

7. **How long have you been in the U.S.?_____**

8. **What is your zip code? _____**

9. **What is your gender?**

   O Male
   O Female

10. **What is your age:**

   O Less than 20
   O 20 to 30
   O 31 to 40
   O 41 to 50
   O 51 to 60
   O Over 60

Appendix C- Photo Images

Contains the 5 photo images that were used for photo-elicitation process.