Transnational health and treatment networks: Meaning, value and place in health seeking amongst southern African migrants in London

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ABSTRACT

Drawing upon research undertaken with migrants from southern Africa living in London, this paper examines the important role played by transnational health networks in influencing individual’s treatment seeking decisions. As well as exploring the ways in which these networks provide important sources of help and support for people in times of ill health, the paper examines the ways in which treatments from particular places and contexts carry certain associations, meanings and values, which are in turn, considered vital in influencing health care outcomes.

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1. Introduction

Research on the interconnections between migration, culture, place and health has stressed the diverse backgrounds of migrants, the commonalities they face through their social positioning within the host country, and the fluid nature of cultures and identities as they are bound up with place and with wider socio-economic circumstances and processes (Dawson and Gifford 2001; Soskolne and Shtharkhall 2002; Manderson and Allotey 2003; Dyck 2006; Thomas et al. 2010). In recent years, attention has also been placed on examining the ways in which migrants seek to shape healthy spaces through every day practices which facilitate ‘belonging’, enabling enactment of the familiar via activities such as spiritual and religious practices and via the use and consumption of materials such as food and forms of treatments and therapies (Dyck 2006; Dyck and Dossa 2007; Collins 2008; Longhurst et al. 2009).

While such research has contributed much to understandings of the interface between migrant subjectivity, health and well-being, it has also highlighted a need to further examine the ways in which perceptions of ill health and subsequent health seeking decisions and responses are transferred, persist or evolve across time and space. As van der Geest (2005, 13) states, what a person living with ill health feels is not only biologically determined but is “situat[ed] in a web of social-cultural and psychological meanings”. In attempting to understand how such issues intersect to influence migrant identity and health outcomes therefore, important questions are raised about the ways in which medications and treatments not only involve the “in-body-ment of substances”, which perform a therapeutic and healing function (Nichter and Vuckovic 1994, 1509), but also exist as social and cultural phenomena with a range of practical and emotional meanings, values and effects (Cohen et al. 2001; van der Geest and Hardon 2006; Schumaker and Bond 2008).

In seeking to examine such issues, this paper draws upon research undertaken with black migrant communities from southern Africa living in London, to highlight the important role of transnational health networks in influencing peoples’ decision making over treatment seeking and consumption. While it is recognised that treatment seeking is heavily influenced by factors of circumstance and accessibility, the paper focuses particular attention on the ways that treatments from southern Africa can carry particular associations, meanings and values for migrants, which are in turn, considered important in influencing health care outcomes.

2. Placing health and treatment within transnational networks

Although the past decade has witnessed an increase in attention being paid to the use of complementary and alternative medicines (CAM) amongst the population of the UK (Thomas et al. 2010)
medical and health research and policy agendas continue to be dominated by the impact of mass produced biomedical drugs and the increasingly globalised pharmaceutical industry (Williams et al. 2008). At the same time, recent approaches in the international development field have given precedence to developing the role of diasporic communities in poverty alleviation and health promotion in the global South (Global Commission on International Migration 2005; Mahroum et al. 2006; DFID 2007). Under such circumstances, the majority of research on the ‘mobile’ nature of medicines (cf. Reynolds Whyte et al. 2006) has tended to reflect this assumption of a predominantly unidirectional flow of medical knowledge and treatments from the ‘developed’ to the ‘developing’ world (Cohen et al. 2001), and has focused primarily on the ways in which pharmaceuticals are being incorporated into ‘local’ understandings of health, illness and treatment (Etkin 1992; Schumaker and Bond 2008).

While such approaches provide valuable insight into the assumed hegemony of biomedical knowledge, they fail to recognise the ways in which processes of globalisation have increased and facilitated other forms of transnational interactions and links (Koser 2003; Bloch 2008) and overlook the far more complex realities which people face as they interpret and respond to their ill health. The increasingly multi-sited nature of the lives of many African migrants in the UK, for example, requires them to deal with a range of coexisting and often seemingly contradictory socio-cultural contexts and influences when seeking health care and treatment. In such situations, materials, treatments, understandings and beliefs are exchanged within and across a range of health, treatment or ‘therapies’ networks (Krause 2008), which often extend far beyond the relationship between an individual and their doctor. Indeed, the existence and use of a plurality of medical approaches is well documented for people living in countries across much of southern Africa, where upwards of 70–80% of the population have been reported to use multiple medical practices and treatments from different sources (Stekelenburg et al. 2005; Peltzer et al. 2008). Studies undertaken within southern Africa have emphasised the ways in which people seek out different forms of treatment, often concurrently, ranging from ‘modern’ biomedical pharmaceuticals,1 to the use of plant and/or animal based treatments, to prayer and other forms of spiritual practice. The extent of use of such treatments is often based on a combination of factors including those of accessibility, pragmatic need, socio-cultural expectation and personal belief and preference regarding the meanings and values of different treatments. Recognising that rather than abandon previous identities and affiliations, migrants conduct their lives simultaneously across multiple spaces and via multilayered and coexisting networks, linkages and connections (Nagel and Staeheli, 2008; Grillo and Mazzucato 2008; Nelson and Hiemstra, 2008). This paper argues that there is a need to decentre dominant assumptions regarding the unidirectional flow of health and treatment seeking, and calls instead for greater acknowledgement of the role of transnational health and treatment networks in enabling people, particularly migrants, to deal with, and make sense of, episodes of ill health. In doing so, it is recognised that such ‘networks’ can be socially and spatially uneven, and often loose and ephemeral in nature (cf. Mercer et al. 2009). Rather than existing as static or even necessarily enduring connections, therefore (Levitt and Glick Schiller, 2004), networks are here taken to refer to the periodic engagements that migrants make with people and materials in a transnational context.

3. Study methods and participants

This research was undertaken as part of a larger study on treatment seeking and treatment management amongst migrants from southern Africa living in London. Ethical approval for the study was obtained from the East London and The City Research Ethics Committee and the Institute of Education, University of London, and informed consent was obtained from all informants prior to participation. This paper draws primarily upon data obtained through eleven focus group discussions held with seventy black African migrants from Zimbabwe (n = 39), Zambia (10) and South Africa (21). Of the participants, thirty nine were women and thirty one men. Five of the groups were single gender, and six were mixed according to the preference of participants. The aim of the focus groups was to gain insight into people’s understandings and experiences of health care services in the UK, and their access to, and use of, ‘alternative’, non-biomedical sources of treatment. A grounded theory approach enabled data to be coded and analysed as themes emerged from the data. Of particular note was the insight the insights discussions provided into the ways that social, cultural and economic factors influenced people’s understandings of their ill health, how such factors had oriented them towards seeking particular types of treatment and the role of the UK and transnational networks in facilitating access to biomedical and non-biomedical treatments.

Being in the UK as a migrant, living in London and being aged over 18 were the selection criteria for participation in focus group discussions. The majority of participants from Zimbabwe and Zambia were accessed via community support groups and in most cases these participants had arrived in the UK within the past decade. The educational background of participants was wide ranging, reflecting the diverse array of migrants who used these support groups. While religious affiliation was not asked, one community group which helped to recruit participants had a strong Christian focus, and it is likely that this played some part in influencing the beliefs and opinions of some of those attending this group. In order to involve a broader cross-section of migrants and to reach participants from South Africa, it was necessary to hold four group discussions comprised of participants accessed via more informal social networks, e.g. friends of key contacts. The majority of participants in these four groups had been in the UK for over a decade, had relatively high educational backgrounds and were legally able to work.

Many of the Zimbabwean participants who had arrived in the UK in the past decade were asylum seekers or refugees. Most of those who had arrived in previous decades, as well as the majority of the Zambian and South African participants, had come to the UK on student or work visas, and many had later applied for leave to remain on compassionate (usually health-related) grounds. Immigration status has a direct influence on people’s ability to travel, with those seeking asylum usually facing restrictions on visits to their home country. While such restrictions may have repercussions on the ways in which people seek certain types of treatment, all of those involved in the study maintained some, usually regular, contact with family and friends in southern Africa and were able to access health and treatment networks there via telephone, email, postal and/or freighting services.

It is important to recognise that study participants came from a variety of different backgrounds in Zambia, Zimbabwe and South Africa and as such, some of the experiences they reported on were specific to the particular context in which they had been practiced. Whilst acknowledging these differences, this paper seeks to provide an overview of the treatment practices that were more commonly reported on by participants from across the three countries. The following sections provide an overview of the UK and transnational health and treatment

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1 Hereafter referred to as ‘biomedicine’.
networks that were available to migrants from southern Africa living in London. This is followed by a more detailed discussion of the factors which influence people's decisions to draw upon or avoid transnational health networks and the meanings and values associated with treatments and therapies sourced from southern Africa.

4. The UK based health and treatment networks

Within the UK, the National Health Service (NHS) provides a vital source of health care and treatment and the majority of those participating in the study had sought out the services of a General Practitioner (GP) at times when they had experienced ill health. The availability of biomedicines via health services and pharmacies in the UK was greatly appreciated by all study participants, many of whom had come from areas of southern Africa where such 'modern' and 'advanced' treatments were unobtainable or prohibitively expensive. For those who had experienced long-term ill health, ongoing relationships with individual doctors and hospital staff were particularly important in their pursuit of a positive health outcome. However, a significant number of people, especially those with refused or undecided asylum claims, reported difficulties registering with a GP, and some reported being charged for using health services (cf. Thomas et al. in press).

In such situations, and in cases of undocumented migrants, individuals were forced to rely more heavily on personal contacts in the UK and abroad to help them to secure treatments. Some people reported self-medicating using over-the-counter treatments, and treatments sent from their home country. In some cases, people explained that they had only been able to access NHS treatment without being charged prohibitively high fees when they became so ill that they were admitted directly to Accident and Emergency departments.

In addition to NHS services, a number of people with long term or chronic conditions sought assistance from community based support groups in the UK. This was particularly apparent amongst migrants from Zimbabwe and Zambia, at whom several such groups are targeted. Some people also reported accessing more generic health support groups, many of which were working in partnership with the NHS. Interestingly, such support groups, while primarily established to provide support and advice centred around the use of biomedicines, also acted as useful sources of information on alternative types of treatments that were available via a range of other networks. A number of people attending HIV support groups for example, reported that their participation enabled them to meet other people with similar health conditions and to share information on how best to access treatments which they could use in combination with, or as alternatives to, the anti-retroviral therapies that were available via the NHS. In such situations, the perceived stigma associated with HIV amongst their own community led a number of people to link to health and treatment networks with people from other countries in Africa.

Churches in the UK also provided an important source of therapy and support for southern African migrants. While Pentecostalism was widely followed, Apostolic and Roman Catholic churches were also commonly attended within the UK. For some people, individual prayer was deemed helpful in strengthening their well-being and belief that they would recover from their ill health. Others, particularly those living with more serious forms of illness, and who attended Pentecostal or 'African' churches, reported that their respect for, and relationship with the pastor was of ultimate importance in providing them with a link to God, which in turn, would facilitate their recovery from ill health. In such circumstances, individuals sought salvation from illness through following instructions dictated by the pastor. It was widely reported that this could involve fasting, the provision of donations to the church and the relinquishing of all forms of medication in favour of prayer.

While the UK based health and treatment networks played an important role in the lives of most migrants, the difficulties people faced accessing 'formal' health services, as well as a desire to use treatments from their home country, meant that for many people, transnational networks were called upon, often simultaneously with those in the UK, to bolster their health and treatment seeking outcomes.

5. Transnational health and treatment networks

The majority of focus group participants (regardless of immigration status, gender, age or educational background) had used—or expressed a wish to use, therapies sent from their home country in the treatment of different health conditions. In most instances, this involved curative treatments in herbal form, although there was some evidence that pharmaceutical medicines thought to be difficult to obtain in the UK (particularly by undocumented migrants and those who have to pay for national health services) were also being sent. In some cases, people sought and used herbal treatments in combination with biomedicines obtained from 'formal' health services in the UK (such as hospitals and GPs), whilst in others, they were used as alternative forms of therapy.

In addition to herbal and pharmaceutical medications sent between southern Africa and the UK, spiritual healing was found to play a significant role in the pursuit of health and well-being. It was commonly reported, particularly amongst the Zimbabwean community, that people would consult a prophet in their home country to help diagnose their ill health. While this was usually done over the phone, it was also possible to conduct a consultation with a healer via family and friends. The outcome of such consultation usually involved the prophet blessing some form of item (for example, water or stones), which was then sent or given to the ill person to carry with them for luck and/or protection.2

Website-based companies (some of which also advertise via text messaging) offer services for the freighting of goods including medicines and treatments to and from southern Africa, and research participants reported common use of such services. A number of study participants reported that upholding their claims to support from transnational networks required significant investment. For some participants from Zimbabwe and South Africa, this involved the sending of financial resources to help relatives undertake important socio-cultural processes such as cleansing and purification rituals or ceremonies to help ensure that the ancestors were appeased. As Gardner and Grillo (2002) have discussed, ritual performances can involve a range of inputs across transnational spaces. In the present research, such contributions were considered important in enabling migrants to play a continuous (if slightly detached) role in the act of important ceremonies and rites, which, in so doing helped ensure ongoing investment in their and their family's health and well-being.

A desire to ensure the health and well-being of family members and to retain links with important health and treatment networks also resulted in some people sending biomedicines from the UK to southern Africa. This scenario was most commonly mentioned by participants from Zimbabwe, where current economic and social conditions have taken a heavy toll on health.

2 As well as providing protection from ill health—especially illness caused by witchcraft—these items were also used in bringing good luck in immigration cases, job seeking and in relationships.
service and treatment provision. Some people reported that they had been able to access medications to send home via GPs and hospital staff, although this was always done at the doctor’s discretion, and, given the potential for such action to damage the legal reputation of the health professional, was only possible where trustworthy relations had been built. Although men have traditionally been considered the main breadwinners in many parts of southern Africa, both women and men in this study reported that their relatively economically advantaged lives in the UK (even if only perceived as this by people at ‘home’) conferred on them a felt obligation to provide such support for relatives in Africa.

A number of internet-based services also provide opportunities for people in the diaspora to purchase ‘health services’ for relatives within southern Africa. This includes services such as blood tests and X-rays as well as medications such as anti-retroviral treatments for HIV. It was also reported that such services were sometimes used in self-treating amongst migrants in the UK. Whilst this applied mainly to refused asylum seekers and undocumented migrants who feared that the authorities would be alerted to their existence, it was also said to apply to people who were living with illnesses deemed to be discrediting, in particular HIV and AIDS, which remains extremely stigmatised within most southern African migrant communities.

6. Treatment meanings, values and associations

Herbal medications from southern Africa were reported by participants to be difficult to obtain in the UK and, as such, people relied heavily on networks in their home country to secure these treatments. The main reason that people asked family and friends to send them medicines from ‘home’ was so that they could ensure that the treatments they used came from a reliable and trustworthy source. Some people claimed that they did use African shops in London when they knew, or had been recommended to the vendor by someone that they trusted, or when they recognised the medications as being from the same (usually plant-based) source as those available to them in their home country. Similarly, some people reported that they had used Chinese medicines which they recognised as performing the same functions as treatments they knew from home. However, considerable suspicion existed regarding medicines from sources that were not well known to the individual concerned; not only could medicines obtained from elsewhere be fake, the fact that they may have been tampered with and/or cursed was also considered to make them potentially dangerous.

In most cases, people explained that they did not tend to discuss personal health issues with people that they did not know well. As such, only a small number of people, mostly younger women, claimed to have used the services of traditional healers from Africa who are based in the UK, instead, preferring to consult healers that they knew in southern Africa. As the following comment demonstrates, it was very commonly reported that DHL and other freighting companies were doing extremely brisk business transporting medicines between southern Africa and the UK.

You don’t tell others that you didn’t know before about your problem—so what you rely on is your traditional healer back home. You might call your aunt or your mother who has to contact that traditional healer with that problem. You know, DHL is doing quite a lot of work! You hear people say ‘I am expecting a parcel’—because people still want to get these things from someone that they trust rather than if I just hear about someone [a healer] in Peckham. I would trust someone I hear about from my family more—the family healer. So people do still get things from back home. (Jo, Zimbabwean men’s focus group)

In addition to this important issue of trust, the use of treatments from ‘home’ was felt by many people such as Vivien to be an important means of establishing and reasserting their individual and cultural identity, reaffirming a sense of duty and respect towards the beliefs of their family and reflecting a commonly held belief that medications with which they had grown up were indeed useful in the treatment of ill health.

I’m a typical African myself—I still use some African herbs, I still follow my ancestors. Whenever I go home I always try to bring back some herbs that I can use for a period of time. Sometimes when it’s finished, I call home and ask if they know anyone who is coming here and I ask if they can bring this and this. If they do, it’s better for me because its part of me [from] when I was born. It’s always been there, my ancestors used it—it follows the blood. (Vivien, Zambian mixed gender focus group)

Many people used treatments obtained from southern Africa in combination with treatments procured via health services in the UK. However, a widely held belief that there were a number of ailments which could not be treated by biomedical and recognition of the potency yet relative safety accorded to herbal medications (cf. Thomas et al. in press) meant that treatments from home were often used in preference to those available through more formal channels in the UK. For some people, there was a very real concern that the health services in the UK would not be able to diagnose and treat such health conditions, particularly those that were considered to have an aetiology that eluded biomedical frameworks of understanding. As Tony and Kelvin state, some people felt that such situations could only be dealt with effectively via transnational health and treatment networks.

A lot of South Africans don’t have confidence in the NHS. For instance, I’ve had this flu since last week, I’ve not been to the clinic because I do not want to go there because they are not going to do what I believe should be done to me. And if I was at home, I would have been able to get the herbs and treatment. (Kelvin, South African mixed focus group)

This is when you get DHL coming in—there are some ailments when people tell you to go to a GP but you know that they will not be able to attend to you. You know like dizziness and things like that. We know if you go to this particular tree and cut bits of it, that is what you will take. This is what we grew up with; it has become part of us. (Tony, Zimbabwean men’s focus group)

This attitude was exacerbated by the difficulties many people reported registering with a GP, the short nature of GP appointments, a widespread perception that doctors in the UK did not take their patient’s needs seriously and the difficulties people had experienced in getting referrals to specialists. Under such circumstances, people commonly felt that they would receive more personal and informed treatment from healers who knew them, and/or their family’s histories and circumstances. As the

3 While such services are undoubtedly helpful in improving the health prospects of some people, their unregulated nature raises some cause for concern and could be usefully investigated in further depth.

4 This is in marked contrast to medicines from West Africa, which are widely found across markets and African shops in London.

5 Advertisements for the services of traditional healers from Africa are commonly published in newspapers such as The Voice and The Metro. They are also distributed via leaflets at train stations and markets in areas with high numbers of African people, and are advertised through word of mouth.

6 All names have been changed to protect participant identity.
following discussion demonstrates, some people felt a need to involve people from their home country in decisions over diagnosis and treatment to help ensure that the underlying cause of their ill health was fully understood and could thus be effectively dealt with.

Paul: They [the ill person] won't know what is wrong with them, what is happening to them so maybe their employer [in the UK] would simply refer them to the hospital or GP. Normally people don’t really know what is happening to them.

Nina: And I think in that regard, it is important now to make it clear that when people from countries like South Africa, when something like that happens to them and they get sent to hospital, the relatives in South Africa must be informed. Because they might say he has to come back home so we can do one, two and three. Or they might even go to a sangoma [healer] right there and say okay, there is this problem. Or even if they don’t say there is a problem, they can ask for the healer to throw bones to find out what is happening and they may say that that your son needs to come over here so we can do this one, two and three. So it is important that the NHS or whatever, they must contact the person’s relatives at home.

(South African mixed gender focus group)

The need to draw upon transnational health and treatment networks was considered particularly important in situations where ailments were thought to be affecting a person’s mental health. It was reported that many such conditions were thought to be caused by witchcraft, or by a failure to show adequate respect to relatives and ancestors. As the following conversation demonstrates, attempting to treat this kind of ill health with biomedicine was widely considered pointless and even harmful.

Donald: In our culture, almost every mental health problem is related to witchcraft or spirits, or demons or probably that it’s like a curse. If maybe my grandfather was involved in killing someone—even if he was just present—his daughter or grandchildren might have a mental illness because their grandfather witnessed this but he didn’t do anything about it. If you go the hospital it’s not going to go away, you have to go to a healer.

Simon: It gets worse if you go to a hospital.

(Zimbabwean men’s focus group)

Study participants frequently commented that providers of biomedicine in the UK responded to mental health conditions concerning reproductive health and some sexually transmitted infections, as well as in boosting sexual pleasure, although the very personal, and tabooed nature of such ‘conditions’ meant that involvement of family (particularly elderly relatives) was rarely reported in these cases.

As has been discussed elsewhere (cf. Etkin 1992), the side effects of medicines can be a major determinant influencing people’s attitudes towards various types of treatment. In this research, there was a widespread perception amongst focus group participants that the relatively unprocessed nature of herbal treatments made them potent, yet ‘safer’ and less toxic than medications prescribed via national health services.8 While some side effects of biomedical treatment such as vomiting were considered acceptable and even desirable in helping to purge illness and cleanse the body, study participants frequently commented that the side effects of biomedicines created additional health problems and often only suppressed rather than cured the illness.

Liam: A lot of the (Western) medicines we take, they control the condition that you have—but in most cases they will just create a new condition that you did not have before in the form of side effects. But the side effects part of it is not highlighted as it really should be because some of the side effects are even worse. It’s like chemotherapy—it can kill you because it not only attacks the cancer but it also attacks the good cells in you. It’s not good for you but they will keep on using it until you die.

Quentin: With herbal medicines there are no side effects. In western medicines you are suppressing the illness—in our medicines you are healing the illness.

(Zimbabwean men’s focus group)

7. Evading transnational health and treatment networks

Although involving family and friends in treatment decisions was generally felt to be useful when ill health was thought to fall outside the scope of biomedical treatment, some study participants were sceptical about the use of treatments available through networks based in Africa. Some people claimed not to use herbal treatments at all, usually because they went against their Christian religious beliefs. Participants in their late teens and early twenties who had spent most of their life in the UK also tended to be fairly sceptical of the use of such treatments.

While research has found that the power relations guiding socio-cultural expectations and norms can, in certain situations, influence illness diagnosis and decisions over treatment use (cf. Nichte and Vuckovic 1994; Thomas 2008), the spatial distance separating migrants from their relatives in southern Africa, as well as the fact that many of those in the UK were sending remittances home, gave people more leverage and power than they may have had whilst living in their home country and meant that few people felt obliged to actually use the treatments that were sent by their relatives if they did not themselves believe in them. Similarly, a number of people who had paid return visits to southern Africa reported that they had turned down traditional treatments for pre-existing illnesses or for general health and well-being that were offered to them by other, usually older, family members. A small number, however, explained that they

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8 It is perhaps ironic that convincing people that drugs can be both powerful and safe is a key aspiration of pharmaceutical marketers (Nichte and Vuckovic 1994).

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7 This was reported as a particular issue amongst people from Kwa Zulu Natal in South Africa and areas of Matabeleland in Zimbabwe.
had accepted these treatments so as not to offend their elders, but had later discreetly disposed of them.

As the following discussion amongst a group of Zimbabwean men demonstrates, treatments from Africa were felt by a minority of people to be associated with ‘backwardness’, ‘dirt’ and ‘deceit’ and were a cause of ridicule when ‘modern’ biomedicines were so widely available in the UK. Consequently, it was explained that while a high proportion of people did use treatments from southern Africa, they were often reluctant to disclose their use of such therapies.

Brian: There is this issue about Christianity—people tend to say we are Christians and we are keeping up to date, we don’t want to be associated with traditional things. It’s not easy for you to confide in someone [regarding the use of African medicines] because they will say you are backward.

Dominic: And now we are here we take the western culture which normally doesn’t recognise the traditional. So even if someone is not a Christian they would be worried that people would say ‘ah, I can’t believe that one is taking traditional medicine when there is so much medication around which is available.’ So I think it’s about how we look at traditional medicines, not just here but also back home. Once people are in urban areas and they are getting education they begin to think that these things do not work.

Jo: I think the thing as well is that with these traditional medicines there is not much cleanliness in it—you might think these medicines are dirty—the way that they mix it up they don’t even wash their hands. So even me I might not use these things, not because I don’t believe in it but because of how they do it.

Brian: The other thing about healing is that it is not as genuine as it was. It’s now about people wanting popularity and it makes it all fake.

(Zimbabwean men’s focus group)

For some people, the stigma associated with particular health conditions was a further reason for not (openly) seeking treatments from their home country. Again, this was particularly evident with migrants who were living with HIV, although a number of people did claim to use herbal immunity boosters from southern Africa that were recognised as treating a wide range of health conditions. In such cases, people did not want to give their relatives at home cause for concern or to put them in a position where they might be ostracised by others through their association with an HIV positive person.

8. Conclusions

Research on migration and health has emphasised the fluid nature of cultures and identities as they are bound up with place, and the ways in which migrants seek to shape healthy spaces through familiar everyday practices. Such research has raised important questions concerning the ways in which perceptions of ill health and subsequent health seeking decisions and responses are transferred, persist or evolve across time and space. The findings of this current research, undertaken with migrants from southern Africa living in the UK, demonstrate that both local and transnational networks can impact upon understandings of ill health and consequent health seeking decisions and responses. As such, many research participants considered treatments from southern Africa, and the networks with which they were linked, to hold particular personal and cultural significance and worth in their pursuit of a positive health outcome.

By emphasising the role of transnational networks, this paper has also challenged dominant assumptions of a unidirectional flow of medical knowledge and treatments from developed to developing countries. Thus, rather than giving precedence to the role of biomedical pharmaceuticals in understanding how people make decisions over treatment seeking and consumption, this paper has argued that the realities that migrants face in health based decisions are often complex and draw upon a range of influences beyond the ‘biomedical’.

Interlinked with this, it has been argued that, as social and cultural phenomena, there is a need to explore the associations, meanings and values that different people place upon treatments from particular places and contexts as they seek to respond to their health concerns, and a need to examine the ways in which such issues may be influenced by factors such as gender, and by generational norms and expectations.

While this paper makes no claims as to the medicinal properties of such treatments, and indeed recognises that some such treatments may have potentially adverse physical effects on individuals, it is important to recognise that their use enabled people to interpret and respond to their ill health in ways that they themselves felt most appropriate and that maintaining links with people and contexts which they considered familiar and trustworthy in turn impacted upon their well-being and their experience of belonging and settlement within the UK. Recognition of both local and transnational health networks and the meanings and values that people associate with particular treatments and contexts is therefore of central importance in understanding the health seeking behaviour and outcomes amongst migrant populations in the UK.

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