

The challenges of health promotion within African communities in New Zealand

Kudakwashe Tuwe

2012

**A thesis submitted to Auckland University of
Technology (AUT) in fulfilment of the
requirements for the degree of
Master of Philosophy**

Institute of Public Policy

TABLE OF CONTENTS

Contents

LIST OF FIGURE(S) / MAP(S)	7
LIST OF TABLES.....	8
ATTESTATION OF AUTHORSHIP	9
DEDICATION	10
ACKNOWLEDGEMENTS.....	11
ETHICS APPROVAL LETTER FROM AUT UNIVERSITY	13
ABSTRACT.....	15
CHAPTER ONE	16
INTRODUCTION.....	16
The purpose of the study- Aims of the Project.....	16
Research Question	16
Rationale and Significance of the Study: Why proposing this Research?.....	16
The Background: Putting the Project into perspective – The Concept of Health.....	17
Outline of the Thesis.....	19
CHAPTER TWO	21
BACKGROUND TO THE STUDY	21
Brief History of the African People in New Zealand	21
Figure 1: Map of Africa.....	22
The New Zealand Refugee Annual Quota System	23
New Zealand Immigration Policy of 1987	23
New Zealand Quote Refugee Approvals 1995-2012 (Quota System).....	25
Table 2.1: African Quota Refugee Approvals by Country of Origin 1995-May 2012	27
Table 2.2: African Quota Refugee Approvals by Category (2000-May 2012).....	28
Table 2.3: African Quota Refugee Approvals by Age (2000-May 2012)	29
Table 2.4: African Refugee Quota System Approvals by Gender (2000-May 2012).....	29
African Asylum Seekers/ Convention Refugees Claims (1997 to 3rd June 2012)-by Nationality	29
Table 2.5: African Nations that Supplied Asylum Seekers (1997-2012)	31
New Zealand Asylum Seekers Claims and Approvals in New Zealand: 1997-2006	32
Table 2.6: New Zealand Asylum Seekers Claims and Approvals in New Zealand: 1997-2006	32
Geographical Resettlement of Refugees in New Zealand	32

Table 2.7: African Refugees settled in New Zealand regions in 1993 to June 2012 (All Refugee categories: Quota, Family and Asylum)	34
Number of Africans in New Zealand -Migrants	34
Table 2.8: Breakdown of Visa Category by Nationality of the 46 809 Africans in NZ (early 1980s to end of 2004)	35
Number of Africans in New Zealand (excluding citizenship) as at the end 2008	37
Table 2.9: Breakdown of 65 553 African in New Zealand (excluding NZ citizenship) as at 13th August 2008	38
Grand Total Number of Africans in New Zealand (NZ Citizenship, Permanent Residency & Other Visas Between 1999 and 2008)	38
Table 2.10: Total Number of Africans (Migrants and Refugees) in New Zealand (NZ Citizenship, between 2002 and 2008)	38
African Professional Migrants	40
Religion- Africans in New Zealand (NZ).....	42
Differences between a Migrant and a Refugee Background	43
Table 2.11: Differences between a Migrant and a Refugee	43
CHAPTER THREE	44
LITERATURE REVIEW	44
Health Promotion.....	44
The Definition of Health.....	45
The Concept of Health	45
African Concept of health	46
Cultural Conception of Health Promotion	49
The five key strategies of the Ottawa Charter	50
The Canadian Public Health Association (CPHA): Action Statement for Health Promotion in Canada (1996)	54
Community Development Strategies.....	55
Health Promotion in Aotearoa New Zealand.....	57
The Health Promotion Forum of New Zealand (HPFNZ) and the Maori Mode of Health Promotion in Aotearoa-New Zealand (Partnership, Participation and Protection)	57
The Health Promotion Forum of New Zealand (HPFNZ).....	58
The Maori Health Model-Te Whare Tapa Wha (Holistic and Well-being).....	60
International Literature Review-Challenges faced by Africans in Developed Countries.....	61
Health Promotion Challenges for Africans – United Kingdom (UK).....	61
HIV Challenges for African Communities in the UK	62
Health Promotion, Racism and Socio-economic Challenges in the UK.....	62
Mental Health Challenges for Africans in the in the UK	63

Strategies for Reducing and Eliminating Ethnic Inequalities in the UK	63
Spirituality (UK)	64
Health Promotion, Racism and Socio-economic Challenges in Canada.....	64
Health Promotion Challenges for the Black African- Americans in the USA.....	65
Nutrition Issues for African- Americans in the USA	66
Physical Activities for African- Americans in the USA.....	66
Spirituality, Mental Health Issues, and Health Promotion in USA.....	67
The New Zealand’s Disadvantaged Minority and Marginalized Communities or Groups on Health Issues	68
The Maori.....	68
The Pacific People	69
The Asians	70
Gay, Lesbians, Bisexual and Transgender (GLBT).....	71
Health Challenges for New Zealand-based African Communities in the Auckland Region	72
Some of the Unmet needs for the African Communities	73
Socioeconomic Challenges for the New Zealand-based African Communities	74
Deprivation measures – Africans in New Zealand (NZ)	74
Personal income- Africans in New Zealand (NZ).....	75
Shelter/ Housing conditions - Africans in New Zealand (NZ).....	75
Education - Africans in New Zealand (NZ).....	76
English language- Africans in New Zealand (NZ).....	76
Racism and Discrimination- Africans in New Zealand (NZ)	77
Mental Health- Africans in New Zealand (NZ)	77
Findings from NZ health service provider (HSP) interviews	78
New Zealand AIDS Foundation (NZAF)’s African Health Promotion Programme (AHPP).....	79
Table 3.1: HIV Diagnosis Statistics in New Zealand (1996-2010).....	81
Table 3.2: Summary of HIV cases (1996-2010) in New Zealand-based African Communities	82
CHAPTER FOUR	83
METHODOLOGY	83
Methodological Approach	83
Research Procedures or Methods.....	85
Information Gathering and Process.....	87
Data Analysis.....	88
Justification of the Qualitative Methodology	89
Participants and the Recruitment Method	90

Justification for Selecting Sample participants	91
The Recruitment Procedure Used.....	91
CHAPTER FIVE	94
DATA ANALYSIS AND FINDINGS	94
Analysis of Data.....	94
The Eight Themes Identified as Key Health Promotion Challenges	95
African Communities’ Understanding of the Concept of Public Health	96
African Communities’ Access to Health Services.....	112
Language Barrier as a Main Challenge to Accessing Health Promotion	117
Spirituality and Traditional Beliefs of African Health Consumers.....	122
Lack of Understanding of the Cultural Context of African Communities by Health Practitioners.....	128
Racism and Discrimination within the Health Sector	139
Housing Issues as a Challenge to the Promotion of Health within African Communities	151
HIV and AIDS Related-Stigma as a Challenge to the Promotion of Health within the African Communities	153
Recommendations from participants (community leaders, service providers and focus group)	154
The community leaders	154
Service Providers.....	158
Focus Group	159
Similarities on recommendations for all participants (community leaders, service providers and focus).....	161
Differences on recommendations for all participants (community leaders, service providers and focus.....	162
Some of the recommendations on the Health Promotion for Africans in Developed countries	162
CHAPTER SIX.....	164
DISCUSSION.....	164
African Communities’ Understanding of the Concept of Public Health	164
African Communities’ Access to Health Services.....	173
Language Barrier as a Main Challenge to Accessing Health Promotion	179
Spirituality and Traditional Beliefs of African Health Consumers.....	181
Lack of Understanding of the Cultural Context of African Communities by Health Practitioners.....	185
Racism and Discrimination within the Health Sector	190
Housing Issues as a Challenge to the Promotion of Health within African Communities	195

HIV and AIDS Related-Stigma as a Challenge to the Promotion of Health within the African Communities.....	198
CHAPTER SEVEN	200
CONCLUSION, RECOMMENDATIONS AND LIMITATIONS	200
African Communities’ Understanding of the Concept of Public Health	200
African Communities’ Access to Health Services.....	201
Language Barrier as a Main Challenge to Accessing Health Promotion	202
Spirituality and Traditional Beliefs of African Health Consumers.....	202
Lack of Understanding of the Cultural Context of African Communities by Health Practitioners.....	204
Racism and Discrimination within the Health Sector	204
Housing Issues as a Challenge to the Promotion of Health within African Communities	205
HIV and AIDS Related-Stigma as a Challenge to the Promotion of Health within the African Communities.....	205
Recommendations and actions by the Auckland District Health Boards DHBs.....	206
Recommendations from the New Zealand Refugee participants.....	207
The Conclusions Drawn from this Study.....	209
Limitations	210
References	211
Appendix A: Individual Participant Information Sheet	218
Appendix B: Service Provider Participant Information Sheet.....	222
Appendix C: Consent Form for the Researcher (Interviews)	225
Appendix D: Interview Questions for Community Leaders	226
Appendix E: Interview Questions for Service Providers	228
Appendix F: Research Safety Protocol.....	229
Appendix G: Confidentiality Agreement (Transcriber)	230
Appendix H: Glossary.....	231

LIST OF FIGURE(S) / MAP(S)

FIGURE 1: Map of Africa	22
-------------------------------	----

LIST OF TABLES

Table 2.1: African Quota Refugee Approvals by Country of Origin 1995-May 2012.....	27
Table 2.2: African Quota Refugee Approvals by Category (2000-May 2012)	28
Table 2.3: African Quota Refugee Approvals by Age (2000-May 2012).....	29
Table 2.4: African Refugee Quota System Approvals by Gender (2000-May 2012).....	29
Table 2.5: African Nations that Supplied Asylum Seekers (1997-2012).....	31
Table 2.6: New Zealand Asylum Seekers Claims and Approvals in New Zealand: 1997-2006.....	32
Table 2.7: African Refugees settled in New Zealand regions in 1993 to June 2012 (All Refugee categories: Quota, Family and Asylum).....	34
Table 2.8: Breakdown of Visa Category by Nationality of the 46 809 Africans in NZ (end of 2004).....	35
Table 2.9: Breakdown of 65 553 African in New Zealand (excluding NZ citizenship) as at 13th August 2008.....	38
Table 2.10: Total Number of Africans (Migrants and Refugees) in New Zealand (NZ Citizenship, Permanent Residency & Other Visas between 2002 and 2008.....	38
Table 2.11: Differences between a Migrant and a Refugee.....	43
Table 3.1: HIV Diagnosis Statistics in NZ (1996-2010).....	81
Table 3.2: Summary of HIV cases (1996-2010) in NZ-based African Communities.....	82

ATTESTATION OF AUTHORSHIP

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning".

Name: Kudakwashe Tuwe

Signed: 

Date: 30 March 2012

DEDICATION

This thesis is dedicated to my dear lovely wife **Annette Tuwe** (nee Mutema) who chose to forego and sacrifice most of the irrecoverable family time as I worked tirelessly on this thesis. I would not have completed this winding and thorny journey without your unwavering support. Your God-given pool of patience and unfailing love never stops to amaze me.

This thesis is also dedicated to my two little flowers: **Makanaka Tuwe**, my lovely daughter and **Munashe Tuwe**, my dear son. Hopefully this project will serve as a living and intrinsic motivation in your academic and professional lives.

ACKNOWLEDGEMENTS

“Our lives begin to end the day we become silent about things that matter” Dr Martin Luther King, jnr. Likewise, from an African cultural perspective, it would be equally becoming silent about things that matter; if I do not acknowledge the following individuals/ organizations who made it possible for me to complete this thesis.

Associate Professor, Dr Love M Chile- I would like to sincerely thank my project supervisor, Associate Professor, Dr Love M Chile of Auckland University of Technology (AUT), for all the unwavering support and professional academic guidance given to me. Your profound knowledge and focused guidance made it possible for me to complete this project. Your push for excellence coupled with professional writing skills created within me a better writer, thinker and listener.

Participants -My heart-felt gratitude goes to all my participants- all the 20 African Community Leaders from the New Zealand-based African communities, 10 New Zealand Service Providers and the Auckland-based focus group members. You gave your precious time to share your profound knowledge and experience, as gurus, in this area.

AUT Library staff -A big thank you to the AUT Library staff, in particular Dr Robyn Ramage for your support in teaching me how to use the “EndNote” facility as an effective referencing tool. Indeed you made my life easier.

Dr Abraham Simbarashe Chawanji – your help on proof-reading and advice on the general structure of the write-up was great.

New Zealand AIDS Foundation (NZAF) - I would like to thank my current employer, the New Zealand AIDS Foundation (NZAF), both management and staff for all the support given to me.

My Mother -Special mention goes to my dear mother, **Agatha Tuwe** (nee Kanda), my inspiration, who instilled within me a spirit of hard-work and

endurance, from a very young and tender age. You always said to me “Dzidza zvine simba mwanangu. Rimwe zuva zvichanaka chete” which means “always learn hard my dear son. One day, all shall be well with you).

Annette (my wife), **Makanaka and Munashe** (my children) - lastly, but not the least, a big hug and kisses to my dear lovely wife Annette for all the sacrifices you made, while I spent sleepless nights working on this thesis. Not forgetting my children, Makanaka and Munashe -you stood with me all the way. I really appreciate. I pray that you even work harder in your own academic studies and professional careers. May God bless you as you fulfil your dreams.

ETHICS APPROVAL LETTER FROM AUT UNIVERSITY



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Love Chile
From: **Dr Rosemary Godbold and Madeline Banda** Executive Secretary, AUTEC
Date: 8 June 2011
Subject: Ethics Application Number 11/64 **The challenges of health promotion within the African communities in New Zealand.**

Dear Love

Thank you for providing written evidence as requested. We are pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 28 March 2011 and that on 7 June 2011; we approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 27 June 2011.

Your ethics application is approved for a period of three years until 7 June 2014.

We advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 7 June 2014;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 7 June 2014 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further

enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of AUTEK and ourselves, we wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold and Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Kudakwashe Tuwe ktuwe@yahoo.co.nz

ABSTRACT

The current study seeks to identify the key health promotion challenges faced by New Zealand African communities. I used a phenomenological approach to critically examine the meanings and experiences of participants on health promotion (Polit & Beck, 2004). The use of the phenomenological approach enabled participants to share their “lived” experiences regarding the health promotion challenges within African communities in New Zealand.

In addition, I used ethno-methodology to help me understand how cultural norms, values, beliefs and practices impact on awareness and acceptance of health promotion practices by African individuals and communities in New Zealand (Polit & Beck, 2004).

In-depth interviews with 20 African community leaders, 10 service providers and one focus group with African community members critically examined participants’ personal experiences of health promotion by African communities in New Zealand.

Eight key health promotion challenges faced by African communities’ were identified, namely: African communities’ understanding of the concept of public health; African communities’ access to health services; Language barrier as a main challenge to accessing health promotion; Spirituality and traditional beliefs of African health consumers; Lack of understanding of the cultural context of African communities by health practitioners; Racism and discrimination within the health sector; Housing issues as a challenge to the promotion of health within African communities and HIV and AIDS related-Stigma as a challenge to health promotion within the African communities.

The study concludes that health promotion within African communities in New Zealand can only be effective when these issues are addressed within the African communities as well as the public health sector and institutional systematic levels.

CHAPTER ONE

INTRODUCTION

The purpose of the study- Aims of the Project

This research project aims to identify and expose some key health promotion challenges faced by African communities in New Zealand. Some other minority communities in developed countries have faced similar challenges, such as access to health facilities, stigma, discrimination, racism, and lack of active participation in policy development, empowerment, social justice and human rights (Alexander, 1999). These challenges can potentially affect individuals and community groups' physical, mental, social and psychological well-being. This study therefore sought to understand these health promotion challenges within the African communities in New Zealand with a view to developing appropriate policy responses that will enable more effective health promotion and access to health services.

Research Question

The research question of this study project is: What are the key health promotion challenges faced by African communities in New Zealand?

Rationale and Significance of the Study: Why proposing this Research?

The number of African communities in New Zealand has grown significantly since 1990. The majority of these are from refugee background (Chile, 2002). Given the cultural background of these communities it is important to understand how they access health services. The main objective of this study is to elucidate the challenges that impact on the health outcomes of the fast-growing African communities in New Zealand. The findings of this study will hopefully provide additional methods to engage the African communities more effectively in the development of health services that meet their needs.

While this study includes both African migrants and refugees, refugees face the steepest health challenges due to their traumatic background and the circumstances of their migration and settlement. These circumstances often

include less proficiency in the English language. Therefore the dominate voice in this study will be refugee voice. This is because 60% of the respondents within the African communities were refugees.

The Background: Putting the Project into perspective - The Concept of Health

The concept of health means different things to different people depending on their socio-cultural contexts (Boorse, 1977). For example within most traditional African cultures, being fat is perceived as a sign of good health and wealth (Omonzejele, 2008). Furthermore, the traditional African conception of health as the absence of illness leads to the undervaluing of the need for regular health checks, thus most people do not seek medical attention until they are sick (Omonzejele, 2008). Health promotion within many African communities therefore faces the tension between the two-fold notions of disease and treatment versus maintaining a healthy life style.

Wilkinson and Pickett (2010) stated that in the past, fat women with voluptuous bodies were much admired and regarded as attractive. This trend has now changed such that in many contemporary societies, being thin signals high social class and attractiveness. Women in higher socioeconomic classes are more likely to be dissatisfied with their bodies and monitor their weight by dieting than women in lower socioeconomic groups (Wilkinson & Pickett, 2010). Similarly, women who move down the social ladder tend to place less emphasis on thinness and are more satisfied with their bodies (Wilkinson & Pickett, 2010).

However, not all women want to be thin. For example, in inner-city African-American communities, thinness was associated with an image of poverty, hunger and being on welfare, as well as AIDS and drug addiction. Wilkinson and Pickett (2010) reported that a 19-year old woman in USA said "I've been a voluptuous female all my life. If I start losing a lot of weight, people will think I'm on drugs. In the ghetto, you just can't afford to look too thin..." (Wilkinson and Pickett, 2010, p.99). This shows the perception of community

members and its impact on health promotion, thus perception has some influence on the attitude of people (Bradley & Longino, 2001).

Bradley and Longino (2001) argued that negative stereotypes can have a significant adverse impact on self-esteem, body image, and self-efficacy, and can also contribute to sickness and death, as well as to healing (Ray, 2004). Thus, an individual's or community's perception of their health status can have a strong determining impact on their health choices and behaviours, and health outcomes because of a combination of both self-perceptions as well as how one is viewed by others (Cousins, 1997; Shepherd, 1999). Alexander (1999) argued that racism and discrimination had a strong impact on health determinants of black and minority ethnic groups in the United Kingdom. This was supported by later studies by Carr-Hill (2007), which revealed that racism and discrimination affected the mental health of African and Caribbean communities in UK in at least two main ways. It contributed to mental distress, and could lead to feelings of isolation, fear, intimidation, low self-esteem and anger (Carr-Hill, 2007). It also constituted a barrier to access and provision of appropriate health services (Carr-Hill, 2007). New Zealand-based African communities face similar challenges.

Health promotion seeks to achieve equity in health outcomes for all segments of the population. Therefore health promotion actions aim to reduce differences in health inequalities, secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices (Health Promotion of New Zealand, 2004).

Matheson (2005) argues that for health promotion to achieve the desired outcomes, partnership between the communities and service providers should be taken seriously. This partnership should be anchored on values such as respect, trust and reciprocity (Matheson, 2005). Furthermore, Minkler and Wallerstein (2003) stress the need of a community-based participatory approach, which will help to enhance and further buttress the relationship between communities and health service providers. Such initiatives are

imperative in the process of reducing health inequalities in the delivery of health promotion.

Shepherd (1999) pointed out the importance of participation and consultation of communities on issues that involve their health and well-being. This creates an environment where communities share their knowledge and experience, hence their empowerment. It is therefore important that communities have the opportunity to be actively engaged in decision-making relating to their health and well-being.

Thus, Laverrack and Labonte (2002) argue for a bottom-up approach to health promotion and health development where communities are supported to identify core issues and to develop strategies to address such issues. The top-down approach is at odds with the emancipatory discourse of the Ottawa Charter (World Health Organization, 1986).

Outline of the Thesis

This thesis is organised into seven chapters. Following this introduction which sets out the rationale, significance and context; chapter two provides “background to the study”. It examines significance of the fast-growing number of Africans in New Zealand which comprises of both migrants and refugees, who may address and challenge health and other service providers to provide services that meet the cultural needs of this community.

In addition, the fact that the number of Africans in New Zealand is growing fast will also help in the fair equitable distribution and allocation of resources to address the different needs of people from refugee background. This is about the different challenges faced by refugees compared to migrants when leaving one’s country for a safe refuge in another country.

Chapter three provides a critical review of extent on current international trends of experiences of African communities in other developed countries to see if there are lessons to be learned for African communities in New Zealand.

The literature review also looks at the challenges faced by other minority and marginalized groups in New Zealand, namely; Maori, Pacific Islanders, Asians and Gay, and Lesbians, Bisexual and Transgender (GLBT).

Chapter four explains the methodology, methods of data collection and analysis and the composition of the research participants. I explain why I chose the two methodological approaches used namely phenomenology and ethno-methodology.

Chapter Five focuses on data analysis and findings. It presents findings relating to the eight themes identified as key health promotion challenges faced by the African communities in New Zealand.

Chapter six discusses the key findings linking them to the key areas explored in the literature review.

Chapter seven provides conclusion, recommendations and limitations of the study.

CHAPTER TWO

BACKGROUND TO THE STUDY

Brief History of the African People in New Zealand

Prior to 1990 the opportunity to migrate to New Zealand for Africans was difficult due to New Zealand's traditional source country immigration policy favoring migrants from the United Kingdom, Northern Europe and Ireland (Carl, 2009).

According to Chile (2002), Africa, more than any other region of the world, has experienced most severe problems of "cross-border refugees" and internally displaced people. As far back as 1994, the continent had more than six million refugees and a further 15 million internally displaced people. This was more than five times the number of refugees in Europe and three times than those in Asia. Ethiopia alone generated an estimated 2.5 million refugees between the period of 1990 and 1994. Rwanda had over 1.7 million over the same period. This was during the period commonly referred to as the Rwanda genocide (Chile, 2002).

Between 1992 and 2001, around 3000 refugees from the Horn of Africa arrived in New Zealand under the United Nations High Commissioner for Refugees (UNHCR) quota system (New Zealand Immigration Service, 2004). Historically, New Zealand's refugee policy has been underpinned by a strong humanitarian response and this was bolstered by supportive public opinion (Refugee Migrant Services, 1993). Following World War II, New Zealand was the first country in the world to accept refugees under the "medical/disabled" category of the UNHCR quota system- a commitment that is still adhered to this day, where 75 people (including 20 positions reserved for HIV positive cases) are taken in (www.immigration.govt.nz).

By the late 1980s and early 1990s, more refugees from Africa came to New Zealand with the adoption of a formal refugee quota system in 1987. The

majority were from the Horn of Africa (see Map 1 below) which includes countries like Somalia, Ethiopia, Eritrea, Djibouti and Sudan (Ministry of Health, 2001). Many were fleeing political unrest and famine. African refugees come from extremely diverse backgrounds which include various ethnic affiliations, religion, and a variety of spoken languages.

It was prior to 1995 that there were more migrants than refugees. Between the period 1998 and 2006 was when the number of refugees dominated. The balance between refugees and migrants is now approaching parity due to mainly natural growth from New Zealand-born Africans from earlier migrants and refugees (Chile, 2012, Forthcoming).

Figure 1: Map of Africa



The New Zealand Refugee Annual Quota System

In order to bring into context, the African refugees in New Zealand, it is important to briefly examine the New Zealand refugee annual quota system. Through this system New Zealand accepts a total of 750 refugees, annually from around the globe. The composition of the 750 places is as follows:

- up to 75 places for the Women-at-Risk subcategory
- up to 75 places for the Medical/Disabled subcategory
- 600 places for the UNHCR Priority Protection subcategory, including up to 300 places for family reunification and up to 35 places for emergency referrals (Department of Labour, 2009).

Between the period of 1980 and 2002, a total of 16,556 refugees and displaced persons were resettled in New Zealand under the Refugee Quota Programme (Refugee Services, 2012).

New Zealand Immigration Policy of 1987

For the period between 1987 and 1994, New Zealand took only 375 Black African refugees. But as a result of the escalation of political crises in Somalia (1992-1994) and the Ethiopia-Eritrea war (1991-1993) and the Rwanda genocide of 1994, the number grew in the subsequent years (Chile, 2002).

Until the 1987 Immigration Act, New Zealand laws and regulations restricted or prevented the entry of individuals or groups who were deemed to be “undesirable”, thus, making New Zealand “British” and keeping the country “white” (New Zealand Immigration Service, 1987). People from Britain were actively recruited while those who were perceived as ‘different’ were kept out of the country.

Until 1961 (in law) and in 1974 (in practice) British descendants were allowed free entry into New Zealand. All other migrants, in particular from Asia, faced restrictions as from the late 19th century. Entry of other non-British Europeans was restricted from the early 20th century (New Zealand Immigration Service, 1987). This restriction also made it difficult for people from Africa who wanted to come to New Zealand.

The criteria for entry to New Zealand gradually changed from the one based on race or nationality to merits and skills-based at the beginning of 1974. The introduction of the 1987 Immigration Act finally saw the elimination of both the discrimination against some races and nationalities, and the preferences for others. However, the numbers of migrants and the pre-requisites they had to meet remained tightly controlled and regulated (New Zealand Immigration Service, 1987).

The Immigration Policy Review of 1986 was the culmination of the gradual shift which began in the 1960s. It marked the beginning of the abolition of requirements that earlier on emphasized nationality and ethnic origin as the basis for admitting immigrants in New Zealand. Any person who met specified educational, business, professional, and age or asset requirements was to be admitted, regardless of race or nationality. This policy opened doors for Africans to come into New Zealand (New Zealand Immigration Service, 1987).

Under the Immigration Act of 1987, which followed the review, immigrants coming to New Zealand were selected according to the three following categories:

- **A skills and business stream.** An occupational priority list identified skills needed in New Zealand. Priority was also given to entrepreneurs and business people; business immigrants were expected to transfer at least NZ\$150,000 to New Zealand. Interviews were carried out to assess English language abilities. This category proved by far the most important, and accounted for over half the immigrants who arrived after 1987.
- **A family stream.** Restrictions on family migration were eased under the 1987 Act. Migrants who did not have immediate relatives elsewhere in the world were allowed to join family members living in New Zealand. Up to a third of the subsequent immigrants came under this category.
- **A humanitarian stream.** This was for people whose circumstances were causing them emotional or physical harm. In most years about 10%

entered New Zealand under this category (New Zealand Immigration Service, 1987).

The changes which happened as a result of the Immigration Act of 1987 had a profound effect on the growing significant number of African migrants coming to New Zealand. This means, the changes in the Immigration policy (1987) made it easier for migrants from Africa and other parts of the world, who initially were perceived as “undesirables”, to come and settle into New Zealand.

As from 1991, people from non-traditional source countries found it easier to meet the criteria to migrate to New Zealand. The number of African migrants grew significantly (New Zealand Immigration Service, 1991).

The skilled migrant category which was introduced in 2003 also contributed to the increase of African migrants into New Zealand (www.immigration.govt.nz).

New Zealand Quota Refugee Approvals 1995-2012 (Quota System)

During the period of 1995-2012, a total of 11,361 people from 56 different countries were approved for New Zealand residence through the Refugee Quota Programme. The African continent had 14 countries out of the said 56 which supplied a total of 3,806. This accounted for 33.5%.

This information (1995- 2012) is broken down into two phrases, thus 1995 to 2000 (Chile 2002) and 2000 to 2012 (New Zealand Immigration Services, 2012).

The period of 1995-2000 had a total of 2,889 Quota refugees accepted into New Zealand. Out of this figure (2889), African nations accounted for a total of 1,778 refugees. This translated to 61.54% which was high mainly due to the political unrest coupled with the great famine of 1992-93 which adversely affected the horn of Africa, especially in Somalia and Ethiopia

As for the period of 2000 to 2012, there were 8,472 quota refugees who came into New Zealand. Out of this figure, Africa supplied 2,028 refugees which accounted for 23.94%.

The top five refugee supplying African countries were: Somalia (461), Ethiopia (395), Sudan (287), Eritrea (263) and The Republic Democratic Republic of Congo (DRC) with 195 Refugees (New Zealand Immigration Services, 2012).Please refer to Table 2.1 (below)

Table 2.1: African Quota Refugee Approvals by Country of Origin 1995- May 2012

Country of Origin	Totals 1995 to May 2012	Comment
Burundi	228	6% of Africa
Congo	109	2.9% of Africa
Democratic Republic of Congo (DRC)	195	5.1% of Africa
Djibouti	52	1.4% of Africa
Eritrea	367	9.6% of Africa
Ethiopia	1006	26.4% of Africa
Rwanda	90	2.4% of Africa
Somalia	1316	34.6% of Africa
Sudan	409	10.8% of Africa
Others (Africa)	34	0.9% (Any country less than 50)
Total from Africa	3806	33.50% of grand total
Others (Non Africa)	7555	66.50 of grand total
Grand Total NZ Refugee Intake	11361	100%

Sources:

1. Chile (2002)
2. New Zealand Immigration Website:
<http://www.immigration.govt.nz/migrant/general/generalinformation/statistics/>
: Retrieved 12 June 2012 (Published 24 May 2012)

The five categories of the 8,472 quota refugees were as follows: Medical/ Disabled 321; Protection 5,016; Women at Risk 763; Family Re-unification 2,140 and Emergency 232.

The numbers regarding categories for those from Africa were not given.

Table 2.2: African Quota Refugee Approvals by Category (2000-May 2012)

Medical/ Disabled	321
Protection	5016
Women at Risk	763
Family Re-Union	2140
Emergency	232
Totals	8472

Sources:

New Zealand Immigration Website:

<http://www.immigration.govt.nz/migrant/general/generalinformation/statistics/>:

Retrieved 12 June 2012 (Published 24 May 2012)

The age distribution of the said 8,472 quota refugee was as follows:

- 0-4 years: 893
- 5-12 years: 1,463
- 13-17 years: 1372
- 18-60 years: 4,665 and
- 60+ years: 79 (New Zealand Immigration Services, 2012).

Again the age distribution does not identify those from African countries.

Table 2.3: African Quota Refugee Approvals by Age (2000-May 2012)

0-4 Years	893
5-12 Years	1463
13-17 Years	1372
18-60 Years	4665
60+ Years	79
Totals	8472

Sources:

New Zealand Immigration Website:

<http://www.immigration.govt.nz/migrant/general/generalinformation/statistics/>:

Retrieved 12 June 2012 (Published 24 May 2012.)

Table 2.4: African Refugee Quota System Approvals by Gender (2000-May 2012)

Of the said 8,472 quota refugees, female and male were 4,040 and 4,432, respectively. No breakdown for those from Africa was given.

Female	4040
Male	4432
Totals	8472

Sources: New Zealand Immigration Website:

<http://www.immigration.govt.nz/migrant/general/generalinformation/statistics/>:

Retrieved 12 June 2012 (Published 24 May 2012).

African Asylum Seekers/ Convention Refugees Claims (1997 to 3rd June 2012)-by Nationality

Asylum seekers who are also referred to as convention refugees are people who flee their country of origin and claim refugee status on arrival in a particular country.

During the period between the years 1997- June 2012 (15 year-period) there were a total of 13,991 asylum claims received in New Zealand (New Zealand Immigration Services, 2012). Out of the stated 13, 991 claims, a total of 973 were

from 29 African countries. This accounted for 7%. The top five asylum producing African nations were:

- Zimbabwe: 356
- Nigeria: 108
- Ethiopia: 86
- Algeria: 83 and
- Egypt: 80 (New Zealand Immigration Services, 2012).

Zimbabwe had the highest number of asylum claims (356 applications). Out of the said 356 claims, 289 applications were lodged by Zimbabweans between 2000 and 2003. This was during the period of the chaotic farm invasions in Zimbabwe, which led to political unrest and instability (Zimbabwe Situation, 2001). This was also the period that I left Zimbabwe for New Zealand, though as a migrant.

Table 2.5 (below) gives a breakdown of the 29 African countries which supplied ten and above of the said 973 asylum claims.

Table 2.5: African Nations that Supplied Asylum Seekers (1997-2012)

Country	Totals	Comment / %
Algeria	83	8.5%
Chad	12	1.2%
Congo	25	2.6%
DRC	41	4.2
Egypt	80	8.2
Eritrea	13	1.3%
Ethiopia	86	8.8%
Ghana	30	3.1%
Liberia	24	2.5%
Libya	18	1.8%
Morocco	26	2.7%
Nigeria	108	11.1%
Tunisia	14	1.4%
Uganda	12	1.2%
Zimbabwe	356	36.6%
Others African countries below 10	45	4.6%
Total : Africa	973	7%
Total Others (Non-Africa)	13018	93.1%
Grand Total	13991	100%

Sources: New Zealand Immigration Website:
<http://www.immigration.govt.nz/NR/rdonlyres/FCDA531E-8691-4DE0-807B-DD2484DDA329/0/RF1RefugeeStatusAppsAcceptedAndDecided08NOV2011.pdf:m>
 Retrieved 12 June 2012 (Published 3rd June 2012).

New Zealand Asylum Seekers Claims and Approvals in New Zealand: 1997-2006

For the period between 1997 and 2006, a total of 12,223 asylum claims were received in New Zealand (Chile, 2007). Of this figure, 2,674 applications were approved. This accounts for an approval rate of 23.87%. For more details, please see Table 2.6 (below).

Table 2.6: New Zealand Asylum Seekers Claims and Approvals in New Zealand: 1997-2006

Year	Number of Claims	Approved	Approval (%claims)
1997/98	2591	275	22
1998/99	2649	538	21
1999/2000	1455	473	22
2000/2001	1703	312	13
2001/2002	1441	627	24
2002/2003	955	247	19
2003/2004	713	115	14
2004/2005	399	81	16
2005/2006	317	6	12
Totals	12 223	2674	23.87%

Source: Chile (2007)

Geographical Resettlement of Refugees in New Zealand

When refugees arrive in New Zealand they spend six weeks at Mangere Refugee Resource Centre (MRRC), in Auckland for orientation. This includes health checks, and psychological referrals. They are also taught about resettling in their new adopted country as well as lessons in conversational English, New

Zealand law and social and political systems (Chile, 2002). After the aforementioned six week period, the new arrivals are resettled in different regions in New Zealand- mostly where they will get settlement support from their own ethnic communities who will have been resettled there before them. The major cities where refugees are settled are Auckland, Hamilton, Wellington and Christchurch. The Department of Labour and Refugee Services are deliberately and strategically building strong communities of Somalis (Hamilton, Auckland and Christchurch), Burmese (Nelson) and Congolese (Palmerston North).

It is important to note that most of these refugees live in these resettled areas normally for a period of between 6-12 months mainly because of the support they get from their own ethnic communities. After this period some move to other places within New Zealand or go to Australia or overseas, for “greener pastures”. There is a trend where most of them are moving to Australia especially when they get New Zealand citizenship (Refugee Services, 2012).

According to information from Refugee Services Aotearoa New Zealand, there were a total of 2353 quota refugees who were resettled in New Zealand for the period between 1993 to 2012 (Refugee Services, 2012). Of this total, 525 were from Africa. This accounted for 23.11%. Of the said total of 525 from Africa; they were re-settled in the following cities:

- Auckland: 235
- Hamilton: 131
- Greater Wellington (Including Hutt Valley & Porirua):91
- Palmerston North: 48
- Christchurch: 17
- Nelson: 3

From the above information Auckland absorbed the highest number mainly because of its size and the fact that about 37.5% (1.5 million) of New Zealand population live in Auckland. Nelson had the least. Table 2.7 (below) shows a comprehensive summary.

Table 2.7: African Refugees settled in New Zealand regions in 1993 to June 2012 (All Refugee categories: Quota, Family and Asylum)

Nationality	Akld	Hamilton	Palm. Nth	Greater Wgtn (Including Hutt Valley & Porirua)	ChCh	Nelson	Total
Congo	48	83	48	16	0	0	195
Eritrea	70	31	0	13	9	0	123
Somalia	4	17	0	4	5	0	30
Sudan	39	0	0	35	0	0	74
Ethiopia	34	0	0	5	3	0	42
Others (Africa)	0	0	0	1	0	0	61
Total Africa	235	131	48	91	17	3	525
Grand Totals	813	244	276	617	238	165	2353

Key: Akld=Auckland, Palm. Nth= Palmerston North, Wgtn=Wellington, ChCh=Christchurch,

Source: Refugee Services email dated 2nd April 2012

Number of Africans in New Zealand -Migrants

As from the early 1980s until the end of 2004, there were about 46 809 African migrants (excluding Refugees and those with Citizenship) who had settled in New Zealand. These were categorized mainly in following three groups:

- Permanent Residency 39 325
- Work Permit 5 959
- Student Visas 1 525 (New Zealand Immigration Service, 2005).

The majority of the aforesaid number (46 809) were White South Africans who accounted for 38 930 (83.17%). The South African Magazine (April/May 2012 Issue Number 026) stated that they were approximately 80 000 South Africans living in New Zealand, as at the end of May 2012. The majority live in the North

Shore in Auckland (The South African Magazine, 2012). Table 2.6 (below) shows the breakdown of the stated 46,809. I agree with these numbers because the official 2006 New Zealand Cense figures for Africans in New Zealand were under-estimated mainly because if one indicated that he/she was originally from South Africa and Zimbabwe, they were automatically counted as Europeans (Statistics New Zealand, 2006). In addition, the Censes is self-reporting, thus, anyone who is African can state that he/she is European or any other ethnicity. Census also allows an individual to tick about six different ethnicities, which compromises the accuracy of the data.

Table 2.8: Breakdown of Visa Category by Nationality of the 46 809 Africans in NZ (early 1980s to end of 2004)

Country of origin	Permanent Residency	Work Permits	Student Visas	Totals	Percentages %
Ghana	281	23	5	312	0.67
Kenya	184	60	37	281	0.60
Malawi	194	6	8	42	0.10
Namibia	375	12	11	217	0.46
Nigeria	375	51	32	458	0.98
South Africa	33118	4786	1026	38 930	83.17
Tanzania	43	9	15	67	0.14
Zambia	243	52	24	319	0.68
Zimbabwe	4859	960	297	6116	13.07
Totals	39325	5959	1455	46 809	100

Source: NZIS (Reported 2005)

Between 1996 and 2004 the number of Africans from South Africa and Zimbabwe coming to settle in New Zealand dramatically increased mostly owing to two reasons:

- Most of the White South Africans were likely running away from the government of the African National Congress (ANC), after the collapse of apartheid. They were not sure how the Mandela-led ANC government was going to treat them. Some of them thought Mandela was going to revenge the evils of the 46 year-apartheid system (1948-1994). However, he did not. Instead, he chose peace, tranquillity and reconciliation. In addition, after independence in 1994, the South African government introduced policies that promoted Black Empowerment Programmes and as a result many business opportunities and government jobs were given to indigenous South Africans who were oppressed for a long time. Such initiatives were meant to address issues of inequality which had been going on for 46 years (1948-1994). Such programmes caused some of the Whites South Africans to question whether they were still wanted in a new South Africa. As a result, there was an exodus during the 1990s of many skilled white migrants and the majority of them came to New Zealand (The South African Magazine, 2012). The Black Empowerment Programmes in South Africa were similar to the Zimbabwean Affirmative Action Group (AAG) initiative which was designed to economically empower the indigenous people who were political oppressed and economically marginalized and excluded, before majority independence in 1980. I support such initiatives as these are intended to re-address the inequalities and imbalances of the past.
- For Zimbabweans, the skilled Black migrants and White farmers were fleeing away from the brutality of the ZANU (PF)-led regime, especially after the historic and haphazard farm invasions of the year 2000. In particular for the Zimbabwe White farmers, the majority had lost their farms and property. For the indigenous skilled migrants, the economy was deteriorating as a result of the political instability. This adversely affected the quality of life. So the majority of them came to New Zealand

for a better live and education for their children. (Zimbabwe Situation, 2001). I am one of those who came to New Zealand (as a migrant) from Zimbabwe in 2002.

The massive exodus of people coming from Africa to New Zealand tells us that the African communities in New Zealand are growing at a faster rate.

Number of Africans in New Zealand (excluding citizenship) as at the end 2008

According to a comprehensive breakdown supplied by the New Zealand Immigration Services (NZIS) in an emailed dated the 13th August 2008, there were 65 553 Africans in New Zealand who had different types of visas such as: Limited Purpose (Diplomats), Permanent Residency, Student Visa, Visitors Visa and Work Visa (New Zealand Immigration Service, 2008). This figure excluded those with New Zealand citizenship. In comparison with a total of 46,809 as at the end of 2004, there was an increase of 18,744 Africans in New Zealand, over a period of only four years. This translates to an increase of 40.03%. This shows that the number of Africans in New Zealand rapidly grew, over that period of time.

It is also important to note that the said figure of 65 553 is almost double the Census (2006) figure of 34 743. This shows a huge difference of 30 810, without including those with New Zealand citizenship.

The breakdown of the stated figure of 65 553 Africans in New Zealand (excluding New Zealand Citizenship) as at 13th August 2008 is indicated below on Table 2.9

Table 2.9: Breakdown of 65 553 African in New Zealand (excluding NZ citizenship) as at 13th August 2008

Type of NZ Visa	Limited Purpose (e.g. Diplomats)	Permanent Residency	Students Visa	Visitors Visa	Work Permit	Grand total
Totals	90	52 193	2 972	8 611	1 687	65 553

Source: NZIS Email dated 13th August 2008

Grand Total Number of Africans in New Zealand (NZ Citizenship, Permanent Residency & Other Visas Between 1999 and 2008)

According to an email dated the 8th December 2008 from the Department of Internal Affairs (DIA), there were 25 796 Africans in New Zealand who had been granted New Zealand Citizenship between the years 2002 and 2008. Once again, this shows that the African communities in New Zealand are growing very fast. South Africa had the highest number of those granted New Zealand citizenship, thus 16 730 (64.85%). Zimbabwe was the second highest at 3 288 (12.74%). The reasons for having high numbers from South Africa and Zimbabwe have already been explained. The breakdown of the aforementioned figure of 25 796 is as follows:

Table 2.10: Total Number of Africans (Migrants and Refugees) in New Zealand (NZ Citizenship, between 2002 and 2008)

Year	2002	2003	2004	2005	2006	2007	2008	Total
Numbers of African in NZ	3092	2923	3625	3709	4406	4935	3106	25 796

Source: Depart of Internal Affairs- NZ (Reported 2008)

An aggregate of the 2008 Immigration figure of 65 553 (all visas save for citizenship) and the 2008 citizenship figure of 25 796 will give a grand total of 91 349 Africans in New Zealand by end of the year 2008. These figures are as follows:

- All Visa category (save for citizenship) end of 2008 = 65,553
- Citizenship only, end of 2008 = 25,796
- Grand total as at end of 2008 = 91,349

It is important to note that there were some people who may have left the country, after this period, for example visitors, students, diplomats and others. Some may have gone back to their country of origin and some to Australia and other overseas countries for “greener pastures”. In addition, some may have died.

Equally the same, there are some people who may have come to New Zealand after this period. Therefore all these variations and factors may affect the stated figure of 91,349, by a significant margin.

Therefore this data from New Zealand Immigration Services (NZIS) and the Department of Internal Affairs (DIA) shows that for the year ended December 2008 there were close to 100, 000 Africans in New Zealand, with about 30% having full New Zealand citizenship (Email from NZIS dated 19th August 2008 and email from DIA dated 8th December 2008, refer). This shows that the African communities in New Zealand are growing very fast.

However, this figure of 91 349 Africans in New Zealand as at end 2008, is at odds with the 2006 New Zealand Census figure of 34 743. The difference is 56 606, which is huge.

It is not the fault or problem of the New Zealand Census (2006) for this discrepancy. Some of the reasons for this discrepancy would be any of the following:

- Census is self-reporting and as such some Africans may have chosen not to indicate that they were Africans, for whatever reason

- Some of the Africans were not born in Africa and therefore did not report as Africans
- Some of the Africans were born in Africa but they now have citizenship of other countries, and as a result may not have indicated that they are Africans.
- Some were granted citizenship in New Zealand and therefore may have reported as New Zealanders.
- As mentioned above the majority of Africans who came to New Zealand from both South Africa and Zimbabwe were classified as “Europeans” in the New Zealand 2006 Census , (Auckland District Health Board (ADHB), 2011).
- In the New Zealand 2006 Census ,some of the African counties like Algeria, Egypt, Libya Tunisia and Morocco were accounted for as part of Middle East and not as Africa) (Pio, 2010).

It is critically important to highlight this huge difference of 56 606 between the statistics from the 2006 Census (34743) and the information from NZIS and DIA (91 349). Such huge underestimations of the African population in New Zealand have a negative impact on the health delivery system for this population. It would mean small budgets and resources are allocated, based on these understated figures, for the health needs of this minority population which is already facing other different settlement challenges. This may also have some adverse effects on economic, social and political fronts for this fast-growing Africa population in New Zealand, as resources are allocated based on numbers. From a political perspective, this underestimation may result in the marginalisation of the African communities in New Zealand because politics is about a game of numbers.

African Professional Migrants

Most of the migrants who came to New Zealand were mostly professionals who came from English-speaking countries like Zimbabwe, South Africa, Ghana, Kenya and Nigeria. For example, Zimbabweans were accepted by New Zealand

government, under the Zimbabwe Special Residency Policy, on the basis that they were coming from an English-speaking country (New Zealand Immigration Service, 2006). The majority of the Zimbabwe professionals were mainly nurses and tradesmen. These tradesmen include categories like, Fitters, Fitter and Turners, Electricians, Diesel Plants Fitters and Auto-Mechanics. The abovementioned professionals from Zimbabwe had left their country of origin mainly because of the poor economic performance of the country triggered by the political instability. The major two reasons for the economic downturn of the country were:

- The unbudgeted huge payments in favour of the war veterans in 1999. These war veterans had participated in the 1970s armed struggle which liberated the country from the Smith-led Rhodesian minority white government (Zimbabwe Situation, 2000).
- The haphazard invasion of the white-owned farms by the war veterans in the year 2000 (Zimbabwe Situation, 2000).

As for Zimbabwean professionals, the majority of them are settled in Auckland, followed by Wellington, Christchurch, Hamilton, Palmerston North and then other smaller places, like Hawke Bay (Zimbabwe Association in New Zealand, 2012).

As explained before, most white professional migrants from South Africa were likely fleeing away from the Mandela-led ANC government. The majority of them are settled in the North Shore area in Auckland (The South African Magazine, 2012). According to the South African Magazine (2012) some of the professions are: Recruitment & Selection Specialist, Accountants, and Lawyers & Solicitors, Medical Doctors (Optometrists-eye specialist), Estate Agents, Immigration Advisors, Motor Mechanics and Butchers, (The South African Magazine, 2012).

In the case for professional migrants, there is a tendency to move to Australia, for “greener pastures” to work in the mines, especially in Western Australia. As for most refugees, they also normally leave for Australia when they get New

Zealand citizenship (Refugee Services, 2012). It is reported that some of the mines pay tradesmen about three times more than what they can get for an equivalent job in New Zealand. A lot of Zimbabwean nurses and tradesmen, especially from Wellington, have moved to Australia, for these greener pastures (Zimbabwe Association in New Zealand, 2012).

In most of New Zealand's higher learning institutions, like universities, we now have sizeable numbers of students who are studying different courses. These students are "professionals in the making" and once they finish their studies, this will increase the number of African professionals in New Zealand. For example, they were about 450 African students at Auckland University of Technology (AUT) at the end of 2011 (Auckland University of Technology, 2012).

Religion- Africans in New Zealand (NZ)

Religious convictions are as strong as political persuasions. Religion is also a socioeconomic determinant of health as it strongly influences cultural practice and perceptions of health as well as lifestyle choices (Auckland District Health Board (ADHB), 2011). In the Auckland region, the majority of African people are religious. Most Africans were Christian (65%) while Muslims accounted for 20% (Auckland District Health Board (ADHB), 2011).

Differences between a Migrant and a Refugee Background

There are significant difference in terms of backgrounds, between migrants and refugees. Table 2.11 (below) summaries some of these differences.

Table 2.11: Differences between a Migrant and a Refugee

Refugees	Migrants
Leave country of origin by force - no choice. They flee in response to a crisis	Have a choice to leave country of origin and settle in a country of their choice
No time to prepare for leaving	Have time to prepare for the trip and looking forward to it most of the time
No time to bid farewell to family and friends	Have enough time to prepare emotionally and bid farewell to family and friends
Often flee without proper travel documents	Have proper travel documents
At times leave without family members- often some family members are killed in the process	Can plan to leave together with family or make arrangements for them to follow
Not easy to return to country of origin	Can easily return to country of origin, any time they like
Traumatized most of the time	No trauma, in most cases
Refugees arrive in their new country ill-prepared	Usually well prepared and well-motivated to settle in a new country of their choice
Less economic independence	More independent, economically
Language barrier is a big issue	Normally speak the language of the host country

Source: Ministry of Health (2012): Refugees Health Care: A handbook for health professionals (2012.p. 5)

CHAPTER THREE

LITERATURE REVIEW

Health Promotion

Health promotion is a process of making people to be aware of their health and well-being and also empowering them to take charge of their health and well-being.

The above definition is supported by the following three different definitions of health promotion:

- The World Health Organization (WHO) defined Health Promotion as “a process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health” (World Health Organization, 1986.p.1). It has come to represent a unifying concept for those who recognise the basic need for change in both the ways and conditions of living in order to promote health. Health promotion represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health to create a healthier future (World Health Organization, 1986).
- The Ottawa Charter (1986) defined Health promotion as “the process of enabling people to increase control over, and to improve, their health” (World Health Organization, 1986.p.4).
- The Health Promotion Forum of New Zealand (HPFNZ) has a different definition which states that “Health promotion is the process of supporting people to increase control over the factors that influence their health and quality of life” (Health Promotion Forum of New Zealand ,2002.p.1).

The Definition of Health

In order to have a clear understanding of the definition of the term “Health Promotion,” it is important to first of all define the contestable and debateable term “health” (Seedhouse, 2004).

At its 52nd World Health Assembly, in Geneva, Switzerland, WHO defined the meaning of health (in order to accommodate the term spiritual) as “a dynamic state of complete physical, mental, spiritual and social wellbeing, and not merely the absence of disease or infirmity” (World Health Organisation, 1999, p.10)

The inclusion of the phrase “spiritual” was prudent and significantly vital as spirituality plays a major role in other people’s lives (World Health Organization, 1999).

It is also imperative to note that WHO included the following statements to the term “health” at its first International Health Promotion Conference in Ottawa, Canada in 1986 (World Health Organization, 1986):

- “To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment.
- Health is therefore seen as a resource for everyday life, not the objective of living.
- Health is a positive concept emphasizing social and personal resources, as well as physical capacities” (Seedhouse, 2004 p.36).

Boorse (1977) stated that when a person is said to be healthy, it is when all organs and tissues, as well as mental faculties function in accordance with design by which the organisms of the species in question maintain and renew their life. Disease was defined as that which impairs the normal function of the body organs (Boorse, 1977).

The Concept of Health

The concept of health means a lot of different things to different people depending on their socio-cultural contexts (Boorse, 1977). Culture, which is often defined as the enduring behaviours, attitudes, ideas, and traditions shared

by a large group of people and transmitted from one generation to the next, is essentially the lens through which a person views their world (Rosen 2001). What is completely healthy and normal in one culture may readily be defined and perceived as deviant and disorderly in another. For example, the Japanese place a high value on uniformity, hierarchy, reciprocity and harmony. Japan mainstream has a collectivist nature of culture which has a profound effect on issues dealing with mental health (Rosen 2001).

The concept of health encompasses mainly the following factors:

- physical Health,
- mental Health/Emotional Health,
- spiritual Health (Rosen 2001).

African Concept of health

It is important to note that Boorse (1977)'s definitions of health and disease fit well with the Western perspectives of what constitutes health and disease, but such definitions are radically different from what constitutes the African notion of health and disease (Omonzejele, 2008). This is because African concepts of health and disease are embedded in the African world view commonly known as African Traditional Medicine (ATM). According to Dime (1995), the African view of reality emphasizes the structural kinship between men and nature, and men and the spirit world. To African people, the whole multiplicity of things which comprise the universe are mystically one and therefore constitute only one thing, one reality, and thus, cosmos or universe (Dime, 1995). That is, everything is a part of the other that makes up reality, the total cosmos or universe.

Thus, it is probably only within the framework of African world view and African metaphysics that appropriate and accurate African concepts of health, disease, and indeed treatment, can be derived and understood (Boorse, 1977).

The African concept of health is embracive; it cannot be taken in isolation. For the traditional African, health is not just about the proper functioning of bodily organs but good health consists of mental, physical, spiritual, and emotional

stability for oneself, family members, and community (Omonzejele, 2008). This integrated view of health concept is based on the African unitary view of reality. Good health for the African is not a subjective affair. Good health is usually understood in terms of one's relationship with his ancestors (Omonzejele, 2008). Health amongst Africans is not based merely on how it affects the living, because it is of paramount importance that the ancestors stay healthy so that they can protect the living (Chavunduka, 1978). It is customary among urban and traditional communities in Africa to offer sacrifices to their ancestors and gods. This is normally done through slaughtering of animals as blood is believed to be an atonement as well as the linking agent with invigorating machinery of man-essence connecting with the spiritual world (Ozekhome, 1990). The type of a sacrificed animal depends on the ethnic tribe, for example the Ashanti of Ghana prefer the blood of pigs, whereas the Yorubas and Weppa-Wannos of Nigeria use dogs, goats and chicken (Ozekhome, 1990). Most Zimbabweans use chicken, goats and cows, depending on the significance of the sacrifice (Chavunduka, 1978).

Most African ethnic groups believe in reincarnation and also that one's health depends on the mood of the ancestors or the dead. For example, it is believed that a man who is not in harmony with his ancestors is not expected to enjoy robust health (Omonzejele, 2008). According to Gyekye (1987), most Africans communicate through the gods to the supreme God in order to stay healthy. Hence, most African communities would categorise the "spiritual powers and forces" in order of metaphysical hierarchy and importance as follows: God, gods, spirits, ancestors and then humans (Gyekye, 1987).

A certain traditional healer (Okolose) from West Africa claimed that without ancestral harmony, he would be unable to effectively manage the physical ailment of his patient (Omonzejele, 2008). He believed that this was because spiritual/ancestral harmony precedes physical harmony and health.

Disease, from an African perspective, goes beyond organic and tissue malfunctions. In the traditional African setting, disease and ill health are intricately linked to one's destiny and ancestral spirits. According to Iwu (1982),

disease is a sign of a lost battle in the delicate balancing act of appeasing the benevolent spirits and neighbours (Iwu, 1982). Disease is 'two-fold' comprising a physical and mystical cause (Dime, 1995). Diagnosis involves the establishment of the organic and physical causes of the sickness complemented by a divination of the spiritual or mystical causes of the disease (Dime, 1995).

Omonzejele, (2008) stated that when Western therapies fail among urban residents in most African countries, they go back to their ancestral homes in their villages for divination and treatment. According to Ozekhome (1990), divination is "revealing the unknown and at times cloudy future, unmasking the bad tunnel of the dark, unfortunate past, and analysing the vibrant but adaptable present" (Ozekhome,1990,p.64).After divination and appropriate rituals, they go back to the cities to seek Western medical care, if it is still required (Ozekhome, 1990). A medical regimen that has not benefited the patient before the performance of such rituals at their ancestral homes often suddenly becomes effective (Omonzejele, 2008). These situations are so widely known in Africa that many Western-trained African physicians tell relatives of non-responding patients to take their loved ones "home/village." Home/village here means the patient's ancestral rural dwelling (Omonzejele, 2008).

The dual perception of disease in Africa is what makes it radically different from the Western notion of disease. Thus Idowu (1973), observed that most African elites go for divination and make needed sacrifices before they proceed to Europe for medical treatment for a serious medical condition, so that the medication and general treatment they receive in Europe will be effective.

African concepts of health, disease, and treatment are best understood within the framework of African metaphysics, ethics, and cosmology (Omonzejele, 2008) and cannot be effectively evaluated exclusively from a Western medical paradigm, which will inevitably result in ideological, epistemic, and perhaps ethical conflicts (Omonzejele, 2008).

In traditional Africa, everyone is entitled to healthcare because traditional medicine is accessible to every member of the society. In extreme cases, the community takes over the healthcare of a member whose family members are clearly unable to carry out necessary sacrifices on their own for their loved ones, due to financial constraints or whatever reason (Omonzejele, 2008). Healthcare is therefore a communal responsibility and monetary reward is secondary (Idowu, 1973).

The objective of this discussion is not primarily to critique the African Traditional Medicine but rather to highlight the ethical precepts of African concept of health.

The traditional African conception of health as the absence of illness leads to the undervaluing of the need for regular health checks, thus waiting until a person was sick before seeking medical attention (Omonzejele, 2008). Health promotion within many African communities therefore faces the tension between the two-fold notions of disease and treatment versus maintaining a healthy life style. It is further complicated by intertwined relationship and interactions between African supernatural beliefs and cosmology (Omonzejele, 2008).

Cultural Conception of Health Promotion

Understanding of health promotion differs from community to community depending on a number of factors. Recent government public health policies in the United Kingdom (UK), such as 'Choosing Health' (Department of Health (UK), 2004) have declared that as far as possible, programmes supporting people to become healthier should be tailored to meet individual needs.

While this is ideal, health promotion programmes are directed at particular populations or community groups to achieve cost effectiveness. The challenge is

how to ensure that these programmes meet the needs of the individuals within these groups and communities.

The five key strategies of the Ottawa Charter

The Ottawa Charter stipulated five key action strategies namely:

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Re-orient health services (World Health Organization, 1986).

The above five action strategies will be critically examined, in context, to see if these are operational within the programmes that target the African communities in Zealand.

Building a healthy public policy means prioritizing on the agenda of policy makers. This should be done in all sectors and at all levels, directing them to be aware of the health consequences of the decisions they make and to accept their responsibilities for health (World Health Organization, 1986).

In New Zealand most health policy issues are spear-headed by the Ministry of Health (MoH), on behalf of the government. The MoH works in consultation with other key stakeholders in the sector. As for the African communities in New Zealand, there are no many organizations within the health sector that are targeted at meeting the needs of this community. There are currently only two, namely the New Zealand AIDS Foundation (NZAF)-African Communities Programme and the New Zealand African Welfare Service Trust (NZAWST). The NZAF has a focus on HIV health promotion (New Zealand AIDS Foundation, 2009). The NZAWST provides social welfare service and a smaller component of health and wellbeing mainly through giving advice and making referrals to appropriate agencies (New Zealand African Welfare Service Trust, 2012).

On policy matters the NZAF is only consulted when it is to do with HIV and AIDS. On the other hand NZAWST is not always consulted on matters regarding social welfare services since the government heavily relies on child Youth and family (CYF) which is a government department^{1*}. This shows that there is a disconnection between the policy makers and those organizations that directly deliver the health services to the communities. These gaps and disconnections do not empower communities. They dis-empower these communities which are already disadvantaged, especially in the case of the African communities in New Zealand. It is important to note that decisions that affect health and well-being of the members of the African communities are made without their input. According to the Ottawa Charter (1986), the New Zealand government should be aware of the consequences of the decisions they make and to accept the responsibilities for health (World Health Organization, 1986).

Creating supportive environments makes the link between people and their environments in order to improve health. This involves addressing the cultural values, social norms, physical surroundings, political and economic structures that make up the home, workplace and community environments in which we live (World Health Organization, 1986).

There are no proper supportive environments for the African communities in New Zealand when it comes to cultural matters. The cultural values and social norms for the African communities in New Zealand have no impact on the New Zealand main-stream population and politics, mainly because the numbers are still small. The political and economic structures are not in favour of the African communities, at the present moment. Owing to the political system, there is not a single African representative in either local or central government politics (Local Council Boards, Councils and Parliament). Again it is crucial to recognize that decisions that affect health and well-being of the members of the

¹ **Personal telephone conversation with Frank Amoh (General Manager-NZAWST) dated 26 June 2012.*

African communities are made at these levels (Local Council Boards, Councils and Parliament).

Strengthening community action involves the empowerment of communities through strengthening social networks and support for social change by providing resources, clear information and learning opportunities (World Health Organization, 1986).

Since the numbers of the Africans in New Zealand is still relatively small, there are not many professional organizations (save for NZAF and NZAWST) that have been established in order to deal exclusively with this community. This excludes individual ethnic communities, of which some have received some level of support in form of community grants (money). As for NZAF, the government has done a good job in terms of providing the required resources. These resources include salaries for four African employees and a reasonable budget to carry out community awareness programmes nationwide.

There is nothing much done regarding strengthening communities for social change, learning opportunities, for the African communities in New Zealand. Other minority communities like the Maori and Pacific have allocated resources to strengthen their social networks and social change. They also have special learning opportunities, for example at tertiary educational level. This opens up avenues and opportunities for these communities which the Africans do not have. The African community in New Zealand is still one of the most marginalized and disadvantaged one (Auckland District Health Board (ADHB), 2011). This has an adverse effect on the health and well-being of the members of the African communities in New Zealand.

Developing personal skills focuses on supporting personal and social development through providing information, education for health and enhancing life skills. This increases the options available to people to exercise more control over their own health and over their environments and to make choices conducive to their health (World Health Organization, 1986).

As mentioned before some of the minority communities in New Zealand have unique opportunities like first preferences in certain university courses (Law and Medicine). The members of the Africans do not have this opportunity. Such opportunities are aimed at developing personal skills for the individual concerned. This empowers the individual and the community so that they are equipped to fully exercise control over they own health and well-being.

Re-orienting health services creates opportunities to share the responsibility for health promotion among individuals, community groups, health professionals, health service institutions and governments. These groups must work together towards a health care system which contributes to the pursuit of health. Re-orienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health service providers, which refocuses on the total needs of the individual as a whole person and communities. This moves the health sector beyond providing only medical/clinical services towards meeting the more holistic needs of people using a multi-sectorial approach (World Health Organization, 1986).

It is important to note that though re-orienting health services requires stronger attention to health research, there is not much research that has been devoted to the health issues of African communities in New Zealand. At the moment there is no authoritative research to provide empirical evidence on African health issues, (in New Zealand) especially health promotion. However, it is crucial to acknowledge that there is currently a sizeable joint-research (by Massey and Otago Universities) being done on Africans in New Zealand. The research will be focusing on knowledge, sexual behaviours and attitudes regarding mostly HIV. This research is been sponsored by the New Zealand Ministry of Health and managed by the Health Research Council of New Zealand (Health Research Council of New Zealand, 2011).

In addition, The Ottawa Charter identified the following prerequisites for health: peace, shelter, education, food, income, a stable eco-system, sustainable

resources, social justice/human rights and equity (World Health Organization, 1986).

African communities in New Zealand are fortunate in the sense that prerequisites such as peace, education and food a stable-eco-system sustainable resources, social justice and human rights are fairly available compared to many African countries. However, the issue of income which is related to employment poses a challenge to many Africans in New Zealand. Though this is more of a health outcome it has some negative impact on the promotion of health within this community.

The Canadian Public Health Association (CPHA): Action Statement for Health Promotion in Canada (1996)

The Canadian Public Health Association (CPHA) clearly stated that, poverty is on the rise and the income gap between rich and poor is daily widening. Unemployment continues to be on the increase regardless of economic growth. Communities are under increasing and constant pressure from global economic practices that put in danger the environment and consolidate wealth and power in private individual corporations with few legal responsibilities to the common good. Cuts in government funding threaten the social fabric safety net and health system that have served people well in the past (The Canadian Public Health Association, 1996).

Same as indicated by Canadian Public Health Association (CPHA), the gap between the rich and poor is widening in New Zealand thereby adversely affecting those on the lower socio-economic ladder. Poverty is on the rise; and the prices of basics commodities like food, fuels and accommodation are also going up. The most affected are Africans, especially those from a refugee background (Auckland District Health Board (ADHB), 2011).

The current National-led government has been cutting community funding and education allowance for post-graduate students. It is important to note that such funding cuts adversely affect communities' initiatives which have

benefited them in the past. It also threatens the social fabric safety net and health system that have been working well for communities in the past.

Community Development Strategies

It is crucial to identify actions and commitments that address and focus on the determinants of health, through health promotion strategies that will enhance and promote community development initiatives. The Bangkok conference in 2005 (World Health Organization, 2005) agreed on the following strategies; which could, in my view, also benefit African communities in New Zealand.

- **Advocate** for health based on human rights and solidarity. It is important to note that without embracing the principles of human rights it will be almost impossible to implement effective health promotion programmes in any community and thus, includes the New Zealand-based African communities. Access to health and health promotion information is a basic human right to all members of a society. This includes those on the lower socio-economic groups, migrants and refugees.
- **Invest** in sustainable policies, actions and infrastructure to address the determinants of health. Policy makers should consult and include affected communities in the decision-making process if they want their policies and programmes to be effective and respected by those community members. If affected communities are left out of the decision-making process there is a natural tendency to resist any policy even if it will be for the good of the community. Equally the same, the African communities in New Zealand should be involved in all policy decision-making that affect them.
- **Build capacity** for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy. Without a clear and genuine capacity-building programme, it will be difficult to develop a vibrant and effective community. Capacity-building needs

genuine commitment without hidden agendas, especially with the service provider. Communities have complained about some service providers who do not give genuine training, transfer knowledge and pass on key leadership skills to its members with a hope of continuing to hold on “power” in the name of “capacity-building”. In other words this suggests that the community members are not yet ready to take over the leadership of community development initiative, thus they still need further training.

- **Regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people. The more people feel protected from any form of harm the more they adhere and follow the legislated regulations. If people feel exposed to danger and unprotected by the regulations, they are bound to disrespect those rules in place. It is therefore critically important to make sure that all health promotion regulations are viewed to be protecting communities.
- **Partner and build alliances** with public, private, non-governmental and international organizations and civil society to create sustainable actions. It is imperative for service providers to partner and build strong and genuine alliances with communities they are working with. The communities should be treated in such a way that they feel that they are regarded as equal partners. The moment they feel treated as less partners, they will develop mistrust. Therefore, for effective health promotion to take place in New Zealand, for the African communities, it is critically important they be considered and seriously taken as equal partners (World Health Organization, 2005).

Health Promotion in Aotearoa New Zealand

The Health Promotion Forum of New Zealand (HPFNZ) and the Maori Mode of Health Promotion in Aotearoa-New Zealand (Partnership, Participation and Protection)

The health Promotion Forum of New Zealand (HPFNZ) was established in 1986 with the primary objective to build leadership, relationships and the workforce in health promotion consistent with the principles of the Treaty of Waitangi, (Health Promotion Forum of New Zealand, 1997). Treaty principles and provisions of particular relevance to health are partnership, participation and active protection (Barrett., 1996). These three principles are briefly explained below:

Partnership

Partnership refers to ongoing relationships between the Crown and Maori. Under the principle of partnership, the Maori are to be equal partners with the crown in all matters that affect Maori health. As for this study, in reference to partnership, the service providers, the government, non-governmental organisations (NGOs) and all key stakeholders should treat the New Zealand-based African communities as equal partners in all health promotion issues. The aim will be to identify principles of empowerment from the perspective of members of the African communities. The researcher acknowledges the fact that participants, in this case the African communities in New Zealand, are key holders of crucial information and as such should be considered as critical contributors to this process.

Participation

Participation emphasizes Maori involvement in all aspects of society within Aotearoa-New Zealand. Within health promotion this includes involvement of Maori stakeholders in the planning, delivery and monitoring of programmes that are relevant to Maori. In the context of this research, it is important that the African communities in New Zealand are given a genuine space to fully and

effectively participate in all health issues that affect them. Excluding them will be marginalizing and disempowering them.

Active Protection

Active Protection recognizes that the Crown needs to be pro-active in health promotion and the development of preventative strategies. This may mean putting in additional resources so that Maori are able to enjoy equitable health status with non-Maori, for example Europeans (Waa, Holibar, & Spinola, 1998)

Health is understood as a holistic concept embracing a Maori model of health where good health is recognized as being dependent on a balance of factors affecting wellbeing. Some of these factors are: wairua (the spiritual), hinengaro (mental), tinana (physical), te reo rangatira (language) and whanau (family) (Barrett., 1996).

This approach requires that Maori health be understood in the context of the social, economic and cultural position of Maori (Health Promotion Forum of New Zealand, 2002).

For the purposes of this research, the principle of protection will take into account issues regarding sensitivity to cultural values and beliefs of African community members. These should be respected and protected by the service providers and other key stake holders.

All these three principles have a critical role in understanding health and sickness; the development of health policy and the delivery of health services and programmes (Waa, et al., 1998) .

The Health Promotion Forum of New Zealand (HPFNZ)

In Aotearoa-New Zealand, health promotion practice takes account of the 1986 Ottawa Charter for Health Promotion and the 1840 The Treaty of Waitangi, which is the country's founding contract between Maori (the indigenous people) and the Crown (Health Promotion Forum of New Zealand, 2002).

The Health Promotion Forum of New Zealand (HPFNZ) stated that an important characteristic of health promotion is its focus on groups of people, either the whole population or specific subgroups. It places emphasis on changing the environment to enable behaviour to change. Health promotion draws upon principles of: social change, physical change, policy development, empowerment, community participation, equity and health, accountability, building partnerships and alliances between groups (Health Promotion Forum of New Zealand, 2002).

The Health Promotion Forum of New Zealand argued that in order to achieve a state of complete physical, mental and social well-being, individuals and groups must be able to identify and realize their aspirations, satisfy needs, and change or cope with the environment (Health Promotion Forum of New Zealand, 2002).

The Health Promotion Forum of New Zealand has played a significant role in health promotion in New Zealand. Some of the outstanding contributions to health promotion in New Zealand are:

- In 2005 the Forum (HPFNZ) signalled a shift in strategic direction by launching a new *tohu* (logo) and a slogan “Haoura- Everyone’s Right”. The new focus was on human rights approaches to health promotion. This included the need to address inequalities for disadvantaged groups like Maori, Pacific, Asians and Refugees and Migrants (Health Promotion Forum of New Zealand, 1997).
- In 2008, many changes happened which included amending the constitution and strengthening the infrastructure of the forum. These initiatives included:
 - The expansion of the Manukau Institute of Technology (MIT) Certificate of Achievement in Introducing Health Promotion
 - The support for MIT establishing an undergraduate qualification - The Diploma in Health Promotion (Level 6, with 120 credits)
 - Participation in other tertiary education development

- The establishment of five reference groups, namely (i) Maori, (ii) Pacific, (iii) Primary Health Care, (iv) Academic and (v) South Island
- Launch of a new website in 2008 and an e-bulletin “Rongo Korero o Hauora” which reflected works in progress as the Forum continued to seek to keep pace with rapidly changing and expanding electronic communications (Health Promotion Forum of New Zealand, 1997).

The Health Promotion Forum of New Zealand demonstrated its commitment to the Treaty of Waitangi , determinants of health and human rights based approaches by having a strong focus on Maori, strengthening Pacific participation and the growing voice of Asian communities in both governance and in its service delivery (Health Promotion Forum of New Zealand, 1997).

The Maori Health Model-Te Whare Tapa Wha (Holistic and Well-being)

Durie (2009) developed a model of holistic health and wellbeing called *Te whare tapa wha* which explains how the four dimensions work. The four dimensions are:

- *te taha hinengaro* (psychological health),
- *te taha wairua* (spiritual health),
- *te taha tinana* (physical health) and
- *te taha whānau* (family health) (Durie, 2009).

Barrett (1996) states that in addition to the above four underpinning dimensions, there are other two equally important factors to the Maori health model which are *Te Ao Turoa* (the environment) and *Te Reo Rangatira* (Language). Barrett briefly explains the aforementioned two factors as:

- *Te Ao Turoa* - the environment. The relationship between Maori and *te ao turoa* (the environment) is one of *tiakitanga* (stewardship). It is the

continuous flow of life source. Without this type of natural environment, the people cease to exist as Maori (Barrett., 1996).

- *Te Reo Rangatira - the language*. This is the dimension that expresses the importance of language. This is an essential part of Maori culture. It is a *taonga* (treasure). The language expresses the values and beliefs of the people and a focus of identity. The root of Maori culture is the language, a gift from (their) ancestors (Barrett., 1996).

Health promotion for Maori means having control over their health or *tino rangatiratanga o te hauora* which is about self-determination. Health promotion for Maori should therefore be aimed at working with whanau to develop appropriate health and wellbeing choices (Barrett., 1996).

Maori involvement in health promotion means, among others, the following:

- achieving potential
- making decisions
- maximising choices and
- being part of the consultative process (Barrett., 1996).

International Literature Review-Challenges faced by Africans in Developed Countries

Health Promotion Challenges for Africans - United Kingdom (UK)

The United Kingdom (UK) contains an African and Caribbean population of around 1 148 738, many of whom live in London and other large cities (Office of National Statistics, 2003). Despite the fact that these minority groups have been established in the UK, public health practitioners still lack robust evidence of what initiatives are most successful in encouraging and sustaining healthier behaviours within these communities.

HIV Challenges for African Communities in the UK

The African community in the UK has the highest levels of HIV infection among all minority ethnic groups. Between 1996 and 2005, both the number and proportion of Africans with the HIV virus increased from 16% (1920 cases) to 39% (17330 cases) (Health Protection Agency, 2006). African and Caribbean populations in the UK are more likely to experience challenges associated with risk factors for HIV infection such as low income, immigration and settlement issues, poor housing conditions, social exclusion, and limited access to training, skills development and job opportunities (Interagency on AIDS and Development (Canada), 2009).

Health Promotion, Racism and Socio-economic Challenges in the UK

Fernando (2002) suggests that proper and effective health promotion can play a pivotal role in promoting a wide range of health and social benefits for people from the African and minority ethnic communities. These include more accessible services, increased employment opportunities and more social inclusion. Africans and other minority ethnic groups are amongst the most socially excluded and marginalised in the United Kingdom (Fernando, 2002). They are more likely than others to live in deprived neighbourhoods, be poor, be unemployed, experience ill health, and live in overcrowded ghettos and unpopular housing. People from black and minority ethnic communities experience the added jeopardy of widespread racial harassment and racist crime that also impacts on their mental health and wellbeing.

Jackson, Brown, Williams et al, (1996) argued that tackling racism is likely to be the most effective route to improving the health of Black and Minority Ethnic groups in the UK . Cumulative exposure to racism and racial discrimination is a key risk factor for mental health problems, notably for depression and is particularly damaging for people who are already vulnerable. Racism affects mental wellbeing in two main dimensions:

- It can lead to feelings of isolation, fear, intimidation, low self-esteem and anger. It may lead to depression caused by feelings of rejection, loss, helplessness, hopelessness and an inability to have control over external

forces (Sashidharan & Francis, 1993). Alexander (1999) suggests that many African people in the UK regard racism and its effects as a major contributing factor to the prevalence of mental health problems (Alexander, 1999).

- Racism can also be a barrier to the access and provision of appropriate health services as clients are excluded from services because of direct discrimination, staff attitudes towards them, or through indirect discrimination such as being unable to access services because of language barriers (National Health Services Executive, 1998).

Mental Health Challenges for Africans in the in the UK

Africans and Caribbeans often experience worse mental health outcomes than the majority White population and occasionally worse than every other ethnic group (Centre for Caribbean Health, 2004). The reasons given for this disparity are , among others, the following: failure to identify psychological problems, lack of culturally appropriate services, over-diagnosis and mis-diagnosis, racism within mental health services and socio-economic factors e.g. deprivation, unemployment and the impact of racism (Bhugra, Leff, & Mallett, 1997)

In the UK, there is on-going concern about inappropriate services, inaccessible to health services and culturally insensitive services for the African communities.

These are relevant to mental health promotion because of the impact of poor services on the mental health of those who use them and their wider community (Breaking the Circle of Fear, 2002).

Strategies for Reducing and Eliminating Ethnic Inequalities in the UK

In 2003 the UK Government came up with some strategies, in its first ever National Plan for Ethnicity and Mental Health that were aimed at reducing or eliminating inequalities affecting minority communities. This included the Africans in the UK (NIMHE, 2003).

The publication set out three overarching strategies in addressing mental health challenges by:

- reducing and eliminating ethnic inequalities in mental health service experience and outcome
- developing a Mental Health Workforce that is capable of delivering effective mental health services in a multicultural context and
- enhancing and building on the capacity within black and minority ethnic communities and in the voluntary sector for dealing with mental health and mental ill health (NIMHE, 2003).

Spirituality (UK)

On spirituality, people from minority ethnic communities in the UK are more likely than the white majority to be practising their religious faith. In one study a higher proportion of African people affirmed a religious belief (predominantly Christian) than that of the white population or other minority ethnic communities (Faulkner, 2000). Some of them have also been identified as using prayer as a major coping strategy for depression. Research has shown that religious involvement is associated with positive mental health outcomes. A growing number of studies also emphasise the importance of spiritual beliefs and the value of support from faith communities for people with mental health problems (Faulkner, 2000). However, other studies have found a resistance to spiritual issues within mental health services, where religious beliefs are sometimes interpreted as symptoms of illness (Friedli 2000).

Health Promotion, Racism and Socio-economic Challenges in Canada

A survey carried out in Canada by Rumball-Smith (2009) on ethnic disparities in hospital care found that discrimination was a key determinant of health outcomes as it negatively affects one's self esteem and mental health. Discrimination has the potential of leading to institutionalized racism which in turn adversely affects access to health services and effective engagement with

health service providers. All this leads to poor health outcomes for the African communities in New Zealand which is already marginalized (Rumball-Smith, 2009).

Issues of cultural differences are closely intertwined with racism, segregation and other “isms”. Pernice (2000) suggests that there are multiple sources of social oppression including racism, sexism, discrimination based on poverty, unemployment and underemployment.

Rumball-Smith (2009) pointed out that racism is one of the main causes of mental health among African refugees, resulting in psycho-social stress that leads to mental illnesses like depression, stress and loss of memory. Waldron (2002) identified three categories of racism experienced by African Canadians, namely: inter-personal racism, institutionalised racism and social racism. Inter-personal racism ranged from personal threats or insults, to subtle changes in people’s expressions and being deliberately ignored (Waldron, 2002).

Health Promotion Challenges for the Black African- Americans in the USA

Despite being one of the older minority communities, African-Americans still experience stark health inequalities. In 2003, African-Americans had the highest death rates for heart disease, stroke, cancer, asthma, HIV/AIDS and homicide than the White population. African-Americans are twice more likely to be diagnosed with type II diabetes than White people and twice as likely to die from the condition. Between 2001-2004, a total of 50% of all HIV diagnoses were among African-Americans (Office of Minority Health, 2007).

African-American men have a 30% higher death rate from heart disease and women are 1.7 times more likely to be obese. The risk of death from stroke is almost double the rates of the White population. African-Americans are also disadvantaged across some of the determinants of health (Pernice, Trlin, Henderson, & North, 2000). In addition to making up 25% of the population, the African-American unemployment rate is twice that of the White population.

A lower proportion of the population has high school diplomas and first degrees, and on average, African-American families earn 40% less than their White counterparts (Office of Minority Health, 2007).

For any health promotion to be successful, issues of inequality, discrimination, racism, marginalisation should be eliminated (Rumball-Smith, 2009). Human rights, social justice and fairness are the underpinning principles that promote effective health promotion in any communities (WHO, 2005). This should also apply to the African communities in New Zealand.

Nutrition Issues for African- Americans in the USA

According to Sloane et al., (2006), the data collected (in USA) on a survey on "Shopping List" and "Health Food Assessment" on African- American women, showed that 70% of stores, in their locality sold fruit and vegetables compared to over 93% in the comparison predominately white residential area. Significant differences in the availability of low fat dairy products ranged from 23.9% for non-fat cheese to 44.3% for skimmed milk. Whole grain pasta, low fat crisps, sugar free cookies and low salt foods were not so more readily available in their local area compared to areas where the majority of white people lived (Sloane, et al., 2006).

For the African-Americans there was no evidence of the replacement of high fat foods with healthier foods like fruit, vegetables, grains etc. (Auslander, Haire Joshu, & Houston, 2000).

Such situations of having fewer shops that sell health food (vegetables) will influence these people to resort to buying unhealthy food. These are part and parcel of socio-economic factors which adversely affect the poor.

Physical Activities for African- Americans in the USA

In a study carried out in the USA that compared the physical activity levels, the findings were that 8% of the African-American women took the government recommended levels of exercise each week, compared to 13% of White women (Ransdell & Wells, 1998). Across all groups, African-American women, over 40 years and without a university education had the lowest leisure time physical activity levels (Ransdell & Wells, 1998).

This shows a correlation between the level of education and knowledge of the benefits of physical activities.

Spirituality, Mental Health Issues, and Health Promotion in USA

Health promotion within faith communities was explored through focus groups with African American women (Drayton-Brooks & White, 2004) and the findings indicated that individuals that could influence participants to adopt healthier lifestyles included God, church pastor, nurse, family and church members and their general practitioner. Basing health promotion activities within a church setting was preferred by most women, explaining that they would feel more at ease and accepted in this familiar environment (Drayton-Brooks & White, 2004).

This shows that spirituality plays a pivotal role in the lives and health promotion of people and communities.

Pastors of urban African American churches, regularly supported individuals with severe mental illness, substance abuse issues, suicidal tendencies and personal crises. This support often took the form of combined psychological and spiritual counselling. Some of the referrals came from health professionals. Pastors often referred individuals to health or social services. The community appreciated and supported this aspect of community-initiated health promotion (Young, Gittelsohn, Charleston, Felix-Aaron, & Appel, 2001). During counselling sessions pastors used health promoting functions of storytelling explored by Banks-Wallace (1998) in order to reinforce the importance of providing a safe space within which affected individuals can share their personal experiences.

The above findings show that spirituality plays a significant role in the health and well-being of people. Also, spirituality has some influence on mental health issues and health promotion initiatives in communities.

The New Zealand's Disadvantaged Minority and Marginalized Communities or Groups on Health Issues

In Aotearoa-New Zealand, the following groups are marginalized or disadvantaged when it comes to the health promotion and health delivery system: Maori, Pacific Islanders, Asians, Gay, and Lesbians, Bisexual and Transgender (GLBT) and Refugees and Migrants.

The Maori

An analysis of Maori health in the context of New Zealand's colonial history may suggest possible explanations for inequalities in health between Maoris and non-Maoris, highlighting the role of access to health care (King, 2003). Explanations for these differences involve a complex mix of components associated with socioeconomic and lifestyle factors, availability of health care, and discrimination (Ramsden, 1997). Improving access to care is critical to addressing health disparities, and increasing evidence suggests that Maoris and non-Maoris differ in terms of access to primary and secondary health care services (Ramsden, 1997)

Pomare (1980) used data from 1954 through 1975 to provide a comprehensive overview of Maori health status. The results indicated that, rates of cause-specific mortality, including deaths from respiratory diseases, infectious diseases, cardiovascular diseases, diabetes, cancer, and unintentional injuries, were higher among Maoris than non-Maoris (Pomare, 1980).

A number of different explanations have been suggested for the inequalities in health between Maoris and non-Maoris. One common suggestion is that these differences are due to genetic factors (Hall & Stewart, 1989). Environmental factors played the major role (Pearce, Foliaki, Cunningham, & Sporle, 2004).

Non-genetic explanations for differences in health between Maoris and non-Maoris can be grouped into four major areas namely: socioeconomic factors, lifestyle factors, access to health care, discrimination and employment.

A significant proportion of the excess mortality among Maoris stems from diseases for which effective health care is available, suggesting differences in access to health care (Smith & Pearce, 1984). In this context, access has been described in terms of both "access to" and "access through" health care, the latter concept taking into account the quality of the service being offered (Lurie, 2002).

The role of discrimination and racism in adversely affecting the health of people in any community is not new; but has received increasing attention over the past 20 years (Krieger, 2003). Conscious or unconscious attitudes of health workers contribute to reluctance by Maoris to seek medical care for their asthma until it is absolutely necessary (Pomare, 1991). Another study on barriers to Diabetes Care, reported that barriers to accessing diabetes care among Maoris, included issues like unsatisfactory previous encounters with professionals and experiences of disempowerment (Simmons, 1998).

The Pacific People

The New Zealand 2006 Census indicated that there were 265,974 (6.9%) people who identified themselves as Pacific people (Statistics New Zealand, 2006). There are more than 22 different Pacific communities - each with its own distinctive history, culture, language, and health status (Ministry of Health, 2010).

Just as Maori, the Pacific people face difficulties in accessing health facilities in New Zealand and the most identified diseases are:

- Cardiovascular which is the principal cause of death for Pacific peoples
- Stroke is major killer amongst Pacific people.
- Ethnic disparities in cancer survival have increased in the past 25 years and are a major cause of premature mortality and disability
- Diabetes in Pacific populations is approximately three times higher than among other New Zealanders (Ministry of Health, 2010).

The major social and economic factors that have been identified as having the greatest influence on Pacific people's health are: poor and low income, poverty, unemployment and occupation, education, housing, and ethnicity (Ministry of Health, 2010). About 27% of Pacific peoples meet the criteria for living in severe hardship compared to 8% of the total population. In addition, 15% of Pacific peoples live in significant hardship and poverty, with only 1% enjoying 'very good living standards' (Ministry of Health, 2010).

Pacific people in New Zealand also face discrimination and racism (Human Rights Commission, 2010).

The Asians

The Asian community in New Zealand continues to emerge as an important demographic group. The New Zealand 2006 Census showed that there were 355 000 Asians which accounted for 8.8% of the entire New Zealand population. As a result, some New Zealanders have a negative attitude about Asians and think that the greater influx of Asian migration, has perhaps led to an increase in prejudice, racism and discrimination being exhibited towards Asian inhabitants in recent years (UMR Research, 2009).

Some Asians experience long waiting periods before they obtain their Permanent Residency and Visas and this results in significant stress to their daily lives (Immigration New Zealand, 2006). As a result, they resort to abusing alcohol and drugs as a way of coping with such difficult situations (Community Alcohol and Drug Services (CADS), 2008).

About 23.2% of Asians experienced discrimination and racism in a period of 12 months, more than all other ethnic groups, in New Zealand (Statistics New Zealand, 2006).

In addition to the language barrier, Asian culture is hugely different from the Kiwi culture. They also suffer from mental health-related problems. All these factors make it harder for Asians to easily get integrated into the New Zealand mainstream society (Jackson, 2006).

Gay, Lesbians, Bisexual and Transgender (GLBT)

Homosexuality itself was perceived and regarded as a mental illness by the American Psychiatric Association until around about 1973 (American Psychological Association, 2009). Homosexuality was heavily associated with mental illness, such that an open disclosure attracts rejection at best and violence at worst (Banks, 2009). The experience of living in a society where gay men were stigmatized and discriminated led to their mental illness and other associated psychological problems (Banks, 2009).

Banks (2009) indicated that legislative changes in New Zealand throughout the 1980s, 1990s and 2000s worked to alleviate the effects of societal prejudice at an institutional level but, like racism, homophobia has yet to be fully addressed.

GLBT's anticipation and experience of negative experiences have contributed to the avoidance or delaying of medical visits resulting in the detrimental of their health and well-being (Human Rights Campaign Foundation, 2008).

Young gay men experienced mental health problems five times more often than young "straight" men. Being gay was associated with increasing rates of depression, anxiety, illicit drug dependence and suicidal thoughts (Fergusson, Horwood, Ridder, & Beautrais, 2005).

In the UK, gay and bisexual men are over four times more likely to attempt suicide than "straight" men - an astonishing statistic when one takes into account that men in general are already at heightened risk of suicide (Bailey, 1999).

In New Zealand there have been many incidents where anti-gay statements have been made, for an example, in 2008 an Irish pop star, Brian McFadden caused an outcry when he made some anti-gay utterances on Auckland radio station, More FM (Banks, 2009). Coping with racism and homophobia from

society at large puts immense strain on gay men from ethnic minorities (New Zealand AIDS Foundation, 2009).

The 2008 Human Rights Commission inquiry findings indicated that transgender people are discriminated in New Zealand, especially when it comes to employment (Human Rights Commission, 2008).

Some gay men do not disclose their sexuality and sexual behaviors because of the negative attitude of their GPs (Adams, McCreanor, & Braun, 2008). This may result in failing to provide proper health to the patient concerned.

Health Challenges for New Zealand-based African Communities in the Auckland Region

Access to proper health care was poor for most people coming from countries within the Horn of Africa (Ministry of Health, 2001). The health care coverage is poor, with significant disparity between urban and rural health care services. In these countries, most health care is provided by community-based clinics and delivered by health workers (for example, nurses or birthing attendants). Some of these workers are not properly trained. Traditional healers are also used extensively. People from these countries would be unfamiliar with the New Zealand health care system especially relating to general practice services and formalized appointment systems (Ministry of Health, 2001).

The Auckland District Board (ADHB, 2010) reported that, African people who are residents within the Auckland region face the following health-related challenges:

- the second highest group of people diagnosed with HIV and AIDS , after the Gay community, in comparison with all other ethnicities,
- the highest hospitalisation rate for tuberculosis
- have a much higher rate of hospitalisations from respiratory diseases (like asthma, pneumonia and bronchitis) than others ethnicities

- have higher rates of Primary Health Organisation (PHO) enrolment and lower rates of Ambulatory Sensitive Hospitalisations (ASH) and Emergency Department (ED) utilisation than others
- have a higher rate of termination of pregnancies
- higher hospitalisation rate from sexually transmitted infections than others (in women)
- have a lower than expected proportion of people with a community services card (CSC)
- have the lowest breast cancer screening coverage of all compared with other ethnicities and a much lower unadjusted cervical screening coverage than Europeans (in women)
- have a lower prevalence of Cardiovascular Disease (CVD) but a higher prevalence of diabetes compared with Europeans (Auckland District Health Board (ADHB), 2011).

Some of the Unmet needs for the African Communities

The Auckland District Health Board (2011) identified some of the unmet needs for the African population in Auckland, among other, as follows:

- better education and health promotion on sexual health, family planning and antenatal care
- improved access and earlier engagement with secondary mental health services
- better access to oral health services, especially for children
- improved access to breast cancer and cervical cancer screening (for women)
- targeted diabetes education and prevention strategies (Auckland District Health Board (ADHB), 2011) .

Socioeconomic Challenges for the New Zealand-based African Communities

The ADHB (2010) identified some of the following issues as key socioeconomic challenges facing the African communities in Auckland:

- Overall level of socioeconomic status: Deprivation measure
- Shelter: Home ownership, and household crowding
- Employment
- Income: Personal income and employment
- Education: Level of qualifications
- Discrimination
- Social justice and equity
- Access to services
- Racism
- English Language difficulties
- Transport problems
- Telephone facilities (lack of it) and
- Religion, (Auckland District Health Board (ADHB), 2011) .

These socioeconomic challenges are briefly explained below:

Deprivation measures – Africans in New Zealand (NZ)

In the Auckland region, African people were the most deprived community compared to all other groups such as Middle Eastern and Latin Americans. African people have the highest percentage of people living in areas of high deprivation. More than 50% live in high deprivation areas compared with all other ethnicities (ADHB, 2011 p.28). The Ministry of Health reported that communities living in areas of higher deprivation are associated with higher use of general practitioner services (Ministry of Health, 1999) and increased total hospitalizations (Salmond & Crampton, 2000). Communities with higher deprivation have also been associated with higher cardiovascular disease risk factors, diabetes (Ministry of Health, 1999) and nutritionally inadequate and unsafe foods (Parnell W, 2001) .

Personal income- Africans in New Zealand (NZ)

ChangeMakers (2011) reported that refugee participants identified connections between income, employment and health. Unemployed and limited income was a major barrier to attaining good health. Participants reported that the high cost of living in New Zealand made it extremely difficult to live well and be healthy because healthy food was expensive for many families, especially those from refugee-background. Most refugee families live on limited budgets. One refugee participant said *'All these good things are out of our reach, even though you know they are important. The cheapest things are those that can cause health problems. Because the refugees are not earning much, they have to go for the cheaper things.'* (ChangeMakers Refugee Forum, 2011.p. 4).

Thirty five per cent of New Zealand-based Africans had an annual personal income of less than \$20,000 compared to Latin Americans (30%), Europeans (29%) and Middle Eastern (44%) in the same bracket (Auckland District Health Board (ADHB), 2011).

In Auckland, African people accounted for 21% of welfare benefit recipients. Almost sixty per cent of Africans were on an unemployment benefit scheme compared to Middle Eastern (40%) (Auckland District Health Board (ADHB), 2011).

Shelter/ Housing conditions - Africans in New Zealand (NZ)

In terms of home ownership in the Auckland region, African, Latin American and Middle Eastern people had a lower percentage of Home ownership than Europeans (Gushulak, 2007) . The greatest difference in home ownership was identified to be between Africans and Europeans. Housing space influences a family's health and quality of life as there is an association between household crowding and meningococcal disease (Baker, et al., 2000), poor educational attainment and psychological distress (Evans, 2003).

About 23% of African households consist of more than six people. The ADHB report (2011.p.35) went on to mention that all MELAA ethnicities may live in more crowded circumstances than Europeans within the Auckland region.

Participants in a study by ChangeMakers identified that many of their houses were damp and mouldy, lacked proper ventilation conditions which they associated with their poor health (ChangeMakers Refugee Forum, 2011). One refugee participant said *“Refugees get house in very bad places that causes most of the sickness. The house is most important. Housing [New Zealand] never change anything. They just came a few months ago, they paint the whole wall but the mould is still coming... whenever we wake up in the morning we just cough, cough really hard”* (ChangeMakers Refugee Forum, 2011.p 4).

The issue of overcrowding was a problem among refugee-background families because large families were allocated small houses (ChangeMakers Refugee Forum, 2011).

Education - Africans in New Zealand (NZ)

Cutler and Lleras-Muney (2007) reported that good quality of education and literacy are associated positively with improved health outcomes. Despite having similar levels of secondary school qualifications to Europeans, Middle Eastern and African people had a higher rate of unemployment. European people (in Auckland) had the highest proportion of people with no qualifications (18%) yet their rate of unemployment is lower than African people who have better education qualifications (Auckland District Health Board (ADHB), 2011). Refugees and migrants have often voiced difficulties in finding employment in New Zealand, especially as their prior overseas work experiences and qualifications are not usually recognized (Pio, 2010).

This indicates some inequalities and unfairness. Although this is more of a health outcome as opposed to a health promotion challenge, it has some negative effects on the health and well-being of the affected people (Cutler & Lleras-Muney, 2007).

English language- Africans in New Zealand (NZ)

English language competency is an important factor for integration into mainstream society. Poor English language skills limit access and effective engagement with health and social service providers (Auckland District Health

Board (ADHB), 2011), and thus a major barrier to achieving good health. It limits access to service and important information and participation in society (ChangeMakers Refugee Forum, 2011).

The use of trained interpreters who are trusted and culturally appropriate, of the same gender and the use of patient's young children as interpreters were some of the challenges faced especially by refugees (ChangeMakers Refugee Forum, 2011).

Racism and Discrimination- Africans in New Zealand (NZ)

Pio (2010) mentioned that migrants and refugees normally experience negative attitudes and discrimination, particularly if they are visibly different, for example, non-white. Skilled female migrants have been reported to be subjected to ethnic/racial discrimination when seeking for employment and in their career progression.

Pio (2010) stated that racial stereotyping and consequent discrimination has also been noted on personal accounts of refugee and migrant experiences in New Zealand.

ChangeMakers (2011) indicated that participants, especially refugee women felt alienated and discriminated against by doctors and other service providers in New Zealand hospitals (ChangeMakers Refugee Forum, 2011).

Africans in New Zealand have faced racism and discrimination (Pio, 2010) and (Auckland District Health Board (ADHB), 2011).

Mental Health- Africans in New Zealand (NZ)

Health issues such as headaches, sleeping-problems, arthritis, diabetes, and blood pressure problems, were associated with stress (ChangeMakers Refugee Forum, 2011) .

One of the refugee participants had this to say *'The main problem that refugees face is related to trauma and stress. When a person is not in a good condition mentally, he cannot do anything. Stress is most important because if you are stressed you don't eat food and if you don't eat food your body is getting weaker and weaker, you don't sleep properly... ChangeMakers Refugee Forum, 2011, .p. 7.)*

Findings from NZ health service provider (HSP) interviews

The Auckland District Health Board report (2011) identified a number of issues impacting on the health of African communities in Auckland including:

- The main barriers to health care provision were: language and communication difficulties, health illiteracy, high cost of health care, the lack of cultural understanding by Health Service Providers (HSPs), the lack of trust and fear of Western health care models
- The rising prevalence of diabetes and heart disease,
- The changes in diet and nutrition
- Lack of physical activity
- Social issues such as isolation and poverty, that normally leads to depression, stress and loneliness.
- Key cultural differences noted in the African communities in Auckland included:
 - the importance of faith and family engagement in health issues,
 - the differences in gender roles and responsibilities
 - the varying perceptions of illness and disability (Auckland District Health Board,2011, p.98-99)

The Auckland District Health Board health service providers (HSPs) identified in their interviews, the following as the unmet needs of the African communities in Auckland:

- Cultural competency training for HSPs
- Employing HSPs that understand the African culture, beliefs and background
- Availability of face-to-face interpreter services. Health information in a variety of languages

- The appropriate use of interpreters- not having their children interpreting for them. They consider it a taboo as the children will end up knowing their parents' secrets. This may lead children not to respect their parents
- Engaging with religious leaders and community leaders when it comes to issues of their health, especially on matters of culture and death
- A list of relevant services that support members of the African communities
- Greater coordination between services. If possible having most of the HSPs housed under one roof as this results in savings in terms of transport and time, for patients disability (Auckland District Health Board,2011, p.100-101).

New Zealand AIDS Foundation (NZAF)'s African Health Promotion Programme (AHPP)

The New Zealand AIDS Foundation's African Communities Programme is the only programme in New Zealand that deals with health promotion for the New Zealand-based African communities. While the main focus of this programme is on HIV/AIDS health promotion, it also includes in its delivery some other issues like human rights, social justice, advocacy and community development. The programme uses the Ottawa Charter (1986) as its basis in the delivery and implementation of community initiatives. I work for the New Zealand AIDS Foundation (NZAF) as the Programme Manager for the African Communities.

As at the end of 2010 there were about 1800 New Zealanders living with the HIV virus and of this number around 484 are from the African communities. This accounts for about 27% (Otago University Epidemiology, 2011).The African community is the second highest group affected by HIV in New Zealand, after the gay community. Table 3.1 shows the diagnosed figures from

all ethnic communities (1996 to 2010) while Table 3.2 gives a comprehensive summary from the African communities only (1996-2010).

Table 3.1: HIV Diagnosis Statistics in New Zealand (1996-2010)

HIV Diagnoses Statistics in NZ (1996-2010)

Table 22 Ethnicity by time of diagnosis in New Zealand for those found to be infected with HIV (by antibody test and viral load).

		HIV Infection*							
		1996-2003		2004-2009		2010		Total	
Sex	Ethnicity	No	%	No	%	No	%	No	%
Male	European/Pakeha	513	50.0	503	41.4	90	48.6	1106	45.6
	Maorit	60	5.8	84	6.9	15	8.1	159	6.5
	Pacific Island	18	1.8	31	2.5	1	0.5	51	2.1
	African	96	9.3	138	11.3	7	3.8	241	9.9
	Asian	91	8.9	99	8.1	13	7.0	203	8.4
	Other	19	1.9	54	4.4	9	4.9	82	3.4
	Unknown	22	2.1	40	3.3	24	13.0	85	3.5
Female	European/Pakeha	53	5.2	35	2.9	6	3.2	94	3.9
	Maorit	7	0.7	12	1.0	0	0.0	19	0.8
	Pacific Island	13	1.3	12	1.0	1	0.5	26	1.1
	African	88	8.6	148	12.2	7	3.8	243	10.0
	Asian	44	4.3	34	2.8	6	3.2	84	3.5
	Other	1	0.1	13	1.1	2	1.1	16	0.7
	Unknown	1	0.1	11	0.9	3	1.6	15	0.6
Transgender	Total	1	0.1	2	0.2	1	0.5	4	0.2
TOTAL		1027	100.0	1216	100.0	185	100.0	2428	100.0

† Includes people who belong to Maori and another ethnic group

* Includes people who have developed AIDS. HIV numbers are recorded by time of diagnosis for those reported through antibody testing and by time of first viral load for those reported through viral load testing. The latter include many who have initially been diagnosed overseas and not had an antibody test here. Also, the date of initial diagnosis may have preceded the viral load date by months or years.

Source of Data: Otago University Epidemiology Department-2011

Table 3.2: Summary of HIV cases (1996-2010) in New Zealand-based African Communities

HIV Epidemiology Summary in NZ (2006-2010)

Year	2006	2007	2008	2009	2010	2006-2010
Totals of HIV Cases	204	195	227	199	185	1010
African Comm (AC)	61	42	39	27	14	183
Others Ethnic Groups	143	153	188	172	171	827
% AC	29%	21%	17%	14%	7%	18%

Source of Data: *New Zealand AIDS Foundation (NZAF) (2010c). New Zealand AIDS Foundation- African Communities: Get It On ! Retrieved 31st May 2011,*

CHAPTER FOUR

METHODOLOGY

Methodological Approach

A single methodological framework was found not suitable for the purpose of this study because of the complexity of the issues to be addressed in the study. I therefore decided to use a mix of approaches consisting of elements of phenomenology, and ethno-methodology, and qualitative research.

This thesis is a qualitative study which aims to investigate the health promotion challenges faced by the African communities living in New Zealand.

Qualitative study has been chosen over quantitative study as it is interpretive, pragmatic, and grounded in the lived experiences of people (Marshall & Rossman, 1999). Qualitative research has been defined as “modes of systematic inquiry concerned with understanding human beings and the nature of their transactions with themselves and with their surroundings” (Benoliel, 1984) in Polit and Hungler (1995.p.517). Qualitative research therefore raises questions about the nature of humans and questions social policies that enhance the well-being of humans (Higgs, 1999). This means it deals with issues of feelings and emotions of people as opposed to quantitative approach which is mainly about figures and quantities (Polit & Beck, 2004).

On the other hand, quantitative research involves systematic collection of numerical information, often under conditions of considerable control and the analysis of that information using statistical procedures (Polit & Hungler, 1995).In this study, no numerical data was collected hence there was no need to use quantitative research.

Phenomenology focuses on the lived experience of humans and asks the question: what is the structure and essence of the phenomenon (facts) for the

individual or researched community? (Polit & Beck, 2004). Polit and Hungler (1995) stated that phenomenology is “an approach to human inquiry that emphasizes the complexity of human experience and the need to study that experience holistically as it is actually lived” (Polit and Hungler (1995.p 649). Phenomenology has its roots in philosophy, thus philosophical tradition developed by Husserl (1931) which is an approach that focuses on thinking about what the life experiences of people are. Phenomenological studies inquire about the essence of phenomena as experienced by people (Hungler, 1993; Polit & Hungler, 1995). The phenomenological approach will ask the question: what is the essence of this phenomenon as experienced by these people (Polit & Hungler, 1995.p.197). The emphasis here is on the lived experience (Husserl, 1931). In this study, the phenomenological methodology will allow and present an opportunity for participants to share their lived experiences regarding the health promotion challenges faced by the African communities in New Zealand.

It therefore means employing elements of this methodological approach will help provide understanding of the lived experiences of the African communities in New Zealand. This approach helps to uncover the lived experiences of the members of the African community through telling their own stories and experiences regarding health promotion challenges in New Zealand.

In addition, it will also help inform New Zealand health practitioners on how their health promotion practices and attitudes impact on the African communities in New Zealand.

Ethno-methodology enquires about how people make sense of their everyday activities so as to behave in socially acceptable ways. Ethno-methodology shows how behaviour and tradition of a particular group of people share and influence their culture (Polit & Beck, 2004). Ethno-methodology is a branch of human inquiry associated with sociology that focuses on the way in which people make sense of their everyday activities and come to behave in socially acceptable ways (Polit & Hungler, 1995.p.641).Thus; ethno-methodology

draws heavily from the discipline of sociology. Ethno-methodology studies focus on specific cultures and their world views (Polit & Hungler, 1995).

The application of ethno-methodology, in this study, will be important for considering how the traditional and cultural practices of Africans impact on their acceptance and awareness of health promotion practice, in New Zealand. This methodology will investigate the cultural values, norms and beliefs of the Africans in New Zealand that impact on health promotion.

My own personal experience also formed part of this research as I am actively involved in key initiatives in health promotion with African communities in New Zealand. Every effort was made to retain objectivity through regular consultations with my supervisor, advisory groups and colleagues. This means my personal views or bias will not unduly influence the outcome of this study. I have to remain professionally neutral and not detect how the outcome of the findings will be.

Data was collected through an examination of available literature, focus group workshop and oral interviews with key informants (see appendix D and E). Care was taken to ensure that participants were drawn from a diversity of backgrounds such as countries of origin, gender, level of education, professional qualifications and socio economic backgrounds.

Research Procedures or Methods

Data was collected using two main methods, namely: focus group discussions, and oral interviews with key informants.

The total number of participants who took part in individual interviews was 30, thus twenty (20) key community leaders and ten (10) service providers. In addition to the said 30 individual interviews there was one focus group held in Auckland. The size of the African population in Auckland meant that there were twice as many participants in Auckland as the other two centres combined. Composition of the twenty participants (community leaders) was drawn from the following three main centres/ cities as follows:

- Auckland 10 participants
- Hamilton 4 participants
- Wellington 6 participants

The service providers were ten in total, thus, five from Auckland, two from Wellington and three from Hamilton. The reason for having 50% of the service providers from Auckland is that the majority of them are based in Auckland.

These numbers of participants provided a fair representation of the range of participants, consisting of community leaders, and service provider organisations in the three main centres and a focus group in Auckland. It was also manageable for one-on-one interviews that would produce significant findings that help our understanding of the subject under consideration for a Masters in Philosophy (MPhil) study.

Key informant interviews consisted of community leaders within African communities, service provider organisations, service provider organisations that deal with African community members. In New Zealand we currently do not have many organisations that are run by African practitioners targeting the African communities, save for New Zealand African Welfare Service Trust (NZAWST).

In order to have in-depth interviews relating to the health promotion challenges within New Zealand-based African communities, it was imperative to employ the use of semi-structured interviews. Marshall and Rossman (1999) suggest that interviews must acknowledge value and respect the views and feelings of the participants, and allow the perspective of participants to unfold as the interview progresses thereby providing opportunity for participants to further understand the purpose of the study.

Focus group discussions allowed participants to informally and freely share their views and feelings on the topic regarding health promotion challenges within African communities in New Zealand. The use of a focus group had the benefit of enabling participants to shape their views and thoughts as a group and work together in highlighting issues and matters that are pivotal

and important to health promotion for the New Zealand-based African communities. The other added advantage of using focus group was to allow the generation of more information in a short space of time (Neuman, 2000).

Community leaders were consulted in the development of this project design to get their input and support regarding the relevance of the study. The support of community leaders was crucial for identifying prospective participants to the research. The research considered only participants who had a refugee or migrant background and originally from the continent of Africa, who had lived in New Zealand for at least two years. One of the criteria considered during the recruitment process was an ability to speak and understand English. This was meant to avoid the use of interpreters. In addition engaging professionally trained interpreters was going to be expensive and too difficult, in terms of logistics. This was not meant to marginalize or discriminate these people who do not speak English. The age of the participants was 20 years and above.

The participants were identified by random sampling. The help and support of community leaders was used to provide initial contacts and an invitation to participate was sent out to all those who met the criteria. Out of the identified population, random sampling was done to select the 20 participants, bearing in mind important factors such as, balance of gender, country of origin, age, a balance between refugee and migrant background, level of education and professional qualifications. Stratified purposeful sampling was done to achieve this balance (Marshall and Rossman, 1999.)

Information Gathering and Process

Individual interviews and focus groups were audio recorded and transcribed. Data analysis and data collection were done concurrently in order to allow the researcher some flexibility to address more pertinent questions that were generated as the research project began to take shape. This was done and

achieved by talking to different groups of people within African communities and other relevant service providers.

I worked closely with my supervisor for guidance and support on matters of facilitation, maintaining neutrality during interviews and respect for the participants' views and values. During the discussions, all relevant major points were noted and the researcher compiled preliminary summaries after each interview.

Data Analysis

Data analysis and data collection were done concurrently to enable the researcher to have a deeper understanding of the issues raised in the research and an opportunity to further develop issues in interviews and focus groups as the data collection progressed. Key themes arising from the data were identified to help understand their patterns, classes and characteristics as the research unfolded (Schatzman & Strauss, 1973). The emergent themes from the analysis, notes and summaries became the foundation for clustering the data.

As regards the process of organising data, I chose to follow the six stages demonstrated by Marshall and Rossman (1999). These six stages are as follows:

1. The first stage was to organise the data. This was done at the end of data collection. This was achieved by reading through the transcripts several times in order to comprehend it and to begin to reduce it into readable formats. According to Miles and Huberman (1994), this process of organising the data in a compact form allows the researcher to capture all important and relevant information without only highlighting the interesting and vivid events (Miles & Huberman, 1994).
2. The second stage was to generate categories, themes and patterns which came out as a result of continued immersion in the data. The identification of these categories, themes and patterns

became 'baskets' into which information was placed (Marshall and Rossman, 1999, p. 154).

3. The third stage was coding the data. This has been described by Marshall and Rossman (1999) as "formal representation of analytical thinking" (p. 155). At this stage these different themes, patterns and categories were allocated colour-codes that identified them for further analysis. As the process of coding continued, more relevant data was generated, as further comprehension of data was achieved. Different colour codes were used to identify similar patterns within the text.
4. The fourth stage of data analysis was testing emergent understandings, in relation to the research questions which were being explored. These were both positive and negative. The researcher looked out for any similar and contrasting patterns and fitted them into the general discussion as was deemed necessary.
5. The fifth stage was searching for alternative explanations for patterns that were apparent in the research study and then presented an argument that linked the patterns to previous research. According to Marshall and Rossman, (1999) (in doing this) the researcher presented the most conceivable explanation of the findings and offered assertions about the data, provided substantial evidence for those assertions, and built a logical interrelationship among them and related assertions to future research.
6. The final and sixth stage was report writing where the researcher interpreted the information and gave meaning and shape to the whole load of information.

Justification of the Qualitative Methodology

The chosen method of qualitative data analysis does not require sophisticated statistical data analysis. The use of phenomenology focuses on extracting

meaning from participants based on their lived experiences. This is achieved by talking to a number of people and identifying patterns and themes that help understand the phenomenon from those people in their circumstances (Higgs, 1999), in this case the health promotion challenges faced by the African communities in New Zealand.

Statistical analysis is not appropriate for the following reasons:

- It is complicated for most people who are not mathematically minded, thus the moment they see figures, they think it is hard to understand
- Some people have developed an attitude of not liking anything that is statistically interpreted
- It is simple to understand people's stories or experience as opposed to statistical data.

Participants and the Recruitment Method

The participants for this study who took part as community leaders and members of the focus group were all Africans. The services providers were mixed, thus, local kiwis (Maoris and Europeans) and Africans. The term African means anyone originally from the continent of Africa. It is not determined by race, skin colour or religion. However, it is important to note that some parts of the literature review, UK in particular, used the term "Black Africans" in order to differentiate races of people.

In recruiting participants, factors such as gender balance, a fair representation between refugee and migrant background, country of origin, age, and socio-economic status were taken into consideration.

Service provider organizations working with African refugees and migrants, as well as service provider organisations managed by Africans for African were also selected.

In addition, the following factors were considered so as to get perspectives from men and women as well as minimising the effects of bias: education level, work experience and professional qualifications.

Prospective participants who were identified as having mental health issues or conditions were not included in this research project for safety reasons. For some participants, it could have caused some difficulty in getting informed consent. However this does not mean that all forms of mental illness make people unable to express their opinions.

Justification for Selecting Sample participants

These numbers of individual participants (20), service providers (10) and a focus group provided a fair representation of the range of participants in the three aforesaid main centres. As stated earlier, it is also manageable for one-on-one interviews that would produce significant findings that help our understanding of the subject under consideration.

There is sophisticated statistical justification apart from the fact that as a phenomenological study, 20 key informants provide a reasonable number for in-depth interviews with participants to provide sufficiently good range of opinions to give insights into the health promotion challenges of African communities (Polit & Beck, 2004).

The Recruitment Procedure Used

Initial contacts with prospective participants who were strategic people in their respective community associations in the three main centres were made by telephone and/or emails. These are people well known in the community and who have also been part of the consultation in the development of this project design. These leaders included, among others, the following: elected community leaders, elders of the community (not elected but leaders by virtue of age, wisdom and influence in their respective communities), political leaders, religious leaders and others including leading professionals of African heritage working in senior positions in NGOs and government departments.

The communities that participated in this study were:

- Zimbabwe Association of New Zealand (ZANZ)- Auckland
- Zimbabwe Association (ZimDare)- Wellington
- Ethiopian Community

- Sudan Community
- Somalia Community
- Ghanaian Community
- Nigerian Community
- Hamilton African communities
- Other smaller African communities

In addition to respective community leaders, further contacts were made with leaders of established African organisations or associations, such as:

- African Community Incorporated (Auckland),
- Refugee Coalition Network (Auckland and National),
- ChangeMakers Forum (Wellington),
- Waikato Refugee Association (Hamilton),

From the above it is clear that three of the four organisations are refugee associations and one generic (African Community Incorporated (Auckland)). The reason is that in New Zealand, there are more organisations that serve refugees as opposed to migrants. Refugees have more settlement challenges compared to migrants.

Some preliminary meetings were held with respective community leaders with the intention of officially informing them of the research as well as soliciting for their support in the recruitment process. I attended key and strategic community meetings and gatherings and presented the research proposal to these communities. I also asked for permission to distribute information sheets and consent forms to all members present at the meetings and gatherings and invited people to participate on voluntary basis. This was done by filling in relevant forms and these were returned to me in pre-paid self-addressed envelope. Providing pre-paid and self-addressed envelopes minimised losing potential participants due to postal costs that may be incurred. It also ensured that those who chose to

participate had time to consider the invitation, and also to respond in private to maintain their confidentiality.

I also left copies of the information sheet and consent forms with respective community leaders for distribution to their members who did not attend the meetings/ gatherings but may be interested in participating. In order to have a wider pool for prospective respondents, information sheets and consent forms were also left with different service provider organisations, who work directly with African communities in their respective regions, to hand them over to people who may not be members or affiliated to any of African community /associations.

The recruitment process was aimed at attracting a broad and diversified number of community members. Those who responded and met the stipulated requirements were then invited to participate in the study.

A number of service provider organisations were contacted directly. Some of these, among others were:

- District Health Boards (DHBs) in Auckland, Hamilton and Wellington
- Refugee Services- Hamilton Office
- Auckland Regional Migrant Services (ARMS)- Three Kings Office in Auckland,
- Refugees as Survivors (RAS) in Auckland
- Refugee Coalition Network, National Office in Auckland and
- Waikato Refugee Forum in Hamilton and
- ChangeMakers Forum in Wellington.

CHAPTER FIVE

DATA ANALYSIS AND FINDINGS

Analysis of Data

The analysis of the data in this research followed two important principles. The first principle is about allowing the voices, views and concerns of the participants in this research to be heard (Ellis & Berger, 2002). Secondly, the analysis will make an attempt to go beyond the voices of the participants in such a manner that the participants' views in this research are understood from both their immediate and wider contexts (Strauss & Corbin, 1998). In this particular study, the immediate context refers to the twenty community leaders and focus group members who are all members of the African communities in New Zealand. The wider context on the other hand is referring to a part of the ten service providers who are not members of the African communities, but play a key role in the delivery system of health promotion in the New Zealand-based African communities. It is therefore important to note that the members of the service providers are mixed, thus, some are Africans and some are not. While the data analysis will totally respect the individual perspective(s) of each participant, it will make an attempt to view such perspectives in relationship to the collective comprehension and understanding of the rest of the other participants. This therefore means that the researcher will endeavour to reflect, in all honesty, the voices and views of all participants, within the context of the health promotion challenges that are been faced by the African communities in New Zealand (Ellis & Berger, 2002). This is the main reason why I have decided to use both the phenomenology (lived experiences) and ethno-methodology methodologies. The phenomenological methodology deals with "lived" experience of the participants whereas the ethno-methodology methodology looks at how people make sense of their everyday activities so as to behave in socially acceptable ways (Polit & Beck, 2004).

However, as a researcher, I believe that it is also fair that the experience of each individual participant should be comprehended within the context of the group's understanding regarding the health promotion challenges being faced

by the New Zealand-based African communities. This is therefore the reason why I have chosen to make use of a focus group in this study (Krueger & Casey, 2000).

Focus group discussions will also allow participants to informally and freely share their views and feelings on the topic regarding health promotion challenges faced by the African communities in New Zealand. The use of focus groups has the benefit of enabling participants to shape their views and thoughts as a group and work together in highlighting issues and matters that are pivotal and important to health promotion for the African communities. The other added advantage of using focus groups is to allow the generation of more information in a short space of time (Neuman, 2000).

I also believe that the views of the interviewed 20 individual African community leaders from the stated three main cities in New Zealand and members of the focus group, regarding the health promotion challenges faced by the African in New Zealand, is representative of all members of the New Zealand-based African communities. The main reason is that the selection and recruitment of all participants took into account both refugee and migrant backgrounds, diversified country of origin, level of education, fields of professions and the length of stay in New Zealand.

The Eight Themes Identified as Key Health Promotion Challenges

The three groups of respondents identified several health promotion challenges faced by the New Zealand-based African communities. These have been grouped into the following eight key themes:

1. African communities' understanding of the concept of public health
2. African communities' access to health services
3. Language barrier as a main challenge to accessing health promotion
4. Spirituality and traditional beliefs of African health consumers
5. Lack of understanding of the cultural context of African communities by health practitioners

6. Racism and discrimination within the health sector
7. Housing issues as a challenge to the promotion of health within African communities
8. HIV and AIDS related-Stigma as a challenge to the promotion of health within the African communities

Some quotations/excerpts may be cited in full in more than one place discussing different points. There are two main reasons for that. Firstly, one quotation may be mentioned more than once under different headings and places in order to make plain the points that I may need to discuss. Secondly, it is important to cite as many of the quotations and narratives in order to unearth and unpack contextual meaning(s). For this reason, I have decided not to cite short phrases only unless the entire meaning and sense is contained. Such a practice may appear and sound repetitive but I think it is a good method to make sure that the voices of participants are not lost in the process.

The aforementioned themes will be discussed (below) covering the views of all the three respondent groups.

African Communities' Understanding of the Concept of Public Health

Lack of Understanding the Concept of New Zealand Public Health System

All the 20 community leaders, all focus group members and 50% of the service providers indicated that understanding of the concept of New Zealand's public health was a challenge to the majority of the African community members in New Zealand. The theme on the African communities' understanding of the concept of public health was the most cited health promotion challenge by all participating groups (community leaders, service providers and focus group), hence ranked as number one challenge.

Fifteen community leaders (75%), all focus group members and 5 service providers (50%) specifically mentioned that a lot of the African community members in New Zealand lack an understanding of how the New Zealand public health system works. If people do not understand how the health system

operates, it will be impossible to utilise the facilities for their benefit and wellbeing. This becomes a serious health promotion challenge for the New Zealand-based African communities. From the interviews, it was evident that many members of the African communities in New Zealand do not understand how the public health system operates. One community leader said:

- *“.....I think it’s very hard to just find a doctor because first of all you have to understand the system and how it works.” WCLI 5 p. 222.*

One of the service providers was quoted as saying:

- *“..I can think of..... lack of understanding about the health system; how the NZ health system works. Yeah, how it operates. And I think that’s very crucial to understand...” SPI 1 p. 137.*

Appointment System

More than 50% of the community leaders and all focus group members mentioned that they had an “appointment” system in their country of origin. If they visited their family doctor without an appointment, they still got an opportunity to be attended to. They find it both strange and difficult in New Zealand, as one cannot see his/her family doctor without making an appointment-even if one is seriously ill. In Africa, even without an appointment, you simply join a queue and you get attended to. Some of the community leaders said:

- *“...there were difficulties in terms of not understanding, especially the appointments system because in Zimbabwe, if you are really sick you can just phone – you have your own private doctor....and they’ll say ‘you come–you know? Here, it’s like, when you fall sick on a Monday, you’ve got to wait until maybe Wednesday to get an appointment with your doctor. It’s different from where I come from. What if I’ve got something that is really serious? Why wait instead of going to a doctor? WCLI 1 p.168.*
- *“...In Somalia or Pakistan the doctors are there, without an appointment, you go there and see the doctor immediately. And in some instances also you might not need to go to the doctor.....you get medicine over the counter (without a prescription).You know that sort of informal... in NZ everything is quite formalised....” WCLI 6 p. 233 & 234.*

- *“..Yeah, in Cameroon.....I never had to make an appointment before I see the doctor or I never had to answer lots of questions before I do an HIV test....”* ACLI 4 p.53.

On the issue of making appointments, all service providers (100%) mentioned that some of the members of the African communities are finding it difficult to accommodate and understand the system of making appointments with health professionals since they are not used to do it in their country of origin. As stated earlier, most health professional (doctors, in particular) in Africa will accept and attend to their patients even if there is no prior appointment made. However, this is not to say that there is completely no appointment system in Africa. In countries like Zimbabwe, the appointment system is widely used. The appointment system is there but if a patient turns up without an appointment, especially to his/her family doctor, they will join the queue and finally get attended to. They are never turned away, as is the practice in New Zealand.

One service provider said:

- *“...health promotion in the community, health...for example, when people just arrive in NZ, they have different experience with the health system back home. For example... refugees ... didn't need to make an appointment with GPs or with the specialists or...you just go. Or in the hospital; we just go there and assume that you could see GPs or you could see specialists the same day. And also, in some other countries where refugees come from, you can go to the pharmacy and buy whatever medication you want without prescription you can go and buy it, yes. Very easy. But here, when they come, we educate them that that's not going to happen here. You cannot buy prescription medication from a pharmacy without a prescription and you have to make an appointment.....”* SPI 5 p. 164.

Waiting List and Time Delays at Emergency Hospitals

All the 20 community leaders (100%) indicated that the hospital “waiting list” in New Zealand is too long and it takes a lot of time before one is seen by a specialist. They also mentioned and strongly complained about the prolonged delays at “emergency” hospitals, when people go “after hours”. People wait for more than four to five hours before they see a doctor. At times there are no explanations given for these prolonged delays. Some of the community leaders said:

- *“...I waited at Wellington Hospital for more than five hours with my son...”* WCLI 1 p 167.

- *“.....my first experience....I went to the doctor ...The time it takes for a doctor to see you–you just wait and wait and wait and wait and you wonder if the doctor will ever see you but it finally happens. So it takes time getting used to it...” WCLI 6 .p. 234.*

The same challenges of prolonged delays especially at “emergency” hospitals and “waiting lists” for specialists were also cited by both service providers and focus group members.

Lack of Employer-assisted Medical Aid Schemes

Lack of medical Aid schemes that are co-funded by employers and employees was cited as one of the challenges of health promotion in New Zealand for the African communities. Most of the employers in Africa (Zimbabwe in particular) provide Medical Aid schemes to their employees as part of benefits- such that employees can visit a private doctor or get treated without paying cash up front. This works like a medical insurance scheme. The majority of the participants for this study indicated that most of their employers in New Zealand do not offer Medical Aid or health insurance. As stated by one of the community leaders, this results in a negative impact in the health delivery system, especially if a patient gets sick and does not have cash .One community leader said:

- *“....the health services that we experienced in Zimbabwe, is quite different from here. We had our health Medical Aid Schemes/health insurance. It was more like– everyone; almost each and every one had it. Here (NZ), I came and there was nothing like that. In Zimbabwe, if you had your own medical insurance, you’d be helped. Particularly if you get sick, you would go to a private hospital and you would be looked after by a private doctor. If you were pregnant you would go to a gynaecologist to monitor your pregnancy. Here it’s different; you go to a midwife; you don’t even see a doctor. Yeah, it’s quite different...” WCLI 1 p.167.*

No Prescriptions of Antibiotics and Injections (from doctors).

All the 20 community leaders, all focus group members and some of the service providers (particularly from the African communities) raised a concern that New Zealand medical doctors rarely prescribe antibiotics and injections to their patients, a practice which they (Africans) are used in their countries of origin. However in New Zealand it was discovered that doctors advise their patients to

drink a lot of water or do some physical exercises. This leaves a lot of African patients dissatisfied as they will be expecting to be given antibiotics and injections. They believe that antibiotics and injections are effective ways of treatment. This shows a clear difference between the African communities' understanding of the concept of New Zealand public health and the ones from their countries of origin:

- *"...But my first impression was that perhaps I will get the same medications like antibiotics as we normally used to get back home in Africa.....but here, it's... they just give you Panadol and more advice that you have to take more water or perhaps keep yourself warm...we're used to that stereotype of injections and antibiotics because back home (Africa) we have experienced that once you have been injected, that's the first way of healing the sickness.." WCLI 2 .p 182 & 183.*
- *"..... I guess here (NZ) it's just 'drink some water' and you don't get...you feel like you're not being taken seriously as a client..." WCLI 5 p.223.*

Lack of Medical Check-ups

All the 20 community leaders (100%) and all focus group members mentioned that having regular medical check-ups is not a traditional practice in Africa. People have a habit of only visiting a medical doctor when they are really sick and unwell. Some people, due to cultural beliefs, believe that there is no need to visit a nurse, doctor or any service provider unless they are very sick. Some believe in the biblical concept which says that "it is the sick that seeks for medical attention- not the healthy and the fit". One community leader said:

- *".....sometimes in Africa, if you get sick, you don't go and see the doctor until you are bad, bad, bad; the worst comes.....But here (NZ), whatever you have, some kind of symptom, you go and see the doctor..."ACL I 10 p. 112 & 113.*

A member of the focus group mentioned that it is a concern that most African community members in New Zealand, do not go for regular medical check-ups. They only visit the doctors when they are real sick and almost dying. He compared the issue of medical check-up to that of warrant of fitness (WoF). All focus group members agreed with this statement. He said:

- *"...and also it's a time of our people to start to understand that they need to be doing check-up, you know. It's not about only the cars we take after six months*

for a warrant of fitness. People also need to get that warrant of fitness to go to check their GP's regularly, rather than going to GP when you feel sick. You know, those are the areas we need to be putting in our people so they can be educated..."FGI p.342.

Local Health Professionals not Familiar with African Tropical Diseases

A total of ten community leaders (50%) stated that most New Zealand doctors are unfamiliar with African tropical diseases like malaria and bilharzia. As a result of such issues the New Zealand public health delivery system was deemed to be different compared to most African countries. The community leaders mentioned that in Africa at times the doctors do not need to carry out any medical test to diagnose the illness- they can tell by merely physically looking at the patient. Some of the community leaders made the following quotations to bring out this point clearly:

- *".....So it's difficult and maybe coming from a different continent or country like South Africa, maybe they're not familiar with maybe tropical diseases or whatever...They (South Africa doctors) also rely on what they see on you; your eyes, your skin colour and your nails—all those things....I guess here it's just 'drink some water and you don't get...you feel like you're not being taken seriously as a client..."WCLI 5 p.222 & 223.*
- *"..I've got a good example of somebody else who went out (Africa) and then when he came back here (NZ), he had caught malaria. So when he came here, he was quarantined and I don't know what they thought that he was suffering from..... Only after I had called an African medical doctor, originally from Ghana,....to say ok, this is what has happened, he (Ghanaian doctor) suggested it was possibly malaria...And then he went there (hospital) he was diagnosed malaria"ACLI 3 p.35.*
- *"...African people come from countries where we have different diseases. I remember coming here...in Somalia I hardly heard of the word cancer—it wasn't in our psyche; it wasn't in our vocabulary. I come here and you sort of hearing quite a lot of diseases and different types of diseases here than we're used to back home in Somalia....for us it was malaria, TB; .., those sorts of tropical diseases. So I guess that makes it challenging for us; that sometimes we might feel that our health needs are not being met because people ...are being questioned about these other diseases that they're not familiar with....it's a perception...people sometimes form the assumption that maybe the NZ doctors aren't....equipped enough....about dealing with African diseases..." HCLI 2 p. 273.*

Incorrect Diagnosis by New Zealand Medical Doctors

About 15 community leaders (75%) mentioned that incorrect diagnosis is one of the challenges facing the members of the African communities. At times these incorrect diagnoses can be costly. One of the participants was visibly angry and emotional when she was narrating her personal experience of an incorrect hypertensive diagnosis which resulted in her Australian Visa being declined. She also had to pay exorbitant international non-resident consultation fees on three occasions to the same doctor, yet she did not suffer from hypertension. She said:

- *“.....I’ve had a very serious problem seeing one of the doctors in NZ. Actually my family and I were looking forward to moving to Australia so we went in for a medical exam and I got diagnosed with hypertension...three times yet I was ok.... I visited the cardiologist and... I was not hypertensive... I paid a lot on international fees and had my Australian visa declined because of that. So to me, it was a bit of an issue when I went to see this doctor because on three occasions I did not feel even comfortable. His manner of approach to me was very negative and very unfriendly....And it was a very, very costly experience because seeing the doctor...we did not just see the doctor for free; we had to pay money each time we visited.... And on the three occasions, we had to pay still international, non-resident fees...”ACLI 4. p. 50-51.*

Another community leader was sick for the whole year which affected his studies (at a New Zealand university) and the local doctors could not diagnose the illness. It only took a phone call to his former South African medical doctor (in South Africa) who later wrote an email (after the discussion) suggesting a specific test and after undertaking the suggested tests, the diagnosis was correct as proposed. He said:

- *“.. For instance in my first year at University in NZ, I was sick for the whole year but I didn’t get a proper diagnosis until I rang my doctor in South Africa....for the symptoms...And he (South African doctor) e-mailed to request for specific tests.....just speaking with someone on the phone in a different country (South Africa) and then after they carried the teststhat when I got a proper treatment..” WCLI 4 p.222.*

Lack of Family / Whanau Support

Within an African cultural setting and as a concept of health-living, family members play a pivotal role in one’s life. This affects one’s health and

wellbeing. Missing their beloved ones, who are thousands of kilometres away normally, causes depression and profound anxiety. Eight community members (40%) mentioned that most Africans do not have both their nuclear and extended family members in New Zealand and this has a negative impact on their health and wellbeing. One community leader said:

- *“..We look at health holistically; spiritual, physical, mentally and all that stuff...but for us, our families are not here so instead of me talking to my brother, they are not here. I need money to phone my brother who is maybe 10,000 kilometres away. So as a result my health won't be as good as someone, maybe Maori, who has got some whanau around here. I don't have whanau around me but my belief is that my health includes my family....but here; there is no family for me. If there's no family, I've got to spend money to talk to them. So that's another reason...” WCLI 1 .p. 170.*

In addition to missing family members, most Africans in New Zealand are also scared to be sent to rest homes when they are old. They prefer to live with their families until they die as is the culture and practice in Africa. In most African countries there is no concept of rest home for the aged.

Relationships with Agencies: Non-existent

The issue of relationship between the African communities and agencies that provide health services was said to be almost non-existent. New Zealand is a small country with a small population and there is a tendency of relying on networking as a key way of getting better services.

Unfortunately some of the members of the African communities are new and do not know the key agencies. Thus, they are disconnected and disadvantaged. This poses a challenge in the delivery of the health system in New Zealand, for the African communities. The issue of non-existent relations between the African communities and the service providers makes it difficult for the former (African communities) to understand the concept of New Zealand public health system and how it operates. One service provider said:

- *“.....I think it's understanding what it is you want to talk to the service provider about and therefore get the right one.....I think a lot of it is around relationships; knowing who those relationships are. And I think this is*

something particular about NZ; relationships are much closer here in terms of who you know is really important because the population is smaller; not just necessarily with the refugee community but generally in NZ the population is smaller than for example in the UK. So you tend to deal more on a person-to-person basis than a person-to-organisation basis..." ASPI 1 p.121.

- *"...And there is a responsibility on the agencies to go out and say 'look, I exist' – 'while I might not be able to help you right now, let's build this relationship.' And I think that can be a two-way thing. So even having that initial...knowing who the leaders are and getting to know how the community works, where they live, where they're spread out around Auckland – those sorts of things. ..." SPI 1 p.121.*

Lack of Consultation by Service Providers

Six service providers (60%) mentioned that there is lack of consultation of the African community by service providers when starting new community projects. Most times communities are not involved at the initial planning stage and only get consulted during implementation stage. This does not give the spirit of "buy-in" on the part of the community. There will be normally resistance from the communities as they will feel "used". Therefore lack of consultation by service providers makes it hard for the African communities to appreciate the concept of the New Zealand public system and how it operates. One service provider said:

- *"..I think I would...being quite blunt, yes, I think if there is no consultation...I think consultation tends to happen if there's a particular project on..." SPI 1 p.127.*

Non-Governmental Organisations (NGOs) / Government Departments Creating Dependency Syndrome

Five of the 20 community leaders (25%) mentioned that some of the NGOs and/or government departments are purposely creating a dependency syndrome all in the name of "capacity building". This means service providers receive money from the government or donors as they train community members so that they (communities) take over the leadership and running of health community projects. However in the majority of cases the training never ceases and the take-over does not happen. This was viewed as disadvantaging African communities rather than empowering them. This has some adverse

effects on the delivery of health promotion within the African communities as it creates a lot of “politics” and divisions within the communities. It was strongly felt that this is not community development, but politicking. This causes the communities not to appreciate and understand the concept of New Zealand public health system. One of the community leaders said:

“...the other biggest problem for us is the NGO’s who really get a lot of resources from the Government... and creating a dependency model (syndrome) because they don’t want to lose their jobs. They want to keep the communities weak...the funding; they (NGOs) want to make sure these people need their help. And we say ‘how long do we need your assistance?’... We are capable and confident and capable people. We maybe need an initial couple of months or years support but we don’t need five to ten years or life assistance in supporting our communities. We are hard workers; we don’t need that.....And I think the major barrier.... is that those who are operating under the deficiency model, making sure the communities are weak and always needing support, and they create that kind of welfare notion that we are incapable people....It’s power and....because NGO’s want to keep us like that...” WCLI 4.p.215-6.

Disconnection between Communities and Service Providers: Communities not knowing the “Gatekeepers”

One service provider indicated that in addition to the fact that many African communities do not understand the concept of New Zealand public health system and how it operate, the communities do not know which service provider(s) to talk to on different matters. On the other hand, the service providers do not know how to reach out and connect with the communities. There is no bridging in between the African communities and the service providers and as a result, this affects the delivery system of health promotion to the African communities. African communities do not know who the “gatekeepers” are within the New Zealand public health delivery system. It simply means that there is no connection between the communities and the service providers. Some of the service providers said:

- *“..So I think for a lot of African communities, they might not know who the “gatekeepers” are to opening up all these different doors. ..” SPI 1 .p. 121.*
- *“..I think there are a couple of things (challenges)...communities don’t know who to speak to. And sometimes the service providers don’t know or the communities, they don’t know how to reach out to them. I think that whole bridging sometimes isn’t there...” SPI 1 .p. 121.*

Community Politics /Divisions and Fear of Losing Funding

Community politics and divisions are a serious set-back to any community development. This has been cited by all service providers (100%) as one of the major health promotion challenges within the New Zealand-based African communities. Community leaders do not disclose to service providers that there are problems or divisions within the community due to fear of losing funding. At times one community is divided and split into two or three different rival groups. This normally has adverse effects which result in poor health promotion delivery system. One service provider said:

- *".....I would just like to be told if there are internal divisions going on within a Community Association like this. So, if I'm going in with a project, I don't want to be having to pull the project out and the money out after nine months because the Community Association hasn't told me that 'well, we're having problems just now.' And it's really difficult for Community Associations to tell its service providers 'not right now; we've got other stuff to sort' because they don't want to lose that opportunity and chance for funding....." SPI 1 p.129.*

Lack of Funding Advocacy at Government Level

There is lack of advocacy for the African communities in New Zealand at government level, for funding in particular. One service provider mentioned that the government allocates budgets to Maori and Pacific peoples for their health promotion programmes and public health initiatives but nothing for the Africans. She therefore called for a strong advocacy in this area. She made the following statement:

- *"..The Government setting priorities and in our country (NZ)...the first...a lot of the money for inequalities goes to Maori first, being the indigenous. And then Pacific people have a lot of needs so there's money allocated to them. So then, that's why you need advocates to advocate at the funding level for African migrants or African groups because if you don't, if people like us don't advocate for those needs, and you've got.....they might get forgotten in all the funding. I think allocation of funding is a challenge for African health promotion, yeah..."SPI .4 p. 155.*

Types of Different Food and Environment and Lack of Physical Activities

More education is needed on the type of food which most members of the African communities eat in New Zealand. Food in New Zealand is easily

available compared to some countries in Africa; but unfortunately not all this food is healthy. Most members of the African communities eat any food they come across, especially if it is cheaper. However some do not do physical exercises. However over-eating certain foods e.g. foods high in saturated fat etc. can cause health problems like over-weight and diabetes. About five service providers (50%) made similar comments on this matter. They said:

- *“..I think for anyone coming into NZ there are some health risks around the sort of food that we eat; so a heightened risk towards diabetes, .. risk towards allergies... being intolerant of certain foods like heavy gluten foods or whatever. I haven't seen much example of focus being given to what are the particular challenges that African people have. I see a lot of focus given to what are the challenges that South Asian people have; change of diet and what it means.....” SPI 3.p. 147.*
- *“..Oh, I think that the thing about health promotion too is that people might have had a really healthy way of living and eating in their own country. And then when they migrate here (NZ) that changes for different reasons and the food isn't available that they might have had and there's lots more fast foods. I mean, for the Pacific population over here, that is a major issue and I'm not sure whether it is for African people...” SPI 4. p. 158.*

When people come to New Zealand, they eat different types of food and experience different weather and environment compared to what they used to have in Africa. This was cited as a health promotion challenge faced by a number of Africans in New Zealand. It was indicated by one community leader that some people in Africa have never visited a medical doctor in their entire life mainly because they walk long distances and have a lot more manual work which is equivalent to adequate physical exercises. However when the same people came to New Zealand they are often sick due to the type of food, different environment and lack of physical exercises as they always drive, even short distances. She said:

- *“...health promotion with Africans is a big job; it's not easy.because we are coming to a system not used to.... like in our country, some people, spend all their lives without going to hospital and have no problems. But here, with the different food, different environment, everything different....make other people to be sick and they are not aware about it. I see it really as a big concern....” ACLI 5. P.64.*

Another community leader pointed out that from an African perspective, the more palm oil (cooking oil) used when cooking, the more it shows how rich and well up one is regarded by the community members. In other words, what she meant was that if one wants to show that they are rich they have to use a lot of palm oil in their cooking. She mentioned that the affluent and the rich use much oil in their cooking. The community leader said she is now aware that too much oil in any cooking is unhealthy.

It was also mentioned, within an African perspective, that eating a lot of meat was perceived as a symbol of being rich. In other African countries, “red” meat is perceived to be for the rich and well-up people. However, it is a known fact that “red” meat causes more diseases like gout, than white meat (e.g. chicken and fish).

Some other members of the community base how many years they should live on the life expectancy in their country of origin. For example, if men generally live up to 45 years in Somalia, then a Somali man in New Zealand who is 55 years will believe that he is doing “overtime” for the extra 10 years and therefore there is nothing that should stop him from eating whatever he wants to eat, while he is alive. He must enjoy the “overtime” to the fullest, hence eating whatever he desires. This has been coined as the concept of “overtime” by some of the African community members in New Zealand. She said:

- *“...In my culture we cook with a lot of palm oil but when we got here we changed...we’re still using our palm oil but we make sure...in my culture, when you cook, for people to know that you’re rich, the palm oil must be flowing on top of the soup.....and that’s what makes it yum but when we come here (NZ), we realised that we can’t just be drinking oil, .., like that....” ACLI 7 .p. 78.*

On lack of physical exercises, most people in Africa walk long distances, mainly due to lack of public transport. Fortunately from a health perspective, this is part of physical exercising. However when they come here (NZ) they drive most of the time, even short distances. This culminates in lack of physical exercises. Three (30%) of the ten service providers made comments on the issue of lack of physical exercises on the part of the African community members. One service provider gave an example of an African woman who managed to

experience a peaceful sleep for the first time in five years after she had gone for a swim. She said:

- *“.....for example one woman said, after she'd been coming swimming and it was relaxing and exercising, she slept through the night for the first time since she'd been resettled here (NZ) and she'd been here for about five years and hadn't been able, because of her anxiety and everything, she'd been waking up in the night. And she felt that it was being able to come and swim and relax but come to a place where she felt supported...” SPI 4 p.152.*

The African Concept of “fat” Perceived as Rich Coupled with Lack of Physical Exercises

It was reported by one of the community leaders that in Africa, the fatter one is the more he/she is perceived to be rich and living comfortably. She also noted that when she came to New Zealand (from Africa) she was challenged to see other women of her age looking attractive, well and younger as a result of physical exercises. She therefore mentioned that being fat, overweight and lack of physical exercises was a challenge to health promotion within the African communities in New Zealand. A lot of African men in New Zealand consume large quantities of *sadza/ugali* (traditional food with a lot of carbohydrates) and yet they hardly do any physical exercises. She pointed out that being fat and overweight can cause diseases and other serious conditions like obesity and high blood pressure. She said:

- *“..For example, when I came to this country (NZ) I was 86 kgs though I just had a baby then. But in Africa, the bigger you are the richer or comfortable you are...that was the concept. But coming to NZ...you start seeing people your age...are keeping well. And also, with being overweight you have some other challenges... obesity, high blood pressure .But coming here, you see people exercising and while we are there we start challenging ourselves. Some of our men, they'll go eat semolina /sadza/ugali like, three times a day.... without any physical exercises...” ACLI 7. p.78.*

Lack of Health Needs Assessment for the African Communities

There is no health needs assessment done for the African communities in New Zealand. As a result there is no understanding of how the African communities conceptualize the issue of public health systems in New Zealand. Again public health professionals in New Zealand will never come to know about the health promotion challenges that face the African communities if health needs

assessments are not carried out. It was mentioned by one service provider that within service providers' circles, this matter is treated as a private issue and not talked about. She said:

- *"..I guess there hasn't been a huge amount of work done in terms of understanding what the health needs of the African communities. And it's often a very private thing and people don't talk about it...people don't always want to publicly talk about what the issues are. So you know, probably the understanding of what locally the health needs are;" SPI 8 p.305.*

Ineffectiveness of the New Zealand Public Health System

Twelve of the 20 interviewed community leaders (60%) mentioned that the health promotion delivery system in New Zealand for African community is ineffective. The main reason mentioned was that the New Zealand public health delivery system is based on a mono-cultural approach that predominately suits and favours the Pakeha (white New Zealanders). It was described as "placing everyone in one box and in one basket" regardless of ethnic back ground, culture, beliefs and country of origin considerations. One community leader said:

- *"...The health promotion mainly for African communities is not that effective...the NZ system puts everyone in one box; in one basket-where everything is done the same regardless of the background, the cultural background, cultural sensitivities...." ACLI 1. p. 4.*

Another community leader mentioned that the public health delivery system in New Zealand was ineffective mainly because of what he called "selective health promotion". When asked to elaborate he said that at times the system is selectively used to suit different people and situations and that a lot of things are not talked about. He further mentioned that the majority of Africans end up being marginalised by the system. He said:

- *"..New Zealand has what I call selective health promotion so to speak. A lot of things do not get talked about. When things go wrong, that's when people start running around and playing the blame-game....To a certain extend I don't think it's effective" ACLI 3 p.33-34.*

One community leader who is an international student clearly indicated that the public health system in New Zealand for the African communities is not

effective because she personally experienced poor public health services. She said:

- *“...I would say my experience of health promotion in NZ hasn’t really been effective....because as an international student...seeing the doctor or having access to health services, has been very, very poor because I have to have that income and I have to be able to have my insurance paid...So health promotion... has not been that effective...” ACLI 4 .p.50.*

Lack of Research on African Health Issues in New Zealand

There is lack of research focused on African health issues in New Zealand. Since the number of Africans in New Zealand is steadily increasing, due to migration, there is need to understand the health needs of this population. The community leader who raised this issue was deeply concerned and felt that Africans in New Zealand are been left out and ignored by the government when it comes to the issue of equality, especially on public health matters. Maori and Pacific people are allocated research funds. There is nothing for Africans. She mentioned that Africans are on the “bottom of the pit” in comparison with the Pakeha, Maori and Pacific, when it comes to research on health needs assessments. She said:

- *“...But at the same time, New Zealand can also empower Africans by doing research on Africans because there’s nothing really on Africans. There is nothing. If I look around, there’s nothing. We’ve seen a lot of equity issues, you know. They talk about equality and equity issues of health; it’s more to do with Maori and Pacific. There’s nothing on Africans....The government should also look after us as well in terms of research; allocating research money, which focuses on Africans. Because we’ve seen a lot of research results that show that there’s a gap between the mainstream Pakeha and the Maori and the Pacific now are coming up but I know very well that Africans were at the bottom of that pit. What are they (government) doing about African health.....?” WCLI 1 .p.169.*

However, it should be acknowledged that there is a current research on New Zealand-based African communities called “AfricaNZ” been carried out jointly by two New Zealand local universities and funded by the Ministry of Health through the Health Research Council of New Zealand.

African Communities' Access to Health Services

Out of the aforementioned eight key themes, "Accessing health services" has been ranked as one of the main health promotion challenges faced by the New Zealand-based African communities.

Prohibitive General Practitioners (GPs) Consultation Fees

It was mentioned that it is expensive to pay consultation fees for visiting a General Practitioners (GPs), especially if it's after hours. This is an economic challenge. Some of the community leaders said:

- *"...The economic one is very, very—the most important one. Seeing the doctor can be costly...of my kids, me or my wife— can be sick but we have to maybe just use Panadol or some other techniques; stay in bed and things like that because we don't want to go and pay \$40..." ACLI 1 p.6.*
- *"...And the other thing is....I was surprised that GPs don't work on weekends... Mm, mm, it's very expensive. For me one time it cost me more than \$100..." WCLI 1 .p. 168.*
- *"...And cost-wise, to see a family doctor— lots of people refuse to go and see a family doctor because of the costs..." ACLI 10 p.110.*
- *"...the times you can visit the doctor. It's usually just during the day and...over the weekend, it will cost you more. During the day....will compromise your workplace.....It's a lot of things; you can't see the doctor after hours. Most doctors are unavailable after hours and if you go to any other doctor that is available, it's costly; it's very expensive" ACLI 3 .p. 38.*

Still on the issue of high cost for consulting General Practitioners, all focus group members and more than 50% of the service providers mentioned that this was of the greatest challenges facing the African communities in New Zealand.

One service provider said:

- *"...because of the high expenses of the GP's cost..., the GP is very expensive nowadays so it's a challenge for some families, even if they are sick; they may not be able to take their child to the GP—their family member, so it's a challenge..." SPI 9. p. 314.*

Work versus Visiting a General Practitioner and Long Waiting Time

Most Africans are still facing settlement challenges ,especially those from refugee background, and do not have the time to visit a General Practitioner as they will be likely at work. Some compare between the loss of earnings (by working) and visiting a doctor. In the majority of cases, many will opt to go for work. Many find it to be time-wasting and consuming to visit a doctor rather working in order to earn some money. Some community leaders said:

- *“...It's not effective. Because you have to waste time...because here, you survive by working. If you don't work, you don't get money, yeah. And so, there's plenty of time you waste to go to the doctors on things...” ACLI 3 .p.35.*
- *“...when you go to, for instance, an after-hours emergency, say you go to the hospital...you sit there for ages without being attended to...you can sit there in the hospital the whole day before being treated. You know, you have to act and shout before you get proper treatment...You know, I think that's the biggest challenge; it's one of the major challenges; that you don't get treatment on time. You don't get seen by your doctors especially in emergency situations....” WCLI 5 .p .224-5.*
- *“...I mean, the doctors, you can't see them in the evening and if you are, you have to go to your hospital in the evening and be prepared to stay there overnight because the queues are long and it's just... the hospitals is chaotic. The delivery there to everybody is just too chaotic. So maybe somebody will decide not to go there either because of the time and the waiting time they have to be on the queues and all of that...” ACLI 3 .p. 43.*

Referral System

The other challenge regarding accessing health services, identified by the community leaders, is the complicated and time-consuming referral system to see medical specialists in New Zealand.

Some of the community leaders felt that it is a waste of both time and resources to first visit a General Practitioner before seeing a specialist. Their reason was that normally the General Practitioner does very little or at times nothing, save for issuing a “piece” of paper. One ends up paying twice but get the real service from only one party (specialist). He said:

- *“There's something very interesting about the health system here (NZ)...let's say you need a specialised treatment or if you've got a problem with your ear and you know there's an ear doctor somewhere there... but he can't see you until*

you've gone to a GP, pay the GP and then the GP refers you to go to the ear specialist. A very good example is that I had a visiting brother-in-law who wasn't well and he had been operated on ...all he needed was an orthopaedic...he couldn't go directly to the orthopaedic. He was coming from another orthopaedic....overseas but he couldn't go there until he had gone through to the GP. The GP did nothing; ...but they charged him a fee and then they referred him. But yeah, I don't understand the logic in that ..." ACLI 3.p.39.

In addition, community leaders stated that the system of referral is so complicated, especially for those from refugee background. Some of them cannot read or speak English. The system is too involving as one has to go through many levels of bureaucracy. They need someone else to help them. One community leader said:

- *"...And also the secondary care, which is based on the referral hospital ...these other mental issues...and it's very hard to negotiate through the myriad of levels of involvement. And some services are virtually unknown to the community. I mean, I was involved with this young lady who had had a stroke...and it takes quite a while to find out different agencies or different contractors or service providers who would be able to play a role –"so it is really quite a mystery process for a migrant to figure out (accessing health system in NZ) unless they have somebody..." WCLI 6 p.234.*

Immigration Legal Status

The other reason which was mentioned by some of the community leaders as a challenge in accessing health services is that the service providers constantly check and ask patients' legal status in New Zealand, whether they are Permanent Residents or Citizens of New Zealand. This happens especially if one looks/sounds different from the mainstream New Zealanders. One community leader expressed his disappointment and said:

- *"....we've been going there (GP) for years, and then for some weird reason,they want proof of citizenship and residence; after we've been going all those years, , 'how long have we been coming here?' and 'you are new here and...' and they were like 'oh, it's a regulation'. I can't understand the logic behind it. And the way she (Receptionist) was doing it...she was doing it, like; from a militant perspective whereupon...this is a patient...you're like a customer. I thought maybe the approach was not proper...I didn't understand the logic behind it...And then we were citizens we should still enjoy the same services as citizens" ACLI 3 .p.41.*

Immigration Policy

The New Zealand Immigration policy which states that for anyone to qualify for free health services should have been in the country for a period of more than two years, was cited as one of the hindrances to an effective accessing of health services. One community leader said:

- *"...but take for example other people, like new migrants here; you're working and you're paying your taxes but if you don't have two years' work Visa, then you receive....health, .huge bills of (\$30,000?) so what kind of health promotion is that? I mean, you've been allowed to come into the country, you're paying your taxes but can't get treated." ACLI 6 p.76.*

Waiting List for Surgery or Specialists

Though New Zealand has a free health system for its citizens and all those with a legal status (including those with more than two years in the country but without Permanent Residency), it was indicated that the waiting-list especially for having a surgery or seeing a specialist, takes forever. One community leader said:

- *"...the health system in NZ is free' but we are suffering a lot because to see a specialist, it can take one year or two years. And to getsurgery...maybe five years and you are still on a waiting list. So in my country, where there is not many specialists like here, but if you have money you can see them and straightaway you get surgery..." HCLI 3. p. 291.*

Community Members not Knowing Existing Services: Respite Services

One service provider who is a member of the African community and employed by one of the District Health Boards (DBHs) mentioned that there is lack of awareness, within the African communities, of essential services, like Respite Services. Respite services are a facility where one can send a disabled child or a child with a challenging behaviour for some time so that the parent(s) can have a rest. It was mentioned that a lot of Africans who need such services do not know how to access them. They are missing out. He said:

- *"..Lack of awareness...not knowing...even if the service exists. To give you an example, there's a family from Africa with a child with a disability. They don't know there is respite support, where they can take their child and their child can stay overnight or two nights and the parents can rest. There is a child support, you know, where someone can come to help the family. If they don't know these things, maybe they miss out..." SPI 2 p.137.*

African Community Leaders Blocking Health Promotion Initiatives

It was interesting and encouraging that one of the community leaders mentioned that sometimes community leaders are standing in the way of health promotion to be effective within the African community. She called upon community leaders to embrace change and welcome health promotion in the community. She said:

- *“Some community leaders are still sort of closed (to Health Promotion) and as much as health promotion is now happening out there for them, they’re still not opening up the doors so that it comes in to their homes and help them out....” ACLI 6 p.70.*

Community Politics and Divisions

The danger of internal community politics within communities is one of the challenges that hinder an effective access to health services. One service provider said at times there is more than one rival group within one community due to divisions, misunderstanding and internal politics. The service provider said:

- *“...And it might be that there’s lots of different Community Association’s for one particular ethnicity and its which one do you go to; how do you possibly work with the fact that there’s four Community Association’s out there for one community when you’ve only got one grant?...Internal politics is a huge one. If there is in-fighting within a Community Association it can mean that the project that you’re running can fall down...Yes. So whether it’s a Community Association that’s on the point of breaking up or personalities having power struggles; your project can get caught up in that...” SPI 1 p.119.*

Difficulties in Securing Community Funding

The other challenge which was identified by service providers is the frustration experienced when it comes to policy around applying for community funding. The funding is based on a one-year cycle, which is too short such that the time to implement the project(s) is about nine months only. This frustrates communities as most of them do not understand how it works. The following quotation supports the above statement:

- *“...funding, sustainability; one thing I’ve noticed about health promotion in NZ—it seems to be funded for one year, which basically means at the end of all your planning you have nine months to do everything and then you’re on the funding round again whilst from my experience of working in the UK, you get*

three years funding; so you've actually got a chance to develop things and you're not constantly looking around for funding. And I think that's not necessarily just an issue for the African community. I think it's a general issue for health promotion funding.....Yeah. And while you can start right at the beginning and explain that it is one year and you will keep trying, people get bored and tired and frustrated with that stop/start/stop/start and I think that's a big one..." SPI 1 p.119.

Lack of Information to Access New Zealand Public Health System

Lack of information regarding access to the New Zealand health system was indicated as one of the challenges by some of the service providers. One service provider said:

- *"..I guess it's providing more information around the New Zealand health system. There seems to be a lot lacking around....the access... who has what rights to what and it's something that very currently we're looking at and just where to go to from there..." HSPI 10 .p.321.*

Apart from the exorbitant costs of consulting GPs, the focus group members did not say much on this matter mainly due time constraints as they spent most of the time on other pressing issues (according to them) like racism and discrimination.

Language Barrier as a Main Challenge to Accessing Health Promotion

English Language as a Communication Barrier

All participants identified proficiency in English was a major health promotion challenge faced by African communities in New Zealand, especially those from refugee background who do not understand the English language. Twelve community leaders (60%) mentioned that English is a major barrier in communicating with health professionals in New Zealand. To some of them it will be a second language (if not the third or fourth). Some of these people have never spoken a single English word in their country of origin before coming to New Zealand. It makes it more complicated in the event of non-availability of trained interpreters during a hospital/General Practitioners (GPs) visit. The following remarks were cited by some of the community leaders:

- *"...we are coming from French...countries...New Zealand where they speak English so we've got a lot of problems with the language first....So we need an interpreter and that interpreter, we need someone we trust..." HCLI 3 p 287.*
- *"..Yeah, the first time,...it was very, very hard because we can't communicate straightaway with the doctor because of language....So we need to go through to another person-An interpreter.." HCLI 3 p 288.*
- *"...sometimes the language, coming from a non-English background, communicating can be a problem...And sometimes in NZ...GP's don't use interpreters and that's really a big problem.....Because somebody can have a wrong treatment and that can have a serious consequence....." ACLI 1 p.7.*
- *"...It takes time. For refugees, mainly the big problem is using an interpreter; accessing interpreting and the language problem ..." ACLI 10 p.111.*

All service providers mentioned that English language was a major barrier that poses a key challenge to effective health promotion within the New Zealand-based African communities.

All of the focus group members were very vocal and strongly felt that proficiency in English was a challenge to the promotion of effective health promotion within the New Zealand-based African communities. They advocated that it is imperative and important to first address the issue of English language and then we talk about health promotion. One of the leaders said:

- *"..There are so many challenges, like language. Language is a barrier, you know, because we come in the country and it's not everyone as African we speak English, you know? And we come here and sometimes you to a GP and there are some GP's who don't accept Africans or some other culture who they don't speak English, you know? If you don't speak English sometimes it will be difficult for them to say 'no, we don't accept those services. We don't need those people.' So it's about...just to promote language as well. It's those barriers, which we have to fight against and face and then we can look for the health promotion later. I mean, those are the biggest things we should really do..." FGI .p.333.*

Difficult to Communicate with Health Professionals

It was also mentioned that some of the New Zealand-based African community members do not visit the doctors/health professionals (even if they are sick) due to the fact that they can't speak or communicate in English. As a result they

are shy to ask for help from other family and community members. So they stay home and resort to taking panadol, which is medically dangerous. One of the community leaders said:

- *“...They go to the doctor unless...otherwise...because of the language barrier...yeah, so they feel shy to ask everybody ‘come and do interpreting for me’ – so in that case, half of them stay home and take the Panadols....” ACLI 2 p. 20.*

Fear of Community-Gossiping

Some of the people are scared to use community members as interpreters as they fear that their illness will become public knowledge within their communities. Thus, they fear community gossiping and spread of rumours. As a result they alienate themselves and not seeking for medical attention. A community leader said:

- *They are scared because of the stigma. They don't want... for example, if I know someone....is carrier of HIV and AIDS, they areafraid that...I might tell other people....sometimes people don't want ...someone they know to interpret...” HCLI 1 p.265.*

Suspicion: Confidential Information Passed on to Other Government Departments

In addition to the issue of English as a language barrier, some service providers mentioned that some of the refugees were suspicious as they are afraid that if they share some information with the hospital (as a government institution) this information may be passed on to other government departments like Income Revenue Department (IRD), Work and Income New Zealand (WINZ), Police and Immigration Services. The fear is that this may compromise their stay in New Zealand as some accounts of information may be different and inconsistent. This may be deemed as liars by Immigration department and may result in some immigration status been revoked which may lead to deportations. There is also an unfounded fear based on past experience (in country of origin) where some of the refugees have been tortured and abused by government agencies:

- *“....The gaps would be like refugee communities, especially Africans, engaging with the service when it comes to language barrier, whether it is kind of suspicious... like information you share with...say for example, in the health sector.....it may not be passed to other Government organisations, like Inland Revenue, Police, Work and Income. So, there are those kinds of lack of information you know; misunderstanding...” SPI 2. p.133.*

Use of Young Children as Interpreters

All participants identified that lack of English language skills causes some of the parents to use their own children to interpret for them, which has been considered as culturally inappropriate and professionally unacceptable. There are sensitive and private issues that are culturally inappropriate to say in front of one’s children, for example illness that affects private organs. So, it will be both embarrassing and emotionally challenging for non-English speaking parents to use their own young children. Some parents will end up not telling the health professional the exact health problem:

- *“....another difficultyusing the children and there are things that are really so private that the parent cannot say in front of children....instead of explaining the situation as it is because they are already in front of the doctor.... start going around and around and the doctor may get the wrong information and the treatment that will be given won’t be appropriate....I can give you an example...one lady who was having a blood issue; that her periods were not stopping and blood was really running all the time....she went with her son,...the only one who could communicate in English,...to see a doctor. And the doctor asked what the problem was and in front of the doctor, the mother froze; she couldn’t really tell the son what the problem was. Instead she said ‘I’ve got a pain – stomach pain’ and that’s what the doctor subscribed.....” ACLI 1 p.7-8.*

Breach of Privacy and Confidentiality

The issue of using children or family members as interpreters was also condemned by some of the service providers, as this compromise privacy and confidentiality. It was mentioned that by using family members as interpreters, especially young children, this is an inversion of one’s privacy and confidentiality. This practice was deemed to be both unprofessional and unethical. One service provider said:

- *"...When they interpret, the families do not have a good command of English they would like to keep their privacy and they bring some of their family members to interpret, which is not a good way of dealing with professional people, so this is an issue. And this interpreting is an issue for some (parents/professionals?) to get the right information; the right dose for the client; and that's an issue..." SPI 9 p.313*

Community Members Uncomfortable to Use Strangers as Interpreters

On the issue of interpreters, it was stated that community members are not comfortable to have people they do not know to interpret for them. They regard such interpreters as strangers, even if there are professionally trained:

- *"..The language is...people, sometimes they don't trust...when it comes to interpreters... its people they know – to interpret. So the other thing is they can't rely on someone outside their area..." HCLI 1 p.265.*

Possibility of losing Essential Meaning When Using Interpreters

It was discouraged to use untrained community members as interpreters as some may miss out crucial health information in the translation process. Some of the English terms do not exist in some of the African languages or they may have different meanings.

Kiwi Accent: Difficulty to Understand

The other challenge associated with English as a language barrier, is the Kiwi accent, which is not easy to understand even for those who know the English language. When I came into New Zealand for the first time from Zimbabwe, which is an English-speaking country, I had difficulty in understanding the Kiwi accent. It becomes more difficult if people concerned are from refugee background and also coming from a non-English speaking country. Some community leaders said:

- *"..It was a bit difficult in terms of understanding the Kiwi accent; in terms of sometimes–the doctor can't understand exactly what's your problem is. And once they diagnose the issue and then sometimes the medication that they give can take a while to cure the sickness..... " WCLI 2 p.182.*

- “..Zimbabwe uses English as a formal language but still there’s this accent thing and...still people don’t get to understand you...” HCLI 4 p.296.

Lack of Information in African Languages

One community leader echoed the same sentiments regarding lack of public health information in African languages:

- “..like my community, Sudanese community, because there are other services now....the brochures and the health and....all the information is not translated to their language so people who don’t read English, they read it in their own language but we don’t....” ACLI 5 p. 57.

One service provider mentioned that though the New Zealand health sector is good at providing information in different languages, mostly Asian languages, there is a conspicuous gap and deficiency when it comes to some African languages:

- “...there’s an issue....of language and so...it’s interesting.....What we have found is that probably the health sector is the best at providing information in different languages; mental health, health, wellbeing. But if I look at what are the languages that they’re covering off, they typically are the Asian languages. ..Not many African save for maybe Somali...” SPI 3 p. 147.

Spirituality and Traditional Beliefs of African Health Consumers

Spirituality and traditional beliefs were identified by most community leaders, focus group members and some of the service providers (mostly from the African community) as having a great influence in the health and well-being of people.

African Traditional Medicine and Spirituality

All 20 community leaders (100%) and all focus group members acknowledged that African traditional medicine is effective in healing diseases. They acknowledged the importance and significance of African traditional medicine and spirituality in the health and wellbeing of African people. It was mentioned that African traditional medicine and spirituality are inseparable, thus they work hand-in-hand thereby complementing each other. It was also

mentioned that African traditional medicine is effective in healing common illnesses like coughs and colds and cuts:

- *"..Yeah, (traditional medicine) back home we used to see someone who's got some mental health...healed....Yeah, yeah. So they used to bring them someone to the older people and treat them with the traditional medicine...And they'd be well..." HCLI 3 .p. 294.*
- *"...traditional medicines, is very good because we used to use them and sometimes it really worked well..."HCLI 3 p.293.*
- *"....It's only because we are here (NZ) we don't use that anymore (traditional medicine) but when we were growing up it was being used and it was very effective. We never used to go to doctors so much because there were so many traditional medicines for the minor illnesses; like the coughs and colds and cuts and things like that... Yeah, they do work (traditional medicine)....." HCLI 4 p.300.*
- *"..African...spirituality is really important...Spiritual wellbeing is important. And that is used many times to heal diseases, mental illnesses. It does work; many times it does work and it is effective...." HCLI 2 .p. 284.*

African Traditional Herbs and Religion

Another community leader who is both a professional Social Worker and a religious minister (and soon to complete a PhD) mentioned that though a strong Christian believer, she cannot deny the existence of healing powers from the spiritual and traditional forces or ancestors. She said though a religious minister she can't deny the healing power of African herbs. She gave a personal testimony of her uncle (back in Africa) who got healed from diabetes through using African traditional herbs:

- *"..I can't deny the spiritual forces. I can't. And that's what I was telling my student because I also... lecture on Concept of Mental Illness and I told them, well, I'm going to have a PhD very soon. I'm a Minister in the church but...I can't deny the spiritual forces behind things. I mean, coming from that concept, you'd be crazy to say 'oh, it's nothing; there's nothing like that.'-I can't. So in as much as we have the good aspect, we also have the bad aspect...They could also be used to make you well. So it all depends on what you believe in....." ACLI 7 p.83.*
- *"..And in the case of herbs, let me give you an example. When I was at home (Nigeria), my uncle was diagnosed in Nigeria with diabetes... and this is a well-educated guy; chartered Insurer. So he went for the operation...since that time*

he's started taking the traditional herb...– that's the only thing he takes; and he's well and up to now...ACLI 7 p 83.

Strong Belief in God

Some community leaders indicated that most Africans are very spiritual such that if they are sick they pray to God first before going to hospital. Although poverty can be the driving factor for most Africans to be religious, it was mentioned that it is a fact that most Africans are more religious than the majority of local Kiwis:

- *"....I think spirituality for Africans is a very, very important thing...before people can do anything else; to go to the doctor...they will pray first. And that is because of poverty. Poverty is one of the areas that Church Ministers, are really the first contact that they have to find the solution...so the spirituality is more important for Africans...." ACLI 1 p.13-14.*

God's Spiritual Healing Powers: Chronic Diseases like Diabetes and HIV/AIDS

One community leader said she is concerned that the type of health promotion in New Zealand and the Western world is too much disease-oriented and also focused on medication. She indicated that if people believe in God, they can be physically healed. She gave a personal testimony about seeing people who were physically healed by God through prayers from chronic diseases like diabetes and HIV/AIDS:

- *".....Well, when we talk about health promotion in NZ...they're very conscious about health....and, I think it's too much disease-oriented and it has to be about medication... like I said, I'm coming from the spiritual aspect. All these things that we have; the Diabetes, HIV/AIDS..... Foundation, New Zealand AIDS Foundation – where we are coming from ...the spiritual aspect, we have seen people that are being healed....We have living examples that you can see; this person had this disease and because they trusted in God, because they prayed, they didn't have to live with that forever....the spiritual aspect has a very huge impact...It helps your humanity because you know that there's a support somewhere; that somebody cares for you, you know. The spiritual force, you know, well, that has not been promoted here; everything is about medicine and that's what I find challenging... ACLI 7 p. 76.*

It was also mentioned that one can get healed after been prayed for and there won't be any need to visit a medical doctor .However the emphasis is on one's faith. One community leader said:

- *You can be healed without seeing a doctor if you have that faith. It doesn't apply to everyone....."HCLI 4 p 300.*

Ancestors and the "Spiritual World"

One of the community leaders who used to work in a mental health setting, as a trained Social Worker, confessed that the ancestors and the "spiritual world" exist. She also pointed out that traditional ways of doing things in the "spiritual world" works and is effective. She gave an example of a boy who was in their care in a hospital (in New Zealand) but refusing to take medication. But when the boy's father went to his native home and performed some spiritual rituals in the "spiritual world", the boy suddenly started to take medication. He began to positively respond to medication and became well.

- *"...I remember a case we admitted a boy....the boy was sick and he was around for a very long time (in hospital). We were giving him medication and he would just be looking at us and he (father of the boy) said 'ok, you continue to look after him; let me go and consult back home...'– and when he came back the boy was well. Yeah, he started responding to us, started eating, you know? Very young....and you know, when you look at things like that, you can't...science can't prove that. I don't know what he went to do, you know, but it was a spiritual aspect..." ACLI 7 p. 83.*

Psychological Effects: Self-fulfilling Prophecy-A Matter of Believing and Having Faith

It was emphasised that spirituality and African traditional medicine are paramount for the health and wellbeing of African people. An example of a self-fulfilling prophecy which is embedded in psychology studies was given indicating that if one believes in the African traditional medicine they will be healed. It was also mentioned that health is not just about the physical, but it also takes into account the spiritual, mental and emotional aspects:

- *"....Yeah, and spirituality is a very important aspect....if you believe in something... psychology studies have proved that, that self-fulfilling prophecy. If you believe something will heal you, it will heal you even if it's just water. There's just power in that thing that you believe will heal you....So your health is not just about the physical; it's physical, mind, spirituality, emotional, yeah...." WCLI 5.p.231.*

- *“...I’ve read this ...that spiritual people live happier, healthier life than non-spiritual people..., believing in a higher power I suppose and it does help. Because I mean, a disease, while they might have actual physical symptoms, it is a lot to do with the psychology aspect of it isn’t it?....we’ve heard of stories where people have become cured simply by thinking positively about the disease...” HCLI 2 p 284.*

Africans are Generally Spiritual and Traditional

It was also mentioned by some of the community leaders that generally Africans are spiritual and traditional, even if there are not practicing Christians. Most Africans believe in the idea of spirituality from a holistic perspective of wellbeing, which emphasises that living an upright life has an impact on one’s life. This is not about Christianity neither Islam, as there are some people who believe in God (non-practising Christians or Moslems) and ancestors. Two community leaders said:

- *“...from an African point of view, Africans are largely spiritual...even if they are non-practicing Christians, they are still some values they have, which are spiritual... and traditional.....” ACLI 3 p.44.*
- *“..Yeah, we are a very prayerful group and that really impacts on our health and we believe our spirituality plays a big part in our health. ...”HCLI 4 p.300.*

The majority of the focus group members stated the importance of spirituality and significance of traditional beliefs for Africans. All members acknowledged that spirituality has a pivotal role to play in the health and wellbeing of African people.

Principle of “Sankofa”-Relationship between, the Present, the Morrow and the Future

Some members of the African community believe in living an up-right life on a day-to-day basis. They believe that what a person does today, has a profound effect on tomorrow and the future of the individual concerned. This is about the intertwined relationship that links the past, the present and the future. This is known as the concept of “Sankofa” predominately practiced in West Africa. “Sankofa” emphasises on the principle that the past has a bearing on the

present; the present has in turn a profound effect on the future. Therefore this concept promotes an upright living for all humanity. This has nothing to do with religion like Christianity and Islamic:

- *“...from an African point of view, Africans are largely spiritual...even if they are non-practicing Christians, they are still some values they have, which are spiritual... and traditional and these affect their day-to-day lives.....” ACLI 3. p.44.*

African “Holy Water”

It was reported that some people (in Africa) travel long distances from urban areas to the villages (rural) to take “holy” water in order to cure terminal illnesses. They believed that they have been bewitched or it would be a curse from God. So they partake of the “holy” water that has been prayed for in order to be healed.

- *“...they (African patients) wanted to go home and have holy water. They think that is a cure. And they’re in denial; they don’t accept it. Kind of like terminal illness; that if it comes... from God and I have to go and pray. This kind of thing...they need to be aware of it...” ACLI 10 p 113.*

“Evil Eye” Concept

A belief in “evil eye” was mentioned by a number of community leaders. “Evil eye” is a belief that when someone with certain evil powers looks at an individual, that individual will become sick. The only way to recover from the sickness caused by the ‘evil eye’ is through the prayers of a spiritual leader (priest/minister /sheik).

- *“...some people believe that because you suffer from the evil eye of the community and again, that might not be helping the sick person. In fact it might make their situation worse. But again, I mean, that’s what community beliefs are.... Evil Eye = In some customs people believe that somebody can look at you with evil eye and you know, you fall sick...” WCLI 6 .p.239.*

Religion: A tool to Oppress Women

One service provider mentioned that she felt that religion and spirituality were used by African men, as tools to oppress and marginalise their women. The service provider participant said that this oppression limits women from doing things that will benefit their health and well-being. She said:

- *“...Well, maybe the Muslim religion can... from the female perspective...limit what those women can do. And maybe that sometimes impacts on their health...” SPI 4 p. 156.*

Integrating African Traditional Medicine with New Zealand Mainstream Public Health System

One community leader mentioned that most Africans believe in the effectiveness of ancestral worship and African traditional herbs. She also suggested that it would be a good idea for the New Zealand health sector to start embracing, integrating and acknowledging these practices in the public health mainstream system, since they have been found to be effective:

- *“...a lot of Africans, they're quite spiritual and they're believers and it's...very important...they believe in ancestors or they believe in certain products and... herbs. I think it is very important also, even those, to start to be integrated with the mainstream medicine and see how the two can come together to heal and work with the Africans....” WCLI 5.p.231.*

Lack of Understanding of the Cultural Context of African Communities by Health Practitioners

The issue of lack of understand of the African culture by New Zealand health professionals was identified by all participants as a health promotion challenge faced by African communities in New Zealand.

Culture and Health Promotion

One community leader mentioned that culture has a vital role to play in any health promotion, but however, this has been neglected in New Zealand. The insensitivity to cultural issues has a negative effect to any health promotion initiative in any place around the globe, especially to migrants and refugees. Migrants and refugees are mostly affected because they are already dealing with a lot of other settlement challenges like language barriers, employment, racism and discrimination. Equally the same, the issues of cultural insensitivity have a negative effect on the African communities, especially those with a refugee background:

- *“...Culture...has been neglected in NZ health promotion in general. That really has a bad impact on refugees or other ethnic groups who don't come from English background or from NZ; for a Kiwi culture...So culture has got a very, very important role to play in health promotion itself, yes..” ACLI 1.p.5.*

One service provider indicated that existing practices and norms within the New Zealand health system do not meet the cultural needs of the African communities. It was mentioned that therapeutic practices within the public health system do not take into consideration any African cultural values and norms.

- *“...cultural awareness and understanding and actually therapeutic practices needing to be in line with cultural practices. And you know, we don't often see I guess the therapeutic practices adapted to meet the cultural needs...” SPI.8.p.305*

Understanding and Appreciating One's Culture

It was pointed out that for any health promotion to work, there is need for the health professional to understand and appreciate the culture of the group(s) they will be working with. Assuming that certain initiatives or projects will work well in all cultural settings simply because they once worked somewhere else is not advisable. A particular behaviour may be culturally acceptable in one African community and completely unacceptable in another African community. It was categorically mentioned that African cultures are not the same. For example shaking hands with Zimbabwean women is acceptable while it not for Somali women:

- *“..No, I don't think they give weight for that kind of things (culture, tradition & spirituality) because they treat everyone the same, especially finding a new diagnosis. Like, somebody with a cancer and how to handle the family and how to discuss with a patient...they need to know more aware of it; culture, religion and the tradition; all these things they need to learn about a particular group of nature- believing...and all Africans are not the same. People are different. And the way you're brought up is different too. And they shouldn't make generalisations that all Africans...are the same...” ACLI 10.p.113.*

Most members of the focus group mentioned that New Zealand is now culturally diversified and emphasised that there is now therefore a greater need

for New Zealand health professionals to respect and be sensitive to other people's cultures.

Lack of Respect for other Cultures: Arrogance and Negative Attitude toward a Moslem Swimming Project

Lack of respect for other cultures, especially coupled with an element of arrogance, can traumatise other people. One service provider gave an example where a Somali Moslem Women Swimming Programme excluded men and as a result, a white Kiwi man made a formal complaint to the Human Right Commission (HRC) on grounds of discrimination based on sex and religion. His complain was taken seriously by the HRC and the swimming group had to change the name to Women's Swimming Programme:

- *"..yeah, a white...guy from Mt Roskill who used the pool generally and he complained to the Human Rights Commission in New Zealand...His complaint was that the programme was closed to men .He felt discriminated against. So actually the Human Rights Commission took the complaint quite seriously ...and at that stage we changed the name of the programme because we used to call it the Muslim Women's Swimming Programme. We changed it to the Women's Swimming Programme." SPI 4.p.151.*

Non-involvement of Those Who Know the Cultural

For any health promotion to be effective and achieve the desired outcomes, the process must include the targeted population. One community leader mentioned that no project will be successful if those who know and understand the culture are not involved or are given non-influential positions and yet those without cultural expertise are allocated influential positions. This will not work. One community leader said:

- *"...I think understanding a culture is the first thing that people need. So it's really difficult for somebody from a different culture to understand a particular culture. Because sometimes people from other groups might think this will work for these African people but maybe that's the wrong thing; it's the approach...."But if you keep those other guys (who know the culture) right at the bottom and you guys (without cultural knowledge) are at the top, then nothing is going to work..." ACLI 6 p.71-72.*

Cultural Shock: Physiological Effects

One community leader mentioned that some people are not comfortable in engaging with others from different cultures, especially if there are other additional barriers like language. She gave an example of a certain African lady who stayed in-doors (for months) and would not freely talk simply because she was not comfortable with people from other cultures. She only started to talk freely and to socialize when she was approached by this community leader from the African community. The community leader said:

- *".... a lady...from Sudan...She lived in her house; she wouldn't go out...being an African visiting an African...when I got inside, she sort of really... happy; you could see some happiness in her face and she did mention that she just stayed in her house because she didn't know anyone out there. She can't speak English so that was a language barrier as well; so that's something else that can impact on somebody's health as well..." ACLI 6 .p 72.*

Sensitive Health Issues: Gynaecological Matters

For most African cultures, it is a taboo for a woman to openly discuss gynaecological matters with males, even if it's a male medical doctor. Most African women whether Christians and Moslems or non-believers, find it difficult and uncomfortable to freely talk about their private parts to a male gynaecologist or health professional. This is a health promotion challenge for the African women in New Zealand:

- *"...for example, for an African woman to go and explain her gynaecological-what's the name; women's problem-to a male medical doctor, is a huge problem. It's a huge problem...It doesn't matter if he's Muslim, Christian or not a believer...I believe it is a problem for all of them. And that's why...if we have African women who are gynaecologists...and Western women....who understand the culture, then it makes it easier for them to open up. And that's the beginning..." ACLI 6.p.92.*

Equally the same, it is a taboo for other African cultures to have a female health professional examining males, especially if she is young. The following quotation says it all:

- *"It was challenging because it wasn't culturally appropriate. I went there and my first meeting was to meet a...nurse to do a health screening. Under my culture, a young beautiful lady who wanted to screen and touch my body and take off my shirt....it was very challenging to cope with...I was expecting was*

someone who is old enough;...kind of man...back where I came from...you go to see a doctor and it's always...you think it's someone like your dad or someone who's really about 45 plus" WCLI. 4. p.208.

Cultural Ambiguity

Different people have different ways of expressing themselves. At times the same message can carry completely different meanings. For example one community leader said one of her sisters has always had a characteristic way of expressing her medical problem to health professionals. She would always say *"I am sore everywhere in my body'*. The community leader mentioned that her sister's doctor later said to him *"Mr xxxx, now I understand the problem. The problem is African...It is not about the disease itself.....ACLI.8.p.93'*. The doctor here meant the African culture. The community leader said:

- *"..So it's very difficult for the doctor to pinpoint someone who just came in and said 'I'm sore everywhere.' The doctor knows it's not possible...I believe it is more ..; cultural understanding of how the African's express themselves and how they do things to be able to pin down the main problem. I believe that a lot of medical doctors here will have a huge problem with that... But if they (local Drs) spoke the language... it would have been very easy..." ACLI 8 p. 94-95.*

Without a clearer explanation later from the brother (community leader), it would have been extremely difficult for the medical doctor to understand the real medical problem of the lady in question. This ambiguity is embedded in most African cultures. The lady thought she was giving a clear explanation to the medical doctor, yet it meant nothing to the doctor.

Power Dynamics: Health Professional and Patient

There is also an element of cultural shock, on the part of some of the members of the African community, when dealing with health professionals, especially medical doctors. From an African perspective, mostly those with a refugee background, a medical doctor or nurse automatically assumes a position of power and authority, over the patient. The perception is that a doctor knows everything and must not be questioned. What he/she says goes and becomes unquestionable. Asking or questioning the doctor is viewed as being arrogant and disrespectful. On the issue of culture, another community leader stated that

the way local Kiwi doctors ask their patients is too direct and this makes members of the African communities uncomfortable. She said:

- *"...a big problem.....and culturally, we go to see the doctor and the first question is 'why are you here?' and 'how/what can I help you with...?' -...that kind of question is unusual. People come from a different background..." ACLI 10 p.111.*

One service provider (from the African communities) mentioned what he called "Cultural shock" within the New Zealand health delivery system. It was revealed that from an African cultural perspective, medical doctors know everything and their word is final. The patient is only there to listen to the doctor and comply. Yet within the New Zealand health system, the client determines what he wants to see happening in the treatment process and tells the doctor his/her goals.

- *"...there is cultural shock...like, our country (Africa) assumes that the doctor knows everything. So we kind of give that power; that the doctor knows best. So what he tells me, I take. But the NZ system - it's you to initiate your needs, to talk about it, press the issues, then according to that we set a goal, you know, goals to achieve what you want to..." SPI 2.p.137.*

Africans: More Secretive Than Others

It was said that most Africans are more secretive than Europeans when it comes to personal health issues. It was reported that at times Africans do not even share their health issues with family members and close friends while most Europeans talk openly about their personal health issues with family members, close friends and even with strangers. It was stated that this secretive nature causes some adverse psychological effects. One community leader said:

"..Yes, because African people—we are very secretive and we don't really talk about the illness. If you see the European, they talk about it with friends, family, with everybody. But we Africans, we're brought up to keep the secret for ourselves. That's really hurts a lot. We need to have a challenge to open up to talk, to discuss, and we need places to go and to encourage people and to educate people and just exchanging the idea; talk about it, to be open—that would really help because most of it is psychological affect also" ACLI 10.p.112.

Cultural Differences: Direct Talk on Terminal Medical Conditions of Relatives

It was pointed out that New Zealand health professionals tend to ignore issues of culture, religion and tradition when dealing with different people from other cultures, especially when notifying family members about a patient's terminal illness. There is nothing wrong within the Kiwi culture to tell the family that the patient has a few days before he/she dies, but this is unacceptable in an African cultural setting. Most New Zealand health professionals generalise a lot when it comes to cultural issues. They think, for example, that all people from Africa have a similar culture, which is not correct. One community leader said:

- *"..No, I don't think they give weight for that kind of things (culture, tradition & spirituality) because they treat everyone the same, especially finding a new diagnosis. Like, somebody with a cancer and how to handle the family and how to discuss with a patient...they need to know more aware of it; culture, religion and the tradition; all these things they need to learn about a particular group of nature- believing...and all Africans are not the same. People are different. And the way you're brought up is different too. And they shouldn't make generalisations that all Africans...are the same..." ACLI 10.p.113.*

Cultural Gestures and Body Languages

It was reiterated that culture includes the way people verbally speak and communicate in gestures and body language. It therefore takes people who understand a specific culture to be able to understand and know what certain gestures and body languages mean. This is therefore a health promotion challenge for the African communities as they are not understood by New Zealand health professional. This has a more profound negative effect of new arrivals, both migrants and refugee. This is equally true for New Zealand health professionals who do not understanding the gestures and body languages of the members of the African communities. Some of the members of the African community do not verbalize their disapproval but can express it through gestures and body languages, which in the majority of cases is not understood by the local health professionals and the general public:

- *"..I think again, culture is quite...big and you can come from different perspectives. The way you speak and the way you gesture and the way you communicate with people is all different in NZ. And to be very frank with you here, NZ's quite mono-cultural in nature; even biculturalism is still hotly debated in NZ. And if you are coming newly to the country ...you have to change... I mean, the country will not change for you...." WCLI 6.p.237.*

Cultural labels: Stereotyping

Some people fail to recognise that other cultures are different from theirs and as a result they may end up making negative comments and developing attitudes based on false perceptions. All this may lead to stereotyping. One service provider mentioned that before she had an understanding of the Somali culture, she thought there were rude, aggressive and too direct in the manner they spoke. But having worked with this community for 12 years (both in New Zealand and UK) she said it is their (Somalis) way of talking and showing agreement. She made the following statement:

- *"..I think...it's actually not just a language barrier; I think sometimes there's an understanding of culture; how people speak; how people use language... But the subtleties around culture, about how people talk about things, can put barriers up...For example, I've worked with the Somali community in the UK and here, so I've worked with the Somali community for, like, 12 years (UK & NZ)....And so I'm really used to the Somali's--sort of being very direct. A spade is a spade ... - and also the way that sometimes they speak can sound quite aggressive. But actually what they're doing is they're just agreeing with you and just...But I know from sitting in meetings, when there are people who have maybe not met the community before, they feel like 'oh my God; I'm being picked and shouted at.' So there are those cultural things..." SPI 1.p. 121.*

Mono-Cultural Aspect Verves Collectivism Philosophical Approach

The African culture is based on collective philosophical approach which is deeply rooted in the belief of the importance of the extended family: this is in sharp contrast with the Kiwi culture which is centred on nuclear family philosophy. If an African says he has six children, this does not necessarily mean they are his/her biological children. They could include cousins and aunts and this is culturally acceptable. On community leader said:

- *“..But the fact of the matter is...a lot of people have got their relatives back home and again there’s a cultural perception here...in NZ context family is very nuclear in nature whereby in Somalia it’s extended family. And always, you know, it is that extended family that you worry about....” WCLI 4.p.236.*
- *“...they should know that if it’s an African family coming (Refugee Quote), even if they have two children, they might have four children or five children. Their own children might be two but they might have relative’s children that they are looking after....” WCLI 1.p.173.*

Culture and Counselling

Within an African culture the concept of counselling is foreign. People do not speak to strangers about their issues. They do not just “pour” their hearts to strangers. Also the issue of massage, people do not allow strangers to touch and “play around” with their “sacred” bodies, more so if it’s a man massaging a woman. It is unheard of, within the African cultural perspective. One community leader said:

- *“...like counselling...is not our culture...because we don’t just go to a stranger and pour out our hearts; we don’t do that. We are used to talking to friends or talking to family...Or even massage, you know; it’s not our culture to be touched by someone.... Whom you don’t even know. So especially if it’s a man touching a woman; it’s unheard of...Yes, to be touched...it’s taboo...So all those things– we know very well that they are very beneficial to someone’s health but then they’ve got to be introduced well...” WCLI 1 p. 173.*

Health Check-ups

Culturally, the concept of health check-ups is uncommon for most Africans. In the majority of cases people only visit the hospital or the doctor when they are really sick. A community leader said:

- *“...where we come from, we are not aware of these health checks. We don’t know it’s important to be checked – your heart or your prostate or anything. We don’t do that. So as a result we don’t really go...until it’s too late...” WCLI. p.179.*

Culture and Religion

Although Islam is not a culture but a religion, it was mentioned that generally African Muslims prefer to have health promotion initiatives within their

religious settings and environment. They feel uncomfortable, especially women, if these health promotion programmes are held in open spaces like football grounds and stadiums. They will be even happier if programmes are held within their society:

- *"..Generally, African Muslims want the health promotions to promote within their Islamic environment or Islamic culture; not to promote within the mainstream; like, open spaces. Football fields.....in schools. So that's one of the things that they are very conservative... ..they're happy with the programme but they want it to be promoted within their own society..." WCLI 2.p.184.*

Cultural Approaches in Treatment of Mental Illness

In New Zealand the issue of mental health is handled differently than it is in African communities. They approach it within the medical context and they have proper medical names for mental illnesses like depression, psychosis and others. Also in New Zealand mental illness is not something to be ashamed of. From an African perspective, mental illness is mostly treated within the spiritual context. Either a spiritual healer or a priest or a sheik is consulted to cure and deal with mental illness. People tend to hide their mentally ill relatives. This malady is considered to be shameful; it brings disgrace to the family. One community leader said:

- *"..And you know, in our culture there's also that whole other area of perceived illness;.....mental issues....,it's sort of different; that people might be treated differently back home than they were otherwise here in NZ..."...here (NZ) the mental illness is understood within the health context and the doctors have names for different types of health illnesses;....depression, psychosis....So it is sort of treated within that whole health profession whereas for us back home in Africa there are still some types of diseases– especially mental diseases– that you wouldn't then go to a doctor for.... There is either your religious person (the priest or sheikh) or a traditional doctor..." HCLI 2 .p.273-4.*

Cultural Taboos: Women Walking Club/ Physical Exercises

Some African cultures do not allow women to participate or to form walking clubs as a way of physical exercises, just as most Kiwi ladies do. This is considered a taboo for woman to walk around and especially if they are to put on sportswear apparel which is often tight fitting and exposes cleavage. A service provider said:

- *“....You know, so this programme has had to allow them somewhere to go to exercise and we’ve had feedback that ...we’d sort of say, well why don’t you make a formal walking group or something and that’s a very Pakeha way of looking at it. And they’d say we don’t really want to walk around the neighbourhood as women, you know; they give their cultural view back to us and we learn from that. Like, we suggested things and.....they said ‘no, we don’t do that because of different cultural ...” SPI 4.p. 156.*

Conflict: Circumcision Practices and Moslem Religion

Circumcision comes with some cultural conflicts between the New Zealand medical fraternity and part of the African community (mostly Moslems) who practice this tradition. The community prefers that circumcision be done within the first few days after the birth of a boy-child and yet doctors want it done when the child is around four to six years. This is a source of conflict between Moslem practice and the New Zealand medical practice.

- *“...and there is also some issues with the boys’ circumcision, so in the hospital they willat a certain age, the boy is going to be circumcised but if he’s past that age, it will be very difficult to obey the doctors to do the circumcision for the boys or they may not get very quick so that’s also some challenge...I think when they’re born...the earliest is the best...but the doctors in the hospital, they want when they are... Five or six years....So those doctors who do the circumcision, they say they will be at least seven years and above because that means he can look after himself but at three years or four years it’s very difficult...” SPI 9.p.313-4.*

Male Dominance over Women

One service provider mentioned that she feels male dominance over women within the African culture is tantamount to the oppression and marginalisation of men by men. She said that this has a negative effect on the health of women:

- *“....the challenges, I mean, like male dominance...So you know, in that culture too (African), male dominance really holds a lot of key to, I don’t know, the happiness of the home and their relationship I guess. That’s what the ladies told me. Women are oppressed....” SPI 6.p.246.*

Racism and Discrimination within the Health Sector

Racism and Discrimination: A Key Health Promotion Challenge

African community members in New Zealand face racism and discrimination from health professionals. The issue of racism and discrimination was identified by all 20 community leaders (100%), more than 50% of service providers and all focus group members as one of the main health promotion challenges faced by African communities in New Zealand.

One service provider stated that there is overt or open racism within the New Zealand public health system. She gave an example of how family health initiatives for the African communities are hugely different and poorly funded compared to the ones for Maori and Pacific people. It was mentioned that this was based on racism. She stated that this was a big issue which needs to be addressed:

- *“..I think that there is definitely racism in NZ. I think there’s quite overt racism in NZ. I think for example there are some really good matches in terms of how family health is approached between Maori and Pacific and some refugee communities; particularly African communities. ...and a lot of that is based on racial misunderstanding and racism. So I think that’s a big issue...” SPI 1 .p.122.*

Racism and Discrimination: Non-African Queue Jumpers

It was pointed out that other people, especially white Europeans are treated with respect and dignity whereas Africans are not given the same treatment. This was classified and deemed as racism and discrimination. It was also mentioned that at times members of the African community are delayed (for hours) for their appointments at hospitals and clinics even if they come on time and latecomers who are mostly white Pakeha are allowed to jump the queue. No convincing explanation is given for these queue-jumpers. Again, this was viewed as racism and discrimination:

- *“Racism and discrimination.... many times, many times, many times – because there is also how you are stared at by the person that you are going to see...how is that person looking at you? And how is he going to treat you?... at times that*

you go there, you booked at 2pm, you are there at 1.55pm and you're waiting and you're going to see people coming at 2.30pm and they're going straight and they see the doctor and you have been sitting there sometimes until 4pm; you're still there.you go and ask and they're going to give you some explanations, 'oh sorry, we're going to see you soon...." ACLI 1.p.11.

- *"...In that case, there is a lot of discrimination and that's where we really complain; that when people come from some European countries, they are straightaway welcomed into the system; no questions asked...there's discrimination and racism in the NZ delivery system when it comes to health promotion..." ACLI 1.p.10.*

Inhumane Treatment: Use of a Stick by a Medical Doctor

One of the community leaders said that at one time he felt so uncomfortable when his family doctor used a stick to examine his foot, yet he (doctor) had his gloves on. The community leader felt that such a treatment was inhumane. He felt that if the patient was European, the treatment was going to be different, for the better. In simple terms, he considered this as an act of racism and discrimination. He said:

- *"...I went to see a doctor. ...he had his gloves on but he couldn't even touch my feet; instead he was using a small stick ...And there was nothing really major with my feet. And that made me feel really, really, very uncomfortable..." ACLI 1.p.12.*

Dehumanising Treatment: Medical Doctors "Holding and Blocking" Nose - Bad Odour

One community leader mentioned that, on many accounts, some of the doctors "hold" and "block" their nose, as a sign of discomfort and negative attitude, when treating some of the members of the New Zealand-based African communities. When African patients are asked to remove or "lift up" their shirts, some doctors are in the habit of "closing and blocking" their nose. This makes patients feel uncomfortable, not respected and under-valued. This was seen and viewed as racism and discrimination on the part of the doctors:

- *"....Many, many times. Many times that's happened and sometimes.... the doctor is going to be maybe talking to somebody who are blocking his noseyou*

lift up your shirt.....and the doctor... starts holding his nose; really closing his nose, which is really uncomfortable. So we've heard those stories many, many times ACLI 1.p.12.

Institutionalized Racism and Discrimination in New Zealand Health System

A community leader categorically stated that there is institutionalized racism in New Zealand, especially within the health delivery system. He encountered racism when he took one of his family members to a hospital for a tooth operation and the doctor on duty demanded an HIV test, instead of focusing on the required tooth operation. The participant was offended and refused to give in to the doctor's demands, which he viewed as racist, discriminatory and senseless. After a heated argument the participant (patient) had to request another doctor to do the operation:

- *"There is still institutionalised...racism in NZ. One nasty experience we had as a family was when we went to Greenlane Hospital. One of our family members had a problem with a tooth and they had to have an operation. And one of the doctors there said 'were you tested for AIDS?.....For HIV, and I found that very detrimental and there was a heated argument...and we ended up saying that ok, we would rather not have the operation or we'll get somebody else who appreciates us as Africans because that doctor was a racist;.....another doctor was called in and then he did the operation...." ACLI 3.p.33.*

A focus group member who is a trained teacher mentioned that when it comes to hiring of staff, there is always a tendency of open favouritism for the local white Kiwis as opposed to people from other cultures. This was clearly viewed as institutionalized racism and discriminations by all focus group members. Despite having higher qualifications, he is still a classroom teacher. He clearly stated that had he been white, he could have been promoted a long time ago. He believes that this did not happen because he is not white. The focus group member said:

- *"..I think I would just comment...like, discrimination is something, like you did your Degree here and there's two people; there's a Kiwi and there's whatever the culture – the first option will be given to a Kiwi person. But we have got*

student loans to pay; we have got everything to pay. So we have to be treated the same; not to discriminate against people because we have got the same qualification....Yes, and we need to be treated the same..." FGI.p.341.

- *"...You have to go that extra mile. I'm actually giving them a hard time at my school. I'm still a classroom teacher and I've got a Masters. The only other person who has got a Master's in education at my school is the Principal himself. They have deputies; the three deputies and the senior teachers, they do not have. And it's actually ...well, because I got it this year...I know that things are going to turn over and change. It can't be the same like that because I'm earning more than my own Deputy Principal, yes, so things have to change. As an African you have to go to such extremes to prove yourself. If I had white skin, when I got my post-Grad two years ago, I already was supposed to be getting promoted to be a Deputy Principal or at least to be a Senior Teacher, yeah..." FG. P.341.*

Racism and Discrimination: African Accent

Another community leader stated that some of the doctors "switch off" and feign to misunderstand the accent of their African patients the moment they see that they look physically different and especially if they are "men of colour". If the name sounds different, some of the doctors "switch off" again. One participant emotionally expressed frustration because some of the health professionals "switch-off" and play the "accent card" even if they are talking to small children who were born here in New Zealand who have a seasoned and perfect Kiwi accent and know the Kiwi culture. He found it weird and hard to believe. He attributed all this to racism and discrimination. He said:

- *"...they are not going to understand you. And if you tell them your name and have got kids that are...young who possibly speak the English with the same accent as the other people here (NZ), but the moment they see that he is different, they probably won't hear him. You have to speak slowly or something.....I don't know. It's weird. Maybe somebody has to do some research and find out what it is. It's a bit weird. But if it's somebody from anywhere; it's completely different....." ACLI 3. .p 43.*

Another focus group member (a trained Teacher) shared with the focus group that he was openly told by a certain principal that due to his strong African accent he would not be accepted to teach Kiwi children. He could not believe that a government school principal would be so racist openly. He said:

- *“..I wanted a job as a teacher post because I’m a trained teacher. I want to say what I’ve experienced. But when I came here I got registered with the New Zealand Teachers’ Council. As a teacher I trained in Zimbabwe. And when I was now looking for a job, I went to another school here in West Auckland. I got in there and the Principal told me that, ‘oh, my friend, with your accent, you can’t teach our children here...’ ..It’s discrimination....FGI.p.340.*

Racism and Discrimination: Based on Skin Colour and Appearance

One of the community leaders (participant), who is a New Zealand trained and qualified Registered Nurse gave her testimony regarding how she experienced racism and discrimination from a receptionist when she visited her family doctor. She mentioned that the moment the receptionist saw that she was African and black, she completely ignored her and did not bother to serve her as she did to others:

- *“Actually the receptionist, the moment she saw me....that I’m an African or I’m a black person, maybe my colour...and she did not pay any attention to find out what I needed and why I was there. To me that was a bit of an issue...” ACLI 4.p.48.*
- *“.....But coming into NZ, I think just the fact that people see you are that different in terms of even your appearance, your colour, you know...they feel, oh, you are coming from that hole ...where you don’t have enough resources...” ACLI 4 .p.55.*

Racism and Discrimination: False Perception on Health Service in Africa

The same community leader (New Zealand trained Registered Nurse), stated that some of the health professionals think that access to health services/facilities in Africa does not exist. She mentioned that such an attitude and perception is unprofessional, wrong, unfounded, unacceptable and unethical within the health fraternity. She also said that some of the New Zealand health professionals think that members of the African communities should consider themselves extremely lucky to call New Zealand their home;- which she dismissed as baseless and unfounded. In comparison, she stated that some of health facilities in her home country in Africa are more accessible than here in New Zealand. She also mentioned that such a mentality and habit of classifying patients as Africans (or based on race) is tantamount to a negative attitude, racism and discrimination towards patients:

- *“Yeah, I think there is a bit of that issue (racism & discrimination) ...because when people see you as an African, not really people but in a medical field, when you get to the hospital or maybe a medical clinic, people think you are coming from where accessibility to health services is very low or very poor therefore their attention or their support to us here is very low because they think you are in a country by your opportune you know, or you are privileged to be here to have some of these services....Definitely (racism & discrimination).....; they think our health facilities or health services where I come from, Africa, they think it's very low whereas they've got a very wrong perception because where I come from, health services and health facilities are available and accessible and are reachable....But here they make it very difficult with that mentality; that perception that we are Africans....”ACLI 4.p.48.*

All members of the focus group agreed that there was racism and discrimination within New Zealand health sector. The difficulty in understanding the Kiwi mentality was noted to be the main problem in addition to the myth that there is a lack of good health facilities in Africa. Some focus group member thought that they were being judged solely based on the colour of their skin- as black Africans. Some of the focus groups members said:

- *“..Sometimes, like we're being treated, like, not fairly because we are Africans.....” FGI.p.330.*
- *“..They think Africa is just a jungle...They think we do not have some of these basic medical needs for the people.....We've got the cards for the children from birth up to nine months; immunise every stage of immunisation. But here it's different. But they don't take it into perspective to show that these people have got the same system the one they have here. Maybe we have got the better ones. It's only maybe the issues of people...of taking blacks as the last race or whatever in the world. So I think they need to learn now that we are all the same.....I think it's discrimination. FGI p.334.*

New Zealand Health Professionals' Lack of Exposure: Stereotyping and Under-estimating health Care Systems in Africa

One of the focus group participants told the meeting that New Zealand health professionals have a propensity to look down upon health care systems in Africa. All focus group members agreed to this motion. However he gave a personal testimony indicating that some of the health care systems in Africa are more advanced than the ones in New Zealand. He told the focus group that his wife who is currently pregnant had a heart operation in Zimbabwe some ten

years ago and is presently using a heart-valve system. The health professionals were surprised and astounded.

Given her condition she was not supposed to get pregnant .But she fell pregnant in Zimbabwe (10 years ago) and successfully gave birth to a healthy baby boy who is now about 11 years old and currently living in New Zealand. The New Zealand medical doctors could not believe it. The couple had to physically present their 11-year old son to the doctors. Seeing this young healthy boy who was delivered in a hospital in Zimbabwe (a third world country), posed a big challenge to the New Zealand medical doctors. Now if his wife goes to see midwives for medical check-ups, a specialist physician has to be present as part of the medical team. This event exposed the ignorance of some New Zealand health professionals with regards to the health systems in third world countries. It was also mentioned that the first-ever world heart operation was successfully done in South Africa, which is classified as a third world country:

- *“....My wife, she’s expecting...and she has had a heart operation done (in Zimbabwe), which actually, after it was done, they prohibited her from having children. And now in NZ, when she got pregnant, the NZ medical practitioners...said it’s impossible; it can’t happen. But then when we presented our first son, they were shocked to realise that this son was born even after that operation. And it was done in Zimbabwe, you know. So to them now, when she visits to see the midwives, a physician has to be there, you know. Actually, they’re starting to appreciate now that oh, to them now it’s a challenge; that if they fail to perform here, they’ve been challenged by an African doctor. Yeah, it’s a challenge now. Yeah, so some of them – they’re just not exposed. It’s about exposure. Just on the issue of exposure as well; I think you all know that the first heart operation in the world was done in South Africa...”FGI. p.335.*

Racism and Discrimination: Misleading Information about the Goodness of New Zealand verses the Reality on the Ground

A community leader commented on New Zealand, as one of the best places to live and raise a family. However, the reality on the ground shows a completely different picture. There is a negative perception and attitude embedded within some of the New Zealanders towards Africans. This makes it difficult for

Africans to feel that they belong to this country (New Zealand). It negatively affects their settlement process and removes that sense of belonging to a country they have chosen to call their permanent home. She said:

- *"...you know, when you look at NZ, let's say on the Internet or you do some research regarding NZ, there is that attractive information. You look at it as a place where you would like to belong and where you would love to visit and stay for the rest of your life. But coming into NZ, I think just the fact that people see you are that different in terms of even your appearance, your colour, you know...they feel, oh, you are coming from that hole ...where you don't have enough resources..." ACLI 4.p.55.*

Racism and Discrimination: Belief that Africans Live in Holes and Trees in Africa

A community leader lamented that some of the New Zealanders are racist and think that Africans live in "holes" and "trees" in Africa. This is a mere perception which, unfortunately, some of the Kiwis have come to embrace as the truth. This is mostly fuelled by the unbalanced media reports, both electronic and print media:

- *"but coming into NZ, I think just the fact that people see you are that different in terms of even your appearance, your colour, you know...they feel, oh, you are coming from that hole ...where you don't have enough resources..." ACLI 4 .p. 55.*

The focus group members stated that the other reason why racism and discrimination is so strong against Africans in New Zealand was attributed to the bias of Television (TV) documentaries which portray negative coverage concerning Africa. Some of these negative documentaries give a perception that all Africans do not live in proper houses but in slums or in extreme cases just in the jungle like animals:

- *"..I have to say, to change the perception, I think the documentaries that come up on TV or wherever people watch, it just shows this kind of Africa where people live in a jungle or people live in slums. I mean, obviously it's definitely happening but it doesn't show all the sides. That's why everybody's got a perception that, you know, Africa's just a jungle with the slums and everybody who comes from there....you know, some of them are surprised at 'oh, you speak English', like at school, You win a prize because you speak English because anybody can...I mean, it's not really rocket science..." FGI.p.334.*

Racism and Discrimination Experienced by African Health Professionals from Local Kiwis

At times African health professionals experience racism and discrimination from local Kiwi patients. On the one hand African patients suffer racism and discrimination from local New Zealand health professionals. This was likened to a situation where Africans (both health professionals and patients) find themselves between the “devil” and “hard-rock” when it comes to racism and discrimination within the health delivery system in New Zealand.

One of the African community leaders who was a participant in this study and works as a manager at one of the main District Health Boards (DHBs) hospitals testified about how she experienced racism and discrimination from a white Kiwi patient. The patient had to ask to be served by a “real” manager as he did not believe that a black African can be a manager at such a big and mainstream DHB hospital in New Zealand. In the end, the patient had no choice but to be attended to by this African manager. This did not go down well with the manager concerned as she felt racially discriminated. She said:

- *“.....I’d say its racism because I’ll give you an example. I was working in a job (as a Duty Manager) at some stage and somebody came in and was looking for a manager and I was managing at that place at that time. And that person didn’t want to talk to me. He decided to walk around and look for a “real” Manager—that’s what that person said to me. And I said ‘that’s fine; you can walk around and when you find that “real” Manager, then he can sort your issues out... so at the end of the day, he came back because there was no one else. But then it was that whole... discrimination thing and racism. Just somebody looking at you and thinking how can you be a Manager in this country or in this place.....?’” ACLI 6.p.68.*

Racist Attitudes and Tendencies by Health Professionals towards African Patients

More than 50% of the focus group members had touchy personal testimonies regarding the manner in which they have been handled and treated by health professionals in New Zealand, especially Midwives. One focus group member lost a baby due to what he called the recklessness of a midwife. One nearly lost a baby who was born pre-maturely (five months) mainly because of the

negative attitude of a midwife. The other one said he had his son (about 4 years old) tested for HIV because he was African and thus was likely to be carrying the virus.

Another focus group member had to deliver his own newly baby-born in his own house simply because a midwife could not listen to him; that his wife was about to give birth. All these cases were reported to the hospital authorities but no action was taken against any of the staff members. When asked what could have happened if such acts were committed by an African midwife, all members of the focus group stated that she could have been possibly fired, struck off the professional register and mostly probably jailed and deported after serving a jail sentence. The focus groups members agreed that this was an example of discrimination based on race; practiced by the New Zealand health professional targeted at African community members. He said:

- *“...when my wife was about to have the third child... she was about 37 weeks pregnant and she visited the midwife...and the midwife just labelled my wife that because we were from Africa they would just quickly run you through,...So not knowing that the baby had died in my wife’s womb for more than three days and the midwife assumed that the heartbeat was a child’s heartbeat. So the very day that my wife came from the hospital, in the night-time, around 12.30 AM, just crying .., and I said ‘wow, my God’, the baby’s about to come. And lucky, we went for the scan and it was a girl. So we were looking forward to the girl. And it was too hard so I took her to the hospital and they did a scan and everything and it was like... “the baby has died in the womb for more than three or four days”. And I challenged the doctor and said ‘look, this morning my wife went to see midwife in hospital so what is happening here?’ and he said ‘maybe the midwife didn’t check it well, this, this. .., when the report came, it said that the baby had already died more than four days. The midwife failed to check well because she was just rushing; because ‘an African, why should I waste my time on you to check everything?’ So maybe it’s about time, the health people, you know, to wake up and treat....social justice...to treat everybody equal...” FGI.p.329.*

Unfriendly Attitude by General Practitioners: Absence of Family Doctor

Another community leader mentioned that her family doctor is friendly and accommodative but she finds it hard dealing with other doctors (at the same clinic) when her family doctor is away. She stated that this difficulty was mainly due to negative attitude displayed by some of these doctors towards her and her family members:

- *“...They (doctors) are not open to work with other ethnicities so I have found it difficult to see other doctors. My family doctor is friendly and I feel warm when I go to see him and....I can explain everything ...But for others it’s really, really challenging and hard...” ACLI 5.p.59.*

Racism and Discrimination: Refugees Stigma. Getting “Everything” for Free

A service provider indicated that there is racism and discrimination in New Zealand especially targeted at Africans, especially those with a refugee-background. Some of the New Zealanders think that refugees are getting everything for free and are a burden to the state coffers. There is a perception that all refugees are on the dole- and they do not want to work. They are deemed to be lazy and parasites on taxpayers. She finally attributed most of this negative attitude to the stigma attached to refugees:

- *“....I think there’s a lot of racism out there around African communities. And I think also with the refugee stigma as well-it like ‘why are we taking in refugees?’ I haven’t heard as strong a comments as some of the stuff I hear coming out of Australia but I’ve still heard comments around ‘why are they getting everything; all these bloody refugees; they come here and they just go on the dole and they take all this and that and they seem to get all this extra stuff.’...” SPI 1.p.123.*

Somali Women Swimming Group: Racially Abused

Another service provider who facilitated a swimming programme for some of the Somali refugee women from the African community, as part of an integration settlement initiative, faced stiff resistance from local white Kiwi ladies. Surprisingly, these Kiwi ladies were manning the swimming pool facility. The Kiwi ladies made some racial and discriminatory utterances against the African ladies. Some were complaining why one of the Somali ladies had a cell phone as they thought that all African refugees were poor. Such comments worried the service provider in a big way such that she had to arrange some appropriate training so that the swimming pool staff could understand what some of these refugees had gone through in life. The service provider said:

- *“....the staff of the facility (Mt Roskill Swimming Pool) was a challenge actually.we had to actually provide them (White Kiwi staff) with training on the refugee experience because they were making discriminatory comments as well as being bossy and just didn’t understand...’oh, why has that girl got a*

cell phone? I thought these people were poor.' And we said, you know, that's a major...it's actually a discriminatory assumption you've just made and it was a worrying comment to me because I think I heard her say it. And yeah, things like 'oh, they're spending too much time in the showers. What are they doing in there?'" SPI 4.p.157.

Racism and Discrimination: Community Funding

Another service provider stated when it comes to applying for community funding, there is racism and discrimination in New Zealand. He further indicated that if the applicant's skin colour is different from the mainstream white New Zealanders they do not get the same opportunities. Again, he mentioned when one's name sounds different and suggests that it is a foreign one; funders will be reluctant to assist:

- *"..But with the discrimination first of all, when you call to put an application in, they hear your accent and they will say 'oh, we will call you back.' But that will not happen. That will be the end. The second – if the colour of your skin is different you will not get the same opportunities like the mainstream white people will get. If you are black as myself.....And there are lots of other...for example, if your name is Mohammed or Abdul, they will be a little bit reluctant as well...."SPI 5.p.162-3.*

Racism and Discrimination: Employment Issues

Although this is a separate issue, another service provider made it plain that there is generally racism within New Zealand when it comes to employment matters. He said apart from the requirement of local New Zealand work experience, employers' base employability on skin colour and one's appearance. He deemed this as racism and discrimination. He said:

- *"...I think there are a lot of factors. First of all, their experience; employers always give excuse because you are not experienced in NZ. And sometimes their colour; because they feel that they are a different group. So yeah, yeah there is racism." SPI 9 .p. 315.*

Housing Issues as a Challenge to the Promotion of Health within African Communities

Wet, Dirty and Dumpy Houses

Though the community leaders appreciated the accommodation provided by the New Zealand government (through Housing New Zealand Department), they felt that at times the houses are not suitable. Some of them have dirty and wet carpets causing diseases like pneumonia and colds to children in particular:

- *“So ...the house in which they’re going to live... they have to save power; the house is going to be cold. The house is going to bring a lot of diseases into children mostly; and pneumonia and other situations. And the house itself in which people are going to live is not going to be a high standard house because of the lack of employment. The carpet sometimes in the houses of Housing New Zealand – the carpet can be very, very old and dirty...” ACLI.1.p.9*

Some service providers mentioned that some of the houses (Housing New Zealand) given to refugees are not suitable for human habitation as they are old, too cold and have moulds. This leads to sickness like allergies and asthma:

- *“....some of the housing in NZ is old houses. They have moulds, they don’t even have insulation...they are too cold. Sometimes...so some of these families develop allergies, asthma; you know, a lot of health problems....” SPI 2.p.133.*

Some of the focus group members indicated that though the houses provide by Housing New Zealand are far much better than the refugee camp accommodation, there was however need to improve some of the conditions, like warm house and clean carpets. The issue of ghetto style settlement was discouraged by focus group members. Again this area was not properly explored main due to time constrains.

Ghettoized Settlement

The issue of ghetto style settlement, thus, allocating residential areas for the refugees in concentrated areas was raised, in particular for the Somalis. It was mentioned that if this “ghetto “system is not properly managed, it can cause problems later as people will begin to feel that they have been segregated and

settled in poor residential areas. Duken (1998) pointed out that when ethnic minorities become more visible and are concentrated in a particular place, ethnic conflict may occur. The USA is a good example on this matter (Duken.k, 1998). One community leader said:

- *“...Housing, again... particularly the Somali community and other refugee background....housing...is highly congested; it’s small, it’s damp; it’s decaying. And it’s not in a good area. Again, that feeds into the whole wellbeing of the community. And yeah, it is a big problem. It is a big barrier if the house is not good.....”WCLI 6 p.238.*

Smaller Houses

Some of the state houses (Housing New Zealand) are too small for bigger refugee families. From an African perspective and custom, your cousin and aunts are part of your nuclear family. We believe in the principle of extended family as opposed to the New Zealand’s nuclear family philosophy. This cultural way of viewing the family concept is at “cross-roads” with Housing New Zealand policies. The quality of a house one lives in determines one’s quality of health, education, social status and wellbeing:

- *“...for instance, we live in extended families. Your cousins are your sister and there are rules within Housing New Zealand that don’t cater for that and you have problems with housing.....” WCLI 6 p 232.*
- *“...I mean NZ is very small, traditionally...the houses are built for the mainstream. African communities are mainly big communities so 4-5 bedrooms is the minimum house...so that is not there so they will take whatever is available because of their housing needs. And you know, it is very hard to get out of that situation. And then that impacts on the quality of education for the kids, quality of health. You know, it touches on everything, yes. And then once you fall sick...you get depressed and...so it is very bad...” WCLI 6 .p238*

HIV and AIDS Related-Stigma as a Challenge to the Promotion of Health within the African Communities

HIV and AIDS related-Stigma

The theme on HIV and AIDS related-stigma was on the bottom of the list (number eight). As reported before, one community leader felt that he was stigmatized of HIV/AIDS by health professionals (Medical Doctor) when he took one of his family members to hospital for an a tooth operation.

HIV/AIDS Associated with Shame and Promiscuity

It is generally taboo to talk openly about HIV and AIDS because this scourge is associated with promiscuity and prostitution. This adverse effect has a negative impact on the African communities in New Zealand. One community leader said:

- *"..I mean, even HIV/AIDS, you know nobody wants...the shame is still there; the taboo is still there..." ACLI 7.p.77.*

Churches Playing a Pivotal Role

In sharp contrast to the above statement, one community member said that she openly talks and teaches children and congregation members about sex and HIV/AIDS in her church. It's important for people to know about issues like prostitution. A community leader said:

- *"...it used to be taboo to talk about sex in the church. Well, from our church, we are doing it. I teach the children... I talk about sex and I talk about prostitution...." ACLI 7.p.78.*

Targeting Africans with Jail Terms

Some of the community leaders expressed concern that a number of Africans have been jailed in New Zealand after been accused of wilfully passing the HIV virus to others. This becomes magnified if it involves an African man infecting a

local kiwi lady. What worried some of the community leaders is that Africans still became victims even if protection was used (e.g. condoms), since the New Zealand law stipulates that if a person uses protection there is no need to disclose one's HIV status to the other sexual partner. It is not a crime. A case in point was cited where an African man was jailed for infecting a local kiwi lady. He then got deported to his home-country after he was released from prison and shortly passed away on arrival to his home country. A community member said:

- *"..Again, xxxx (name supplied) was a great guy but illiterate.... was a young man lost in this country. He doesn't know how he picked up HIV and he got arrested because they say he knew he had HIV and then he has given it to someone else (Kiwi white lady). He spent time in jail and when he came out, they sent him back to Kenya and he passed away..." ACLI 8.p.87.*

HIV and AIDS related-Stigma: Focus Group

HIV and AIDS related stigma and discrimination were briefly mentioned by the focus group members as the biggest challenge faced by the New Zealand-based African communities.

Recommendations from participants (community leaders, service providers and focus group)

Below are the recommendations from all the three groups of respondents-under each separate group:

The community leaders

On the issue of African communities' understanding of the concept of public health in New Zealand and how the system operates, the community leaders recommended, among others, the following:

- The urgent need for New Zealand health professionals to embrace cultural awareness/safety in their practice and acknowledge diversity in New Zealand. A community leader said

- *“....the first thing I think I would say that NZ health professionals could do is cultural safety ...being aware that your own culture is unique and trying to treat every individual according to their cultural needs and beliefs; where they come from; acknowledging those beliefs and treating them the way they want to be treated ...” ACLI 4.p.53.*
- Medical professionals should learn to accommodate all kinds of patients even if they look different and have a different skin colour.
- New Zealand health professionals to spend more time with African patients as they do with any other patients.
- To start employing qualified Africans within the health sector, where there are significant numbers of Africans to work with Africans as they (Africans) are able to understand the culture and needs of their own people. This would be a replicate of “Maori for Maori” Programmes.
- New Zealand health professionals to understand that the African community is growing and therefore the need to be aware of certain African tropical diseases. This will help and assist the length and endless medical tests which are normally expensive.

On the issue of African communities’ access to health services, some of the community leaders felt that the New Zealand system over protects its workers (health professionals) at the expense of patients. There are too many rules and regulations binding the health professionals from effectively executing their noble duties. They are too sensitive to the requirements of the law and hence been afraid of doing their work properly. One community leader said the following statement:

- *“Like I said, there are a million rules. Yeah, they need to streamline some of these rules. They need to streamline so that they are manageable...“It’s like the medical fraternity is trying to protect themselves more than looking at the patient and addressing the issues that the patient has....“They have to protect themselves first before they attend to the patient, .So they look at the legalities of things when a patient has visited them, first, before they look at the welfare of the patient...” ACLI 3.p.39-40.*

On the issue of English language as a main barrier and challenge to accessing health promotion, some community leaders recommended that professional

interpreters should always be used, especially at GPs clinics. They opposed the use of family members especially children.

Regarding the issue of spirituality and traditional beliefs of African health consumers, it was recommended by some of the community leaders that it is important to respect other people's spiritual beliefs.

- *".....give them a space to allow them to have a space for spiritual; to let them connect; to let them have that relation among themselves...."ACLI.6.p.63.*

As regards the issue of culture, some of the community leaders suggested that New Zealand health professionals should respect other people's cultures. In addition they suggested that it would enhance cultural understanding if qualified Africans are employed to work with their people (Africans). Still on culture, it was also suggested that New Zealand Customs Department should allow people to bring in their own food from their country of origin as a way of maintaining their cultures and also enjoying the food they are used to.

However when discussing such issues there is a need to take into account the by-laws that deal with certain diseases that can be caused by bringing some of the foods in to New Zealand from other countries.

One community leader suggested that as Africans it is important to have a meeting place where people meet and openly talk about cultural issues as a way of helping the community. Some of the community members have issues that need to be unpacked through sharing with others as this has an adverse psychological effect.

It was also suggested that Africans should be more involved in issues that concern them as a way of keeping and maintaining the culture, for example employing Africans to work with Africans. This is similar to the "Maori for Maori" and "Pacifica for Pacifica" programmes. A recommendation to replicate the New Zealand AIDS Foundation (NZAF) African Health Promotion Programme which is staffed and managed by Africans only was suggested.

- *“...what I only know about is the HIV (NZAF); that’s the only programme that... really looks at Africans for Africans.....It is for Africans, delivered by Africans.... But that’s very little compared to what Pacific have and Maori has. We want something like that.....” WCLI 1.p.179.*

As a way of preserving the African culture it was recommended that New Zealand medical doctors have some cross-cultural component (embracing other cultures) in their syllabus during training.

On racism and discrimination the following recommendations were suggested by the community leaders:

- Educate New Zealand health professionals on the importance of eradicating racism and prejudice against Africans:
 - *“...I may suggest.....should educate the health providers on cultural sensitivities and also really to try to eradicate the racism and the prejudice that people have against people coming from African communities....” ACLI 2. p.14.*
- African people to get involved and be heard. To some extent, be aggressive to force change, where necessary.
- NZ health professionals to be more cultural sensitive and supportive when dealing with different cultures.

On housing, some community leaders recommended that the houses provided by Housing New Zealand should be warm and the carpet should be clean and dry as this will avoid allergies and other diseases, especially affecting children. It was also mentioned that care should be taken not provide accommodation for people in “ghettoes” as this may cause problems like violence, in the future.

However, it is important to note that some of the African refugees were living in tents in refugee camps, before coming to New Zealand, so greater caution has to be put into account when talking about the issue of housing in New Zealand. To these refugees, houses being offered by New Zealand Housing cannot be compared with tents there were living in, in the refugee camps.

Service Providers

The service providers made the following recommendations on the issue of the concept of Health Promotion in New Zealand and how the system operates:

- To start employing qualified Africans within the health sector as they (Africans) are able to understand the culture and needs of their own people. This is a replicate of the “Maori for Maori” and “Pacifica for Pacifica” Programmes:
 - *“...like, you know, there should be—like they say, Pacific for Pacific, Maori for Maori; so there should be an organisation that is “Africans for Africans”..... because you know your culture better than any of us so I guess that through workforce development, every organisation – mainstream, Maori or Pacific – they should have an African person working for them within that organisation to be able to tell us exactly how to work and the needs, you know; the needs for that community...” SPI 6.p.243.*
- An understanding of the community structures (stakeholder and key persons) and community politics. It is important to have checks and balances in place to ensure that what the community leaders are saying is representative of the community members themselves. At times community leaders may champion and push their own agendas and interests at the expense of the communities
- Have a “One-stop-shop” for health services where community members can access services, like Work and Income New Zealand (WINZ), Revenue Department (IRD) and Housing New Zealand at one place without travelling long distances. Mothers with babies can have caregivers looking after their babies while they access services. This will encourage people to utilize the facilities and at the same time give them a good access to health services available. This is similar to a UK programme (Department of Health (UK), 2004).
 - The need to have meaningful conversations with the communities.
This will benefit the communities as they will likely be kept informed and knowing what is happening.

- Face-to-face community engagement (oral communication) - as opposed to just sending in newsletters which are not read in the majority of cases.

On access to health, some service providers made the following recommendations:

- A long and reasonable period of time to apply for community funding, say three years as opposed to just one. The shorter the period, the more pressure it puts on the need to look for funding instead of planning, implementing and evaluating/ reflecting on projects for the benefit of the communities.

On culture, some service providers recommended that there is need for service providers to consult African communities before they roll out any project(s) that affect the community:

As regards proficiency in English, some service providers recommended the use of professional interpreters as opposed to the use of family and especially children.

On spirituality and tradition, some of the service providers recommended the importance of respecting and recognizing spirituality as an effective way of promoting health promotion within the African community.

On housing, some of the service providers recommended warm houses with good ventilation as opposed to dilapidated houses.

Focus Group

The focus group made the following recommendations on the issue of the concept of Health Promotion in New Zealand and how it operates:

- Medical check-ups- as we have our six monthly warrant of fitness on our car, it was recommended that community members (Africans) should have regular medical check-ups.

On the issue of racism and discrimination the focus group recommended that New Zealand health professionals should learn to treat other people (Africans) fairly, with dignity and respect- not to practice racism and discrimination. This was evidenced clearly by some personal testimonies given by some of the focus group members. One of the members lost an unborn baby due to the recklessness of a Midwife in one of the hospitals.

- *“...I just think these people in NZ need to be treated the same and for the people who put more effort to go to school ...and graduate in NZ, and when you apply for a job, they don't have to look at the skin of your colour; they need consider the qualification and offer the job to the person who is suitable, full stop...” FGI.p.342.*

The importance of culture was raised by some of the focus group members. They mentioned that culture plays a pivotal role in the health of people and therefore New Zealand health professionals should be embracive and inclusive when it comes to the issues of culture.

On the issue of English as a barrier, the focus group members recommended the use of trained and professional interpreters. The focus group members condemned the use of family members and especially children.

On spirituality and tradition, the focus group members indicated the importance of spirituality and use of traditional medicine in the promotion of health within the African communities.

As regards housing, some of the focus group members mentioned that some of the houses offered by Housing New Zealand are small for some of the big African families.

Similarities on recommendations for all participants (community leaders, service providers and focus)

Some of the similarities on the recommendations by all the above three groups were:

- The need for members of the African community to understand how the New Zealand health system works.
- New Zealand health professionals should not practice racism and discrimination when dealing with the members of the African communities. Non-judgemental attitude of New Zealand health professionals to members of the African community is crucial
- The need for the New Zealand health professionals to embrace and be aware of cultural issues for the African community members.
- Employing qualified Africans to work with African people in New Zealand- where it is justifiable and within reason.
- The importance of understanding community politics.
- Use of trained and professional interpreters. Not using family members, especially children.
- Recognizing and acknowledging the importance of spirituality in people's lives.
- Need to have suitable houses which do not cause health problems later, especially for children (e.g. dumpy areas, cold houses, ghettos and wet/ dirty carpets).
- Keeping communities informed of key projects that affect them.
- Need for African community members to go for regular medical check-ups.
- The importance of having longer funding contract periods for community development by government agencies, as opposed to one year circle of funding.

Differences on recommendations for all participants (community leaders, service providers and focus

There were no major differences on the issues raised by the three groups (community leaders, service providers and focus group). All groups raised almost similar issues and agreed on the approaches and recommended solutions regarding key health promotion challenges faced by New Zealand-based African communities.

Some of the recommendations on the Health Promotion for Africans in Developed countries

According to Carr-Hill (2007), the following recommendations are suggested in order to influence change to the public health and health promotion practices in areas where there is a significant population of the black Africans in developed countries:

- Interventions need to be culturally specific to the community being targeted. This culture can be based on a range of factors, including age, gender, belief, locality, language or community of interest, in addition to country of birth, ethnicity or race.
- Racism can have a negative impact on the mental and physical health of minority ethnic communities, including African and Caribbean populations. As such, tackling racism and discrimination should be recognized as a significant public health issue and measures put in place to eliminate it from any public health or health promotion practice.
- Whenever possible, community resources (individuals, community groups, local agencies, faith communities, businesses, buildings etc.) should be utilized in the delivery of health promotion interventions, to secure community ownership and increase the likelihood of sustainability.

- Community-based participatory research can be used as an effective tool to encourage community engagement and leadership in health promotion initiatives. However, practitioners need to be trained and/or briefed on the process, including its aims and intrinsic values.
- Public health professionals should be encouraged to undertake health promotion interventions that seek to empower communities and individuals and create health promoting environments that sustain healthy behaviour change. Potential funders of health promotion initiatives also need to appreciate the additional investment of time and resources empowerment and societal change approaches demand.
- It is important that the cultural diversity of health promotion practitioners reflects the diversity within the local community. However, diversity alone will not improve the effectiveness of the health promotion intervention being implemented.
- In addition to projects that initiate behavioral change, health promoters should be encouraged to develop interventions that focus on motivating individuals to maintain healthy behaviors.
- Health professionals need to seek and pilot new ways of targeting and engaging African and Caribbean men in health promoting activities.
- Due to the lack of available evidence, further research on health promotion interventions aimed at African and Caribbean communities should be encouraged. Study designs should not be restricted to randomized trials, to encourage practitioners to publish pilot studies. However, researchers need to carefully plan their study designs, paying particular attention to sampling and power. Representatives of the target community should be involved whenever possible (Carr-Hill, 2007).

CHAPTER SIX

DISCUSSION

The research question for this study was: what are the key health promotion challenges faced by the African communities in New Zealand? The present study set out with the objectives of identifying and exposing some key health promotion challenges faced by the African communities in New Zealand. The results of this study identified eight key health promotion challenges.

These eight themes will be discussed; taking into account the evidence, similarities, differences and views of all participants. This is called triangulation.

African Communities' Understanding of the Concept of Public Health

The concept of health means different things to different people depending on their socio-cultural contexts (Boorse, 1977).

Most participants mentioned inability to understand the concept of health promotion within New Zealand context and how the New Zealand public health system operates as one of the greatest health promotion challenges within the African communities in New Zealand. The challenge involves issues like navigating and going through the complex bureaucratic health systems, unhealthy food, lack of physical exercises, making appointments with health professionals, long waiting-lists for specialists, and delays at hospital emergencies, especially "after hours". The other challenge was that of non-prescriptions for antibiotic and injections (as a form of treatment). These challenges make life more difficult and complicated mostly for those members of the African community from refugee background, who cannot read and speak the English language.

Similar challenges have been identified within African communities in Canada, France, UK, France, USA and other developed countries (James, 2006). The

facilities are available; the problem is that the African communities have not fully understood the way in which the system operates so as to benefit.

I agree that the New Zealand public health system is not easy to understand in terms of how it operates. Even some of the local Kiwis find it hard to fully understand how it functions. If it is hard for locals, then it will be even more complicated for the migrants and especially refugees; some of whom are illiterate.

However, complicated as the public health system may appear, I believe that there seems to be an element of complacency on the part of some African community members. There is a need for the members of the African communities to take ownership of their health and wellbeing (Cousins, 1997). Thus, they should take the initiative and effort to understand and learn how the public health system operates, and not to expect to be given all the information. It cannot be over emphasised that it is the responsibility of every migrant and refugee, from the African communities to learn about the public health system in the country they have settled in. New Zealand is now their home; so it is important for them to understand how the public health system works. Otherwise they will not enjoy the full benefits. Learning and understanding how the public health system operates, is part of their integration process within the New Zealand mainstream. This includes networking with key individuals and organizations such as government agencies, non-governmental organizations and other ethnic-based health groups within the health sector.

Regarding the issue of unhealthy food and lack of physical exercise, I just wonder, given the plethora of food choices in New Zealand, these people have a choice in what they can eat. They are not forced to buy and eat unhealthy food. As for physical exercises, there are so many footpaths for them to walk and exercise. There are also many “walking clubs” in many residential areas. Any community member is free to join these clubs at no financial cost. Some of the community members still have the mentality that being fat is perceived to be rich. People should do physical exercises in order to remain fit and healthy. There is a culture of physical exercising in New Zealand. I understand that New

Zealand has one of the highest obesity rates in the world. Some of the African community members are responsible for their own predicaments. People should not just expect the government to do everything for them. There is a need for people to take responsibility for themselves. That is what responsible citizens should do.

Participants said that it is not a tradition for most Africans to have regular medical check-ups. How do they know their health status if they do not go for medicals check-ups? In addition to being a traditional way of life, some people cannot afford medical fees for check-ups. However, though I acknowledge that financial difficulties, especially those on low income or not working, may be a cause for some people to ignore medical check-ups, sometimes I think it is a matter of wrong choices and failing to prioritise. Thus, sometimes people use money on less important things instead of spending on their health.

On the issue of making appointments with health professionals, there is nothing much the African community members can do to change the current system. I think the appointment system is good as it does not waste time for either party involved. Just imagine if twenty patients come to visit the doctor at the same time, without appointments; what criteria would be used by the doctor to call in patients for examination? The situation will be difficult to manage. An appointment system is the most appropriate solution. The members of the African communities should therefore make appointments like anybody else in New Zealand. They cannot expect to change the system in order to have a preferential treatment. If they demand to be exempted from making appointments, they will alienate themselves further from the mainstream New Zealanders. In any case, I am aware that in many African countries like Zimbabwe, South Africa and Botswana the appointment system operates well, just like in New Zealand. The only main difference is that one can visit his/her family doctor without any appointment but should be prepared to join the queue and wait for a chance to see the doctor. In New Zealand, you cannot do that. A prior appointment is needed.

Literature review also revealed that most members of the African community, especially from refugee background are not familiar with the New Zealand health care system especially relating to general practice services and formalized appointment system (Ministry of Health, 2001).

I suggest that the District Health Board hospitals should have some strategies in place to manage these prolonged delays. Apart from the fact that these people are sick and need medical attention, it also reflects a bad image for the organization if people are delayed for more than five hours.

One community leader said that as a way of “beating” the system and avoiding prolonged delays, people have resorted to calling for the ambulance services, even if there are not seriously sick, so that they can get attended to quickly as soon as they arrive at the emergency department. If a patient is brought to an emergency department by an ambulance, he/she is attended to immediately. However, they still have to pay for the ambulance at the end of the day. This system of immediately attending to those who are brought in by an ambulance was viewed as ‘queue-jumping’, by some of the participants. It is open to abuse. It also annoys those who have been in the queue. I suggest that the emergency department authorities should not make it an automatic admission for those who are brought in by an ambulance. There should be a system of accessing the degree of emergency.

While there are delays in New Zealand hospital emergencies, especially “after hours” people will finally get attended to. It is important to remember that it is not only the African community members who are experiencing these delays. Everybody in New Zealand is affected. Once people are finally attended to, they get good health care services. New Zealand has better health care facilities than most African countries. It will be unfair for members of the African communities to magnify the challenge of “delays” at hospital emergencies “after hours”. In some parts in Africa, especially rural areas, there are no hospitals. In some cases, urban hospitals do not have medication and other basic medical facilities. I remember a few years ago, when Zimbabwe was going

through economic hardships, patients were asked to bring their own basic medical requirements such as bandages, pain-killers and wound creams.

It was also mentioned that the New Zealand public health system is ineffective. Specifically, the problem of incorrect diagnosis was mentioned mostly compounded by the fact that local health professionals are not familiar with some of the African tropical diseases. It is true that most local health professionals are not familiar with African tropical diseases like bilharzia and malaria, especially those who have not had an opportunity to practice medicine in Africa. While there may have been incidents of incorrect diagnosis, it does not necessarily mean that the public health system is not effective. I believe that the New Zealand public health system is more effective compared to the majority health care systems in most African countries.

It is true that there are long waiting-lists for patients to be attended to by specialists, especially for those who need special surgical operations. However, once one's turn on the waiting-list is due, the health professionals normally do a perfect job. A few years ago I had a surgery in one of the New Zealand District Health Board hospitals. I had been on a waiting list for a couple of months. My experience was that it was worth waiting for. My health problem was fully addressed and now I have completely recuperated. While I do not justify unnecessary long waiting-lists it is important for the members of the African communities to appreciate that these specialist surgeons can only cope with a certain amount of work load.

Complaints were also raised on the issue of medical doctors not prescribing antibiotics and injections to their patients. While it is true that in most cases doctors in Africa administer antibiotics and injections, members of the African communities need to understand that they are no longer in Africa and the environment has changed. Instead of complaining, I suggest they should ask their doctors why they do not prescribe antibiotics and injections. At one time I asked my family doctor as to why he was not prescribing me some antibiotics and the response was that it is better to have the immune system fight the illness rather than getting used to some antibiotics. I believe that proper and

comprehensive answers will be given, if people ask, rather than merely complain.

It was reported that some of the service providers deliberately act as “gate-keepers” thereby making it difficult for communities to understand how the health system operates. The “gate-keeping” element also makes it difficult for the African communities to benefit financially from central government, non-governmental organizations (NGOs) and other relevant sources.

Some of the community leaders condemned the practice and tendencies of some of the service providers acting as “gate-keepers” and blocking the free “flow “of an effective health promotion system in New Zealand for the African communities.

Community leaders suggested that community members should come up with strategies to overcome this problem. One of the suggested ways was for the community members to make an effort to know key and influential service providers.

Strengthening community action involves the empowerment of communities (by service providers) through strengthening social networks and support for social change by providing resources, clear information and learning opportunities (World Health Organization, 1986).

This is not happening and I therefore suggest that service providers take the initiative to involve and consult African communities on matters that concern their health and welfare. This will likely empower and strengthen social networks with African communities.

I suggest that it is the responsibility of the African community members to find out who these “gatekeepers” are. They should also make an effort to build relationships with these service providers who act as ‘gate-keepers”. Some service providers mentioned that at times relationships between communities and service providers, who are supposed to assist them, are non-existent. Communities should rise up to the challenge and initiate relations if they want

to benefit from the system in New Zealand, which is most based on networking basis. If communities do not do it, no one will do it for them. If the African communities simply mourn and complain about how the system works, nothing will change for the better. It will be a generational problem, thus passing on the same problem from one generation to another. There will not be any solution in sight to “fix” this “gate-keeping” problem if the communities do not take up the challenge to address it.

However, I am not blaming the victim (African communities). It may be that the community members are being marginalized, by the system, to an extent that they do not have the will-power and confidence to challenge the status quo.

Some of the government agencies and non-governmental organizations were accused for creating a “dependence syndrome” by giving an impression (to donors) that communities are dis-organized and not ready to take over leadership and management of their projects. Communities have complained about some service providers who do not give genuine training, transfer knowledge and pass on key leadership skills to its members with a hope of continuing to hold on “power” in the name of “capacity-building”. Thus, they try to convince funders that communities still need further training. This will result in these agencies receiving money from donors, for prolonged periods, which at times is not fully used for the benefit of the communities. This is all about capacity-building. Without a clear and genuine capacity-building programme, it will be difficult to effectively engage communities. Capacity-building needs genuine commitment without hidden agendas, especially with the service providers. There should be mutual trust.

In order to minimise or eliminate this problem of “dependence syndrome”, I suggest that service providers should give genuine training, transfer knowledge and pass on key leadership skills to African community members (World Health Organization, 2005).

I further suggest that African community members should demonstrate to donors that they are able to manage projects. They can do this by providing

comprehensive written project proposals. Again this is not easy when some of these service providers have hidden agendas and a propensity to marginalize and disempower communities.

On the issue of lack of employer-assisted medical aids schemes in New Zealand, I acknowledge that some organizations do not have this facility. Such facilities which act in the same manner as an insurance policy are important to have as they become handy when one falls sick. One can receive special medical attention without financial burdens. However, it is important to note that employee benefit schemes in New Zealand are different from those offered in other countries. For example in Zimbabwe, most companies offer all employees this scheme, as part of employment package. In New Zealand most health facilities are provided for free or at a minimum cost compared to most African countries, hence most companies do not offer employer-assisted medical aids schemes. To those who can afford, there are health insurances in New Zealand which people can buy in order to make sure they get the best of health care. However, not everyone from the African communities can afford the cost involved, especially these on low incomes or on state benefit scheme.

The determinants of health move beyond just people's personal behaviours, cultural, social, economic and environmental living conditions, to include community-focused societal factors such as human rights, social justice and equality, active participation in policy development, and empowerment (World Health Organization, 2006).

In my view some of these important determinants of health do not exist for the African communities in New Zealand. African communities are not involved in policy matters even if these policies affect them directly. At times service providers do not consult communities. For any policy to be effective and achieve the intended outcomes, the targeted audience should be involved in the formulation and implementation processes (World Health Organization, 2005).

I therefore recommend that policy makers in New Zealand should consult and include African communities in the decision-making process, when formulating policies that directly affect them, if they want their policies and programmes to be effective and respected by those community members. According to the Bangkok conference in 2005, if affected communities are left out of the decision-making process there is a natural tendency to resist any policy even if it will be for the good of the community (World Health Organization, 2005). Equally the same, the African communities in New Zealand should be involved in all policy decision-making that affect them. This is therefore a wake-up call to the government, through the Ministry of Health.

Matheson (2005) urges that for health promotion to be able to achieve the desired outcomes and reduce health inequalities, partnership between the communities and service providers should be taken seriously. This partnership should be anchored on values such as respect, trust and reciprocity. Furthermore, Minkler and Wallerstein (2003) stress the need of a community-based participatory approach, which will help to enhance and further buttress the relationship between communities and health service providers. Such initiatives are imperative in the process of reducing hurdles in accessing health facilities (Minkler & Wallerstein, 2003). Such relationships and cooperation between the New Zealand-based African communities and the local service providers is lacking and almost non-existent. This is therefore a serious challenge to health promotion within African communities in New Zealand.

In addition, health promotion is not just the responsibility of the health sector but should include all key stakeholders such as government agency and non-governmental organizations. This involves engaging the partnership of all sectors of society including the voluntary and community sector, such as the African communities, and as well as business and philanthropy (World Health Organization, 2006).

In terms of equality, active participation, human rights and social justice, the African communities are disadvantaged. There is no advocacy at government level for the African communities in New Zealand. From Local Boards,

Councillors and Members of Parliament there is no representation for the African communities, yet the African communities in New Zealand are growing fast in numbers. Advocacy is one of the five key strategies enshrined in the Ottawa Charter (World Health Organization, 1986).

In addressing these challenges, it is also worth noting that it is not only the African communities which are facing some of the abovementioned challenges. Other minority communities such the Maori, Pacific, and Asians are also facing similar challenges.

African Communities' Access to Health Services

Participants mentioned that consultation fees for General Practitioners (GPs) are expensive. These fees range between forty to sixty dollars during week days. These exorbitant consultation fees act as a barrier to accessing health services as most community members, especially those from refugee background cannot afford. As a result of these prohibitive consultation fees, many people do not visit GPs. Given a choice, people would choose to go to work where they get paid rather than going to see a GP and forgo a wage. The cost element is therefore a prohibitive factor that makes it difficult for community member to access health services.

While I am aware that the government provides a subsidy in the form of "Community Service Cards" and on prescribed medications, to low income groups, I still suggest that consultations for GPs should be further subsidised; as this will likely improve access to health services. Most of the community members who are on low income or on government-benefit schemes cannot afford these exorbitant consultation fees.

This is likely to increase the rate of accessing health services by the African community members. This will be for the benefit of the community members' welfare and well-being. Otherwise, accessibility to these health facilities will only be for the rich people in the society. Thus, creating the "haves" and "have not" groups in a single community.

On the issue of people reporting for duty when they are sick, I suggest that community members need to be informed of their right to utilise their off-sick days rather than reporting for duty when one is sick. Due to lack of knowledge, some may think that they will get dismissed if they take time off-sick. It is also imperative to educate community members that if they get injured at work they take off-sick and Accident Compensation Corporation (ACC) is obliged to pay them, as compensation.

Some of the community leaders mentioned that some General Practitioners (GPs) are not accessible during weekends as their clinics will be closed. If these facilities are closed, the only places that are open to the public are "After Hours" clinics which are exorbitantly expensive. After 10 pm most "After Hours" clinics will be closed. The only facilities that will be open (after 10 pm) are District Health Boards (DBHs) hospital emergency departments, where prolonged delays are experienced.

In order to improve accessibility to health services and facilities, I suggest that most GPs should be encouraged to open their clinics for at least half a day on Saturdays. I am aware that some of the GPs operate on Saturday mornings, but the ones in my residential area do not. This is likely to result in more people being seen by doctors, thereby reducing the numbers of those visiting both the "After hours" and emergency departments. In most countries in Africa, for example Zimbabwe, GPs open on Saturdays (up to 2 pm). By closing GP clinics for the entire weekend, it forces the community members to visit "After Hours" facilities which charge expensive consultation fees; around NZ\$100.00; as mentioned by one community leader. However, I am aware that the majority of consultations fees are in the range of \$40 to \$60. It is important to note that such amounts (\$40 to \$60) are beyond the reach of the majority of the African community members. Again, in addition to the existing government subsidy such as Community Service Cards system, I would suggest that consultations fees for "After Hours" be further subsidised by the government so that people can have access to health services.

Before any changes are done, the members of the African community cannot change the current system; they are “forced” to adapt to the situation. This will systematically exclude them from accessing the health services.

The referral system is also too involving as one has to go through many myriad levels of bureaucracy. For example, a patient is examined by many doctors. If the referral system is hard for the locals; it therefore becomes even harder for migrants and refugees, especially those from refugee background as they may not be able to communicate in English. They need someone else to help them- a friend or a family member to navigate the bureaucratic referral system.

I suggest that the responsible authorities (Ministry of Health) simplify the referral system, for example by reducing the number of doctors who examine an individual. I also suggest that it will be a good idea to provide simple and clear instructions in other languages for the sake of those who do not understand English (e.g. some refugees) but I am aware that a plan to introduce Swahili was abandoned because the majority of the targeted group would either speak Arabic or one of the existing languages.

Immigration policy was also mentioned as a challenge in the process of accessing health services. For example if a person has been in New Zealand for less than two years, without permanent residency; there is no free access to public health services. It was also mentioned that New Zealand Immigration department makes it difficult for most people who have a legal status in New Zealand (Permanent Residency or Citizenship) to have their parents (from Africa) visit them, yet is it easy for other nationalities.

While it is important to note that each country has its own immigration laws and policies which should be respected, it is equally vital to pin-point elements of these policies that discriminate against certain people. Regarding the above two-year New Zealand Immigration policy, I suggest that if a person has a work permit (legal status) and working, thus paying taxes to the government, he/she should be entitled to free access to health services. DeSantos (1997) argued that some of the immigration policies are institutionally discriminatory

and act as great barriers to health promotion. In New Zealand, this is a health promotion challenge to African communities.

The New Zealand Immigration department has been blamed for prolonged delays in deciding on cases for asylum seekers, some taking as long as five to six years. During this long waiting period, these people are not entitled to access free health services. They have to pay. In addition, they are not allowed to work. They do not get any help from government departments like Work and Income (WINZ). My suggestion is for these people to be allowed to work whilst they wait for a response (DeSantos, 1997). How does the government think these people will survive; if they are not allowed to work and at the same time they do not get any form of assistance from the government? In any case, if they are allowed to work, they will be paying taxes and thereby contributing to the economy.

On Immigration policies, I have heard other members of the public (politicians included) saying that asylum seekers must have valid papers to legally live in the country and should not have free access to health services. Some have even advocated for deportation. I disagree as this is not only a violation of human rights but also a breach of UNHRC Refugee International Convention (1951) which New Zealand is a signatory. People have a right to seek and claim asylum in New Zealand if their safety is threatened; because New Zealand is a signatory to the said international conventions. It will be unfair and inhumane for New Zealand to deny genuine asylum seekers. A case in point is where one New Zealand-based organisation is contemplating to challenge the New Zealand government for detaining asylum seekers in prison (Auckland Refugee Council Inc, 2012). A UK-based Restoration of Human Rights Zimbabwe group challenged the UK government and won a case over plans by the Home Office to deport Zimbabwean failed asylum seekers (Zimbabwe Situation, 2010).

As a former Board member of the Auckland Refugee Council Incorporated (ARCI), we used to handle depressing cases where as an organization we had to rely on the help from community members and well-wishers in order to help

asylum seekers. Some of the asylum seekers were even contemplating suicide rather than risk being deported to their home countries. I have discovered that many asylum seekers do not just leave their countries for the sake of it. There may be a few cases of misrepresentation, but the majority are genuine. I further suggest that since New Zealand is a signatory to the respected international conventions like The United Nation High Commissioner for Refugees (UNHCR) Refugee Convention (1951), Protocol (relating to Status of Refugees; 1967) and the Universal Declaration of Human Rights (1948) they should accept asylum seekers in the country.

Though the issue of not allowing parents from Africa to visit their children in New Zealand is more of a health outcome than a health challenge, I suggest that New Zealand Immigration department should be more transparent when dealing with their clients. I know of many Zimbabweans who are now Kiwis who had their parents denied visitors' visas when they had important family functions like weddings, graduations and birthday celebrations. Such actions cause stress, depression and isolation which are not good for people's welfare and health wellbeing.

Lack of Information to Access New Zealand Public Health System was mentioned as a challenge. I agree that there is insufficient information to Access New Zealand Public Health System. If this information is there, people do not know how to access it. If people do not know how to access such important information, it is likely that they will not be able to have access to the actual services. I therefore suggest that the responsible authorities should make such information easily accessible. It will be even more effective if such information is provided in languages spoken by majority of African refugees such as French, Arabic and Amharic who do not understand English. Such initiatives should include input from African communities. Health promotion actions aim to reduce differences in health inequalities, secure foundation in a supportive environment, access to public health facilities, access to information, life skills and opportunities for making healthy choices (Health Promotion Forum of

New Zealand, 2004). Most Africans in New Zealand do not have access to most of these facilities; hence it is a profound health promotion challenge.

A service provider (from African communities) who works for one of the DBHs mentioned that as an organization they have discovered that many African community members do not know the existence of some important services that would benefit them. He gave an example of respite service where parents with a child who has a disability can send their child for a weekend for care so that they have a bit of rest. This service is for free.

This is a clear example that shows that many members of the African communities are not aware of these crucial free services they can benefit from. I suggest that responsible government departments should make an effort to educate the public about such important services. As part of advocacy work, my organisation (New Zealand AIDS Foundation) does this bit.

It was reported in this study that most service providers, non-governmental organisations (NGOs) and government departments have the propensity to speak on behalf of communities and at times without their consent.

I believe that most communities are not only aware of their problems but are also able to alleviate these problems. I recommend that the affected members of the communities, who know and understand their problems and challenges, be given an opportunity to prescribe solutions, because they know their issues. This is called epistemic privilege (L. M. Chile, 2009). This creates an environment where communities share their knowledge and experience. This will empower the communities. I think that the scenario where service providers represent communities is basically a deliberate and cruel strategy to marginalize and further weaken African communities (Jackson G, 1998).

Laverrack and Labonte (2000) argue in support of a bottom-up approach as opposed to a top-down approach in health promotion and health programming where communities are supported to identify core issues, to develop strategies to resolve problems and issues. As reported in this study, the public health system in New Zealand favours the top-down approach, which is ineffective and detrimental to the communities in accessing health services.

I recommend that when service providers are dealing with the African communities, they should listen to what they say, thus, making use of the recommended bottom-up approach (Laverrack & Labonte, 2000). If the service providers adopt the “I know it all” attitude, nothing will work out.

This study indicated that some members of the African communities in New Zealand are facing mental health problems. Mental health problems are a health promotion challenge. These problems are caused by, among others: inappropriate services, inaccessible health services and culturally insensitive services. This is supported by a study carried out in the UK (Breaking the Circles of Fear, 2002).

Literature review indicated that most Maori in New Zealand do not access health services, which are available, mainly due to the inappropriate manner in which these services are being offered (Smith & Pearce, 1984; Lurie, 2002).

Language Barrier as a Main Challenge to Accessing Health Promotion

The ADHB report (2011) indicated that English language competency is an important factor for integration into mainstream society. Poor English language skills limit access and effective engagement with health and social service providers (Auckland District Health Board (ADHB), 2011).

Participants in this study mentioned that language barrier is one of the health promotion challenges noted. Some people have advocated for the use of interpreters but I think the majority of refugees who cannot speak English have to make a concerted effort to learn the language. This will benefit them as they will be able to converse with the mainstream New Zealanders. It will also speed up their integration and resettlement process. There are many centres in New Zealand where refugees can do an English course (for free) so that they can communicate. This is likely to empower and benefit especially those from refugee background and those from non-English speaking countries. The

challenge that I can foresee is that maybe some of them may be older and not too keen to go back to “school” and learn the English language.

The challenge of English as a language barrier has, at times, caused parents to use their small children to interpret for them when they visit health professionals. This has been condemned by all participants (community leaders, service providers and focus group) as unprofessional, unethical and culturally inappropriate.

While I am aware that it is parents who bring their children to health facilities, for interpretation, I still find it uncomfortable to use children as interpreters. I agree with the fact that using one’s young children is not only unethical and unprofessional, but also culturally inappropriate. In our African culture, children are not supposed to know the secrets of their parents, especially anything to do with private organs. Once this happens, it will adversely affect the trust and erode confidence in the parent(s). This experience may also have adverse and devastating effect on the young children. Some may be traumatised by this experience. I therefore suggest that New Zealand health professionals desist from this inappropriate cultural practice of using young children as interpreters.

I further suggest that if there are no interpreters in person, language line facility should be used. If there is none of these, it is better to postpone the appointment; if it is not an emergency case until a professional interpreter has been found, rather using young children.

In my view, the issue of using other people, who are not trained interpreters, may have a risk of these being perceived as strangers by the clients. This may result in a breach and invasion of one’s privacy and can tantamount to abuse of confidentiality. No one would like to have his or her confidentiality compromised to this extent.

In the study, there was a mention of community gossiping as result of using untrained community members as interpreters. I am aware of a similar case which happened in our community where a community member who was used an interpreter told his friend about some confidential stuff about another

community member (client). The friend told his other friend and it became a chain-gossip until the majority of the community became aware of this matter. Had they used a professional and trained interpreter, this could have been avoided. Therefore, it is clear that it is more prudent and professional to use trained professional interpreters to avoid all the above-mentioned problems. It may sound as if the issue of using young children, strangers and untrained community members are conflicting against each other; there are not. The recommended practice is to use trained and professional interpreters.

Spirituality and Traditional Beliefs of African Health Consumers

Most participants acknowledged the fact that most Africans in New Zealand are religious. Literature review indicated the same scenario in the UK (Friedli 2000). The majority of them believe in the existence and influence of God, the Creator. They use prayers as a major coping strategy to contain both social and spiritual problems. The findings are similar to another study done in the UK (Faulkner, 2000). Some believe in prayer such that if they are sick they pray first before they visit a doctor and others refuse completely to see a doctor but rely entirely on prayer.

I agree with the above statement that most Africans are religious. Most of the members of the African communities I know in New Zealand are either Christian or Moslem. Though I believe in God, I think it is not prudent for a person to entirely refuse to see a doctor when sick and completely rely on prayers. I have witnessed many children predominately from an apostolic sect in my home country dying in massive numbers. Upon investigations, it was discovered that these people did not immunise their children. They simply did not believe in medicine and the hospital system as they believed it was demonic. They regarded visiting a doctor as lack of faith in God. The government had to intervene in order to save the children.

I also believe that the reason why many Africans in New Zealand are religious is to do with the influence from Africa; churches have in recent times become big business in Africa. The Pentecostal movement is growing fast especially in countries like Zimbabwe, South Africa and Nigeria (Bonnke, 2010).

The other reason I think many Africans are religious is to do with poverty. People are poor and do not have resources; the only source of comfort is to believe in God, through prayers.

The findings of this thesis also indicated that most Africans pray to God the Creator, through their ancestors. Similar findings have been reported by Gyekye (1987); according to him most Africans communicate with the supreme God through smaller “gods”. Hence, most African communities would categorise the “spiritual powers and forces” in order of metaphysical hierarchy and importance as follows: God, gods, spirits, ancestors and then humans (Gyekye, 1987).

From an African perspective, many Africans believe in the above spiritual hierarchy (Omonzejele, 2008). Literature review revealed that many Africans are religious and have a firm belief in God and ancestors (Ozekhome, 1990).

In this study, the majority of the African community participants mentioned that the community leaders, and family members also refer members of the community to church pastors and mosque sheiks for spiritual counselling and guidance, especially when it is do with mental health issues.

Research has shown that religious involvement is associated with positive mental health outcomes. A growing number of studies also emphasise the importance of spiritual beliefs and the value of support from faith communities for people with mental health problems (Faulkner, 2000).

I am aware of a case where a member from my community who recovered quickly from a mental-related illness after a local African pastor fasted for a week as he prayed for him.

On the issue of influence, pastors and some of the church members have a huge influence on the members of their congregation within the African

communities in New Zealand. This influence includes their life-style and what they eat. Thus, spirituality plays a significant role in health promotion. This is supported by a similar study in the USA (Young, et al., 2001).

The literature review also supported the importance of health promotion initiatives within faith communities through an exploration of a focus group with African-American women (Drayton-Brooks & White, 2004). The findings revealed that some of the participants believed in God or placed their faith in the power and control of a higher being. Individuals that could influence participants to adopt healthier lifestyles included God, the church pastor and nurse, family and church members and their general practitioner. Basing health promotion activities within a church setting was preferred by most women, explaining that they would feel more at ease and accepted in this familiar environment (Drayton-Brooks & White, 2004).

On the matter of African traditional medicine, most participants in this study indicated that they believe in the effectiveness of the African traditional medicine. They also believe in the influence and the pivotal role played by one's ancestors. The African concept of health and disease are embedded in the African world view commonly known as African Traditional Medicine (ATM) (Omonzejele, 2008). From an African perspective, there are some diseases that cannot be cured by the use of western medical regimes but these need the intervention of the supernatural powers, which include God the Creator and the powers and sympathy of those who have departed (the dead), commonly known as the ancestors (Omonzejele, 2008).

I believe that some of these traditional medicine and herbs work effectively; however they need to be scientifically tested and also uncover the secrecy that surrounds where the herbs are found and how they are mixed and used.

Some of the participants mentioned the use of "holy water" to heal the sick. They believe in the use of "holy water" to be used in the healing process. While I respect other people's beliefs, I struggle to believe that mere water can be used in the miraculous healing process. I think this is nothing but a mere psychological effect. Since when did water become a panacea of all ills? Though

water is important to the human body, I think it cannot be used in place of medicine.

Some participants in this study also talked about the conflict between the African concept of disease, treatment and healing versus the Western medical paradigm. This confirms what Omonzejele (2008) talked about when he stated that the African concept of health, disease, and treatment are best understood within the framework of African metaphysics, ethics, and cosmology. Hence, the African notion of health and treatment cannot be evaluated exclusively by a Western medical paradigm. The use of a Western paradigm for this purpose will inevitably result in ideological, epistemic, and perhaps ethical conflicts with the African worldview of spirituality (Omonzejele, 2008).

I agree with the above statement because I have seen the effectiveness of African traditional medicine and herbs but the western world-view does not recognise them. I suggest that there should be a reconciliation that balances the two world-views, thus, the African traditional medicine and herbs should be scientifically tested and on the other hand Western system should recognise the fact that the traditional herbs are effective.

In this study, there was a mention of the concept of the “evil eye”; this is in line with the literature review on the issue of divination and fore-telling the future, within the spiritual world. Divination, an integral part of African Traditional Medicine (ATM), is the heart of treatment in traditional medicine in Africa (Omonzejele, 2008).

I do not believe in the concept of the “evil eye” because it does not make sense to me that if someone simply looks at you, you will become sick. I have never heard or seen it so it is difficult for me to believe it. I also think that such beliefs make people prisoners of their own faith rather than liberating them and ushering a sense of freedom and emancipation.

As reported in the literature review, the power of spiritual traditions transcends across cultures and races. An example is the 38-year old white South African man (John Lockley) who made history by becoming the first fully initiated and

trained white Sangoma (witch doctor) in the Xhosa lineage of South Africa (Lockley, 2010).

From the above issues, it seems that there is a spiritual world at work which has a great influence on the lives of living human beings. It is clear that the African Traditional Medicine should have a place within the western treatment regimes.

Lack of Understanding of the Cultural Context of African Communities by Health Practitioners

This study revealed that the New Zealand health delivery system is based on a mono-cultural approach; it favours the culture of the mainstream New Zealanders. It does not take into account other people's cultures and beliefs. In simple terms, the system does not recognise and respect others cultures, yet its society and population are composed of diversified people from around the globe. It has been noted that most of the New Zealand health professionals are hugely insensitive to the cultures of their patients. This includes the African culture.

Cultural competence is about knowing, utilizing and appreciating the culture of others in assisting with the resolution of individual, community or family problems (DeSantos, 1997). In order to achieve this competence, I suggest that health promotion within the New Zealand health care system must go beyond the mere awareness of diversity within the African communities. They need to develop the ability to engage with the culture, beliefs, values and practices that build solidarity and agency with the African communities to access health promotion interventions. From the evidence gathered from this study, this is not happening.

I also suggest that the New Zealand professionals should effectively engage with the African communities by learning and implementing some of the cultural aspects in the health promotion delivery system.

This research has shown that some of the key influences on health promotion for the African communities in New Zealand are factors like personal

behaviours, cultural, social, economic and environmental living conditions. There are several ways that can be implemented to alleviate these challenges. The first and probably the most effective one is a concerted effort by the African communities to learn about the Kiwi way. Laverrack and Labonte (2000) argue that community empowerment is a key factor in any health promotion effort.

Community-focused societal factors such as human rights, social justice and equality, active participation in policy development, and empowerment have positive effect on people's cultures and community health promotion (Laverrack & Labonte (2000). Most of these community-focused societal factors have been raised in this study as conspicuously missing within the New Zealand health delivery system for the African communities. I recommend that such critical issues (to health promotion) as social justice and human rights be embraced and be observed, at all times, when dealing with the African communities.

Chile (2011) argues that effective community engagement should involve active collaborations and partnerships (with communities) to draw on local knowledge, experience, leadership and cultural capital. Chile (2011) defines cultural capital as how people view and engage with their world, their environmental philosophy and ethics, their traditional knowledge, and their political and social institutions. These worldviews determine what they eat, and even how they eat, how they work, play, procreate and even recreate. Cultural capital has a critical role in the collective health and wellbeing of the community and its sustainability (L. M. Chile, 2011). Cultural capital impacts on communities' understanding and even their responses to health development initiatives and programmes (Arabena, 2008).

Cook (2001) and Arabena (2008) stated that cross-cultural frameworks for building health communities seek to privilege indigenous epistemologies, science, ethics and values.

It was also mentioned in this study that it is important to understand cross-cultural issues associated with food, as it is fundamental to building healthy

communities. A study of the eating habits and food type among migrants in the UK (Powell & Kahn, 1995), USA and Europe revealed that those who keep as closely as possible to their original diets, food and eating habits were less likely to become obese or develop conditions like cardiovascular diseases (Gilbert & Khokhar, 2008).

Chile (2012)'s preliminary findings on a study of African communities in New Zealand indicated that community groups that have maintained some level of social cohesion and connectedness were less likely to suffer depression and other mental health issues associated with uprootment.

Most participants made some suggestions and recommendations as solutions to some of these cultural challenges. Chile (2009) argues that the community members are the ones most qualified to prescribe solutions as they have walked the journey and know these issues well. This process (of personally walking the journey) is called epistemic privilege.

The study, which is the first of its kind in New Zealand, has shown that there is a need to understand and appreciate the multi-cultural aspects of the growing African community in New Zealand and how it impacts on the theory and practices of health promotion within the health system (Cook, 2001).

The present study has exposed the challenges faced by African communities in New Zealand; these include prejudices, professional health and human services, power and control in health promotion, from the host community. Laverrack and Labonte (2000, p.255) refer this as the tension between "power over the community through top-down programmes and the emancipatory discourses of the Ottawa Charter".

In order to build healthy communities, Chile (2012) advocates for initiatives and programmes that could be mediated through cross-cultural capital such as, among others, festivals, cultural events, dance and music, community arts, explorations of myth and folklore, rituals and rights and embodied knowledge of communities relating to health. Chile (2012) further points out

that health development programmes need to create opportunities to bring members of the community together for critical reflection on some of their “cultural myths” associated with health practices. These “cultural myths” are important sources of local knowledge that enable better understanding of the meanings associated with health practices, but may be easily misunderstood because of differing cultural assumptions. It has been noted that health development programmes that acknowledge and legitimize cultural knowledge empower and enhance communities’ self-efficacy, and increase community participation (Chile, 2012).

Chile (2012) also emphasizes the importance of taking seriously cross-cultural issues in building health communities. This has the capacity to devolve the power of decision-making to the local community to enable them to take responsibility and ownership for their health outcomes. This is likely to enhance the benefits of positive health to the community over an extended period of time. Literature review revealed that UK government developed a strategy by coming up with a Mental Health Workforce that was capable of delivering effective mental health services in a multicultural context, by enhancing and building on the capacity within black and minority ethnic communities (NIMHE, 2003).

Some of the participants mentioned that at times it is difficult for the members of the African communities in New Zealand, especially those from refugee background, to access information via complicated websites, electronic links and brochures. The use of websites and brochures is actually a cultural barrier. Traditionally, most Africans are used to story-telling as an effective way of learning and exploring new information (Banks-Wallace, 1998).

Though I agree that story-telling is an African tradition, it is important for the members of the African communities to understand that they are now living in New Zealand; they have to adapt to the environment and situation. I therefore recommend that the African community members should learn how to navigate the websites. They should also aspire to be technically savvy.

This study also unearthed issues of cultural insensitivity when it comes to health promotion within the New Zealand-based African communities. Similar cases of cultural insensitivities have been reported in the UK (Breaking the Circles of Fear, 2002). There is on-going concern about inappropriate services, non-access to health services and culturally insensitive services.

Participants mentioned that there are no proper supportive environments for the African communities in New Zealand when it comes to cultural and political matters. The cultural values and social norms for the African communities in New Zealand have no impact on the New Zealand main-stream population and politics, mainly because the numbers are still small. The political and economic structures are not in favour of the African communities, at the present moment. On the political arena, there is not a single African representative in either local or central government politics. It is crucial to recognize that decisions that affect health and well-being of the members of the African communities are made at these levels without their participation.

I suggest members of the African communities should develop a keen interest in effectively participating in policy-making processes as well as in both national and local politics. If they do not participate, decisions that affect their lives will be made by other people who, in the majority of cases, may not have any cultural understanding of this population (World Health Organization, 1986).

Finally, according to Carr-Hill (2007), interventions need to be culturally specific to the community being targeted. This culture can be based on a range of factors, including age, gender, belief, locality, language or community of interest, in addition to country of birth, ethnicity or race. There are several African communities in New Zealand but the health interventions are not culturally specific.

Most participants interviewed by ChangeMakers (2011) recommended that doctors and other service providers need to be sensitive to their patients

'cultures and some basic information on the countries where their patients come from.

Racism and Discrimination within the Health Sector

The majority of participants concurred on the problem of racism and discrimination within the health delivery system. Personal testimonies and individual accounts have been given that clearly indicated the existence of racism and discrimination targeted at African community members in New Zealand within the health sector.

I suggest that the authorities within health institutions should take complaints on racism and discrimination from the members of the African communities, seriously. They also need to investigate them and give feedback to the complaint on time.

This racism and discrimination is not only practiced by health professionals but by some of the main-stream patients who do not accept been served by African health professionals.

I recommend that in the case of a racial abuse by members of the public, African health professionals should report such incidents to the relevant authorities. If no feedback is given, they should make a follow up with a view of escalating the case if they are not happy with the process.

In a survey on ethnic disparities among patients in care at major hospitals in New Zealand, discrimination has been shown to be a determinant of health outcomes as it negatively affects one's self esteem and mental health (Rumball-Smith, 2009). Discrimination has the potential of leading to institutionalized racism which in turn adversely affects accessing health services and effective engagement with health service providers. All this leads to poor health outcomes for the African communities in New Zealand which is already marginalized (Rumball-Smith, 2009). Pio (2010) mentions that racial

stereotyping and consequent discrimination has also been noted on personal accounts of refugee and migrant experiences in New Zealand.

Some participants alluded to the fact that they felt alienated and discriminated against by doctors and other service providers in New Zealand hospitals. A report by ChangeMakers (2011) confirmed this.

Again, I suggest that the affected members of the community should report such cases immediately to the responsible authorities.

There are many African communities that have faced racism and discrimination in other developed countries. For example racial discrimination, social and economic exclusion are key problems affecting France as a nation. The famous civil unrest in France (2005) was a direct result of racial discrimination. More than 9000 cars were torched, 2900 people arrested (mostly Black African French) and dozens of buildings, day-care centres and schools destroyed. The estimated financial cost for this racial unrest was around 200 million pounds (French Unrest, 2005).

Today, children of immigrants in France, claim that they frequently encounter economic segregation and racism. They have problems getting a job, or finding an apartment, or even entering a nightclub, because of their names or skin colour. Such discrimination is not even officially illegal as no laws have been passed in the French national assembly to outlaw racism and discrimination (French Unrest, 2005).

Again in France, many immigration laws are discriminatory against African-French. The draft law, part of French President Sarkozy's promised crackdown on illegal immigration, would allow foreigners living in France to use a voluntary DNA test to prove blood lines to relatives they want to bring into the country. This Bill was reviewed by many African-French as evidence of deep and profound-seated racism in their former colonial master (Proposed French Immigration Bill, 2007).

DeSantos (1997) identified problems associated with immigration such as, lack of tolerance for diversity (by host communities), acculturation, stereotyping, and scape-goating of immigrants, discrimination and segregation. These issues have a negative and emotional effect on people's lives and pose health promotion challenges. In Canada many Africans and Caribbean people have experienced racism within Canadian society in general and in particular with healthcare providers. This causes many people from these communities to be reluctant to seek services from these health services providers when there is need to do that (James, 2006).

Research in the United Kingdom (UK) indicated that racism affects mental wellbeing, acts as a barrier to the access and provision of appropriate services (Sashidharan & Francis, 1993; Alexander, 1999). According to National Health Services (NHS) Executive (1998), Black and minority ethnic communities in the UK feel excluded from services because of direct discrimination, the attitudes of staff towards them, or through indirect discrimination such as being unable to access services because of language barriers.

The other African communities in other developed countries are facing similar challenges (Alexander, 1999). This is also in agreement with what Chile (2002) coined as the imported underclass regarding poverty and social exclusion of the black African refugees in Aotearoa New Zealand. Some of these challenges do affect individuals and community groups physically, mentally, socially and psychologically. These challenges range from issues like equality, access to health delivery system, stigma, discrimination, racism, and lack of active participation in policy development, empowerment, social justice and human rights. Such challenges, within the health delivery system, are tantamount to human rights abuses. It is a violation of social justice and basic human rights, as enshrined in the Universal Declaration of Human Rights (Universal Declaration of Human Rights, 1948). They need to be challenged and stopped.

It should be noted that human rights and social justice are fundamental to the underpinning principles that promote effective health promotion in any

communities (WHO, 2005). Equally the same, African communities in New Zealand are entitled to these rights so as to effectively engage them.

According to the United Nations (1993) human rights are defined as: freedoms and entitlements concerned with the protection of the inherent dignity and equality of every human being. These rights include civil, political, economic, social and cultural rights. This declaration states that the international community has accepted the position that all human rights are universal, indivisible, interdependent, and interrelated (United Nations, 1993).

A number of participants cited that some of the members of the African communities do not visit the professional health service providers because of fear of experiencing racism and discrimination. Evidence from the literature suggests that the role of discrimination and racism in harming health is not new but has received increasing attention over the past 38 years ago; since 2003 (Krieger, 2003). According to The Maori Asthma Review, conscious or unconscious attitudes of health workers contribute to reluctance by Maoris to seek medical care for their asthma until it is absolutely necessary (E. Pomare, et al., 1991)

Racism is considered to be a major contributor to mental health, affecting the lives of African refugees in Canada, resulting in psycho-social stress that leads to mental illnesses like depression, stress and loss of memory (Waldron, 2002). This is a major barrier to access and utilization of mental health services and other health service facilities. Waldron (2002) identified three categories of racism experienced by African Canadians, namely: inter-personal racism, institutionalised racism and social racism.

As a way of emphasising the importance of human rights to health, the World Health Organisation (WHO) came up with a document called "The right to health analytical framework" with a view to make it easier for all people to understand the right to health and apply to health-related policies, programmes and projects in practice (World Health Organisation, 2005a).

From the above points, it is clear that racism and discrimination is a scourge within the delivery of health promotion, internationally. In regards to human

rights in general and human right to health, what the participants in this research said is consistent with the international literature review and standards.

The Jakarta Declaration (1997) stated that health promotion is a valuable investment. The right to enjoy good health is a basic human right and essential for social and economic development. It is a process of enabling people to increase control over and to improve their health (World Health Organization, 1997).

Other ethnic communities in New Zealand like the Asian and Pacific Islanders also face racism and discrimination. For example, the 2009 survey indicated that 23.2% of Asians experienced discrimination in a period of 12 months, more than all other ethnic groups in New Zealand (Statistics New Zealand, 2006).

There is therefore a great need to tackle and fight racism and discrimination in New Zealand targeted at the African communities. Tackling racism is likely to be the most effective route to improving the health of those affected, especially the minority ethnic groups (Jackson , Brown, & Williams, 1996). Cumulative exposure to racism and racial discrimination is a key risk factor for mental health problems, notably for depression and is particularly damaging for people who are already vulnerable, such as mental health service users. Again Carr-Hill (2007) emphasizes that tackling racism and discrimination should be recognized as a significant public health issue and measures put in place to eliminate it from any public health or health promotion practice.

Literature review also revealed that European people (in Auckland) had the highest proportion of people with no qualifications (18%) yet their rate of unemployment is lower than African people who have better education qualifications (Auckland District Health Board (ADHB), 2011).This shows elements of racism and discrimination.

In my view, racism and discrimination have a negative impact on the health delivery system in any country and therefore it should not have any room, in this day and age, what so ever.

The majority of participants unequivocally advocated for a New Zealand where human rights and social justice are respected. This would include acceptance of other people's cultures.

Housing Issues as a Challenge to the Promotion of Health within African Communities

Although most community leaders appreciated the accommodation provided by the New Zealand government, through Housing New Zealand Department, they felt that at times the houses are not suitable. Some of them are too small to accommodate large African families. Some of the houses are dumpy, dirty and have wet carpets; these harbour bacteria and children may be vulnerable. A report by Changemakers (2011) identified that many of their houses were damp and mouldy, lacked proper ventilation conditions which they associated with their poor health (ChangeMakers Refugee Forum, 2011). This is similar to the United Kingdom where Africans and other minority ethnic groups are more likely than others to live in deprived neighbourhoods, be poor, be unemployed, experience ill health, and live in overcrowded ghettos and unpopular housing (Fernando, 2002).

Literature review also revealed that housing space influences a family's health and quality of life as there is an association between household crowding and meningococcal disease (Baker, et al., 2000). About 23% of African households in Auckland consist of more than six people (Auckland District Health Board (ADHB), 2011).

I agree that some of the houses are small for bigger African families, especially those who come to New Zealand through the refugee quote system or family reunification. From an African perspective, cousins and aunts are part of a nuclear family, yet in New Zealand these are regarded as extended family

members. I suggest that Housing New Zealand should be more sensitive and allocate bigger houses to bigger families.

I also agree that some of the Housing New Zealand houses are not in the best of condition (dirty, dumpy and wet carpets) such that they may pose health challenges for the inhabitants, especially small children. I suggest that these houses should be cleaned and insulated before occupancy to provide warmth (especially in winter) and general comfort. If this is done, some of these problems would be avoided.

Most state houses are not in the best of conditions as most of the tenants neglect them and do not properly look after them. In addition, Housing New Zealand is not up to date with the demand for repairs; hence some of the deteriorating and dilapidated houses. I suggest Housing New Zealand should put more effort in making sure that these houses are properly maintained.

Despite the aforementioned problems, as a trained volunteer, (by Refugee Services New Zealand), I have had an opportunity of practically getting involved in settling some African refugee families. This included handling housing issues and I would therefore point out that though these houses are problematic they cannot be compared with accommodation provided in refugee camps. Some of the refugees were living in tents and plastic houses. The houses currently provided by Housing New Zealand are much better than the refugee camp accommodation and the two cannot be compared. It will be unfair to do so. However, this does not mean that African community members should not complain about these houses. Now that they are in New Zealand, their new home, they have a right to complain just like anybody else. It is also worth noting that most people who stay in these state houses pay reasonable rentals. This helps those on low income or on state benefit scheme.

I suggest we should also ask if these problems are only common to Africans communities. What about Maori, Pacific people, New Zealanders and other ethnic minorities in state houses? Do they also complain about dilapidated houses and shortage of accommodation? Yes, they do. It is not only an

“African” problem? The answer is, no. Recently (September 2012), it was reported in the media that a government minister was shocked to discover that there were homeless people in New Zealand. It was further unearthed that a Pacific family (in Auckland) was living in a caravan for more than two years due to shortage of state accommodation (MSN NZ News, 2012). So it means that shortage of state houses is a generic problem.

On the shortage of state accommodation, the media also reported (in September 2012) that Housing New Zealand had more than 500 un-occupied state houses yet there are thousands on its housing waiting-list (MSN NZ News, 2012). In my view, if this report is true, this is irresponsible on the part of Housing New Zealand. How can they have some many unoccupied houses yet other New Zealanders are homeless? I suggest that Housing New Zealand should have or improve their audit system so that they quickly identify empty houses and allocate them, as soon as possible to most deserving cases, as a priority, on the waiting-list. This should be done fairly, without favouring or discriminating against anyone. Again in my view, there is no justification in having more than 500 empty houses yet there are people who are sleeping in “the cold”, cars and caravans. This is a breach of basic human rights.

In order to minimise housing shortages, I would further suggest that Housing New Zealand buys more houses out of the rentals they collect from tenants. In addition to solving the shortage problem, it will be a way of investment prudently.

I have also discovered that New Zealand is one of the few countries which do not have classified residential areas based on one’s economic status- thus dividing the rich and poor (Burnett & Peel, 2001). For example in Zimbabwe where I originally come from, the rich and poor live in “different worlds”. I view this as oppressive, evil, unjust and manipulative. Burnett and Peel (2001) identified that support for people within their own communities and

opportunities for developing links and friendships with the host community was crucial to promoting effective integration and health and well-being.

HIV and AIDS Related-Stigma as a Challenge to the Promotion of Health within the African Communities

The New Zealand-based African communities are the second highest group affected with HIV, after the gay community. The African community in the UK has also been found to have the highest incidences of HIV (Gushulak, 2007).

African populations in the UK are more likely to experience challenges associated with risk factors for HIV infection such as low income, immigration and settlement issues, poor housing conditions, social exclusion, and limited access to training, skills development and job opportunities (Interagency on AIDS and Development (Canada), 2009). In the USA, between 2001-2004, a total of 50% of all HIV diagnoses were among African-Americans (Office of Minority Health, 2007).

This therefore confirms that there is somehow a similar trend between the New Zealand-based African communities and other African communities in the developed world when it comes to HIV issues. Stigma is a direct consequence of the staggering statistics of HIV among African communities. In addition people are ignorant.

As stated before, HIV/AIDS is associated with shame, stigma and promiscuity and as a result it is a taboo to openly talk about it in the society. In the recent research called "Standing in the Fire" which was carried out in New Zealand in 2011 on the black Africans in New Zealand, it revealed and highlighted the issue of stigma. Out of the 14 participants, more than 75% have not told their close family members about their HIV status (Fouche, Hendrickson, & Poindexter, 2011) .

There is an assumption that most Africans are HIV positive. This stigmatization is because of the several high-profile stories where western women are infected with HIV by African men. The press plays a role in these cases. I suggest that

the same press can also play a positive role in reversing this stigma. We have programmes like Campbell Live and others in New Zealand where negative African men can get a public interview and disprove that assumption that all Africans carry the dreaded virus.

As someone who works in HIV and AIDS sector, I am aware that the highest HIV prevalence rates are in Africa, especially in Southern Africa. As a result, many people have a perception that all Africans are HIV positive. In my organization (New Zealand AIDS Foundation) we have been trying to educate people about how people contract the disease and also exposing some myths, such as, that one can contract the virus through sharing utensils and shaking hands. We also inform people on preventative measures; for example use of condoms as a way of preventing HIV virus and other sexually transmitted diseases. Our message is mostly centred on fighting stigma that is attached to HIV and AIDS.

CHAPTER SEVEN

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

This study which was the first of its kind in New Zealand, found that the African communities in New Zealand face a number of significant and key health promotion challenges. The research also found out how the growing multi-cultural community impacts on the theory and practices of health promotion. The participants identified the following eight themes as the major health promotion challenges faced by the New Zealand-based African communities:

1. African communities' understanding of the concept of public health
2. African communities' access to health services
3. Language barrier as a main challenge to accessing health promotion
4. Spirituality and traditional beliefs of African health consumers
5. Lack of understanding of the cultural context of African communities by health practitioners
6. Racism and discrimination within the health sector
7. Housing issues as a challenge to the promotion of health within African communities
8. HIV and AIDS related-Stigma as a challenge to the promotion of health within the African communities

All the above eight themes will be discussed individually (below) in this conclusion and recommendation section.

African Communities' Understanding of the Concept of Public Health

The concept of Public health in New Zealand is not well understood by a number the members of the African communities. A lot of the members of the African communities in New Zealand have different and varied understandings of the meaning of the concept of public health and how it operates. This is not unique to this population as the international literature indicated that different

people/groups, internationally, have different interpretations of the meaning and concept of public health system and how it operates (Boorse, 1977). This is heavily influenced by many factors such as country of origin, culture, traditional beliefs and level of education. As for the New Zealand-based African communities, this is compounded by the fact that the majority, especially those from refugee-background, are not aware of how the health system operates in New Zealand. Not that they choose to, but the way the system is designed. The system is not user-friendly. However, I recommend that the members of African communities should make a concerted effort to learn and understand the system.

African Communities' Access to Health Services

While the health services are available in New Zealand, the African communities do not have access to them because of issues such as the complication in navigating the system, language barrier for those who cannot communicate in English, prohibitive consultation costs for General Practitioners (GPs), referral systems and immigration policies.

The participants mentioned that health facilities are available for the African communities in New Zealand but these are difficult to access. Therefore it means that accessibility is an issue. It is one of the major contributing factors to the health promotion challenges faced by New Zealand-based African communities. It has to be addressed sooner rather than later. As stated before, point number 5 of "The right to health analytical framework" clearly states the importance of what is called "3AQ" principle, which stands for "availability, accessibility, acceptability and good quality" regarding health delivery (World Health Organisation, 2005a). I have noticed that some of the services are hard to access, not that they are bad but simply because they are not culturally appropriate and acceptable for consumption by this population.

I therefore recommend that the authorities within the New Zealand health sector should ensure that they re-look at the current status-quo with a view of

making it easier for the African communities to access these health services. If these health facilities are not accessible they are as good as if they do not exist at all.

Language Barrier as a Main Challenge to Accessing Health Promotion

A sizeable number of people from the African community, especially those from refugee background and non-English speaking countries do have a big challenge when it comes to the issue of English language.

In the findings, it was indicated that a number of the members from the African communities (mostly those from refugee background) were given incorrect prescriptions/ medicine by doctors due to poor communication as a result of not understanding or speaking English. The results can be fatal if extra care is not taken.

I recommend the use of professional trained interpreters as opposed to young children and untrained community members.

Spirituality and Traditional Beliefs of African Health Consumers

Africans are religious and traditional and they would like it reflected when they visit their health professionals.

The findings of this study indicated that Africans are hugely spiritual and religious. The majority believe in God, the Creator as well as their ancestors. From a spiritual perspective, the African concept of treatment is comprehensive and holistic (Omonzejele, 2008). In the traditional African setting, disease and ill health are intricately linked to one's destiny and ancestral spirit.

The element of spirituality and traditional beliefs has a great bearing and influence when it comes to health matters in the lives of most Africans. This cannot be ignored.

From a health promotion perspective, Africans also practice and believe in “lay health promotion” with the use of medicinal meals and preventive healthcare. For instance, in most African households (in Africa) scent leaves (*Occimum gratissimum*) and bitter leaves (*Vernonia amygdalina*) are used to cure many ailments. These are used in traditional soup or are simply washed in water and the extract used as drink (Obuekwe & Obuekwe, 2002).

I think that the African Traditional Medicine (ATM) could be enhanced and improved upon. I also recommend that the issue of sharing information should be properly addressed, in which case the practitioners of ATM would be requested to decode and make plain some of the mysterious aspects of traditional medicine. The ATM is not scientifically tested and as a result it appears to be hidden to the “outside” world. As a result of this “hidden-ness” proof and lack of scientific empirical evidence, makes it difficult for the African notion of health and treatment to be fairly evaluated exclusively by a western paradigm. The use of a Western paradigm for this purpose will result in conflicting views with the African notion (Omonzejele, 2008).

Finally, I recommend that if the African Traditional Medicine (ATM) is properly used within the New Zealand health system, it will work well for the African communities. For the use of ATM to work well for the New Zealand-based African communities, it has to be funded adequately. The use of ATM is critically important, as literature review indicated that about 70% of Nigerians and many other Africans rely on traditional medicine (Nigerian Television Authority, 2004). However, there are some parts of the African Traditional Medicine (ATM) that will not be acceptable in New Zealand, especially the ones that involve element of human abuses, for example human sacrifices. Such practices (human sacrifices) are not even accepted in many Africa nations.

Lack of Understanding of the Cultural Context of African Communities by Health Practitioners

Most members of the New Zealand-based African communities do not access these available health services mainly because they are been delivered in ways that are not culturally acceptable.

Again on the issue of cultural sensitivity, the study found that New Zealand is a bi-cultural society. Thus, it mostly takes into account the Maori and Pakeha (European) cultures only and excluding the rest. This makes it even more difficult for the African communities in New Zealand which are relatively new. Their culture is far from being recognised in New Zealand.

I therefore recommend that health professionals should learn and understand the cultures of other people so that they are sensitive when dealing with these groups.

Racism and Discrimination within the Health Sector

It was evident that members of the African communities face racism and discrimination within the New Zealand health sector.

The study was able to identify as well as unpack and uncover how the community-focused societal factors such as human rights, social justice and equality, active participation in policy development and empowerment were missing for the African communities in the health promotion system in New Zealand.

I recommend that the relevant authorities within the New Zealand health sector should address any issue related to racism and discrimination in a fair, humane and transparent manner. Issues of racism and discrimination must be taken seriously and dealt with as soon as they occur. By doing this, it will create confidence within the African communities and other affected populations.

Housing Issues as a Challenge to the Promotion of Health within African Communities

Although most participants, especially community leaders appreciated the accommodation provided by the New Zealand government, though Housing New Zealand, they felt that at times some of them are not suitable for human habitation. They are old, too cold and have moulds and dirty/wet carpets. This has a likelihood of causing sickness like allergies and asthma, especially to young children. It was also mentioned that some of these houses are small to accommodate large African families.

I recommend that Housing New Zealand makes an effort to maintain these houses so that they are inhabitable. On the other hand, I suggest that tenants should be more responsible and take care of these state houses. They should not have a negative attitude simply because the houses belong to the state. They should attend to minor repairs and maintain them properly.

HIV and AIDS Related-Stigma as a Challenge to the Promotion of Health within the African Communities

The New Zealand-based African communities are the second highest ethnic group affected by HIV, in New Zealand (after gay community) and they have experienced stigma that is associated with this epidemic

As a researcher, a community leader and also a senior employee within the HIV and AIDS sector, I recommend that the African community is continuously educated, in the form of awareness, about the need to openly share freely about the HIV and AIDS issues. I have also discovered that the majority of the members of the New Zealand-based African community find it difficult to share and come out about their HIV status, compared to the local Kiwis. In my view the possible reasons are, among others, the following:

- There is no family support for the African communities, since some of the infected people do not have “nuclear” and close families here in New Zealand. Some are alone hence no support at all. It is crucial to note here that a community is not one’s family. People need their own bonafide

families for moral support. The two (community and family) are hugely different, in this sense.

- Fear of the attached stigma associated with HIV and AIDS
- Fear of community-gossip
- Fear of losing job or not getting employed. I know of some cases where New Zealand employers and fellow employees psychologically forced HIV positive African people to resign and leave their employment. Many New Zealand employers and employees are ignorant about HIV and AIDS. This fuels HIV/AIDS stigma and discrimination.

In view of these challenges, I suggest that the New Zealand government, through the Ministry of Health should have public awareness on HIV and AIDS (Shepherd, 1999). This can be done by introducing HIV and AIDS education programmes in schools, universities and other strategic public places. The other way could be through adverts on television, radio and bill-boards. These initiatives will cover all communities in New Zealand; not just the African communities, as is the current situation. This will help the public to have correct basic facts about HIV and AIDS which in turn minimise the current high levels of stigma.

Recommendations and actions by the Auckland District Health Boards DHBs

According to the Auckland District Health Board report (2011), the actions that should be considered by the three Auckland DHBs (thus, Auckland, Counties Manukau/Middlemore and Waitemata) include:

- Increase and promote cultural competency education
- General Practitioners (GPs) need to be supported on ways to screen and treat patients with mental health conditions in a culturally sensitive way
- Support Health Service Providers (HSPs) to meet the needs of patients from the African communities:
 - Provide targeted services for African communities within mainstream health services (including raising community awareness, education and health promotion), especially around:

diabetes and cardiovascular diseases (CVD) screening prevention, screening and self-management, cervical and breast screening services, antenatal education classes, family planning and contraception education and community oral health services. Improve interpreter services (in order to overcome language and cultural barriers) by increasing access by widening the type of HSP that can use free interpreter services, the availability of face-to-face interpreter service and the awareness of the benefits of using interpreters in primary care to HSPs

- Improve mental health supports services
- Promote community empowerment by improving awareness on the determinants of health
- Advocate for further research on African health needs, including finding ways to improve coding for the African communities (as part of MELLA) should be explored, especially for Zimbabweans and South Africans who would like to be identified as “African” (Auckland District Health Board (ADHB), 2011.p.XIV)

Recommendations from the New Zealand Refugee participants

According to the ChangeMakers report (2011) the refugee participants made, among others, the following suggestions on how to improve health outcomes for people from refugee background communities, which includes those from African communities:

- Fair employment opportunities and options are made available to people from refugee backgrounds.
- To receive relevant information prior to their arrival, so that they have realistic expectations of life in New Zealand.
- Houses are upgraded and maintained so that they are warm and dry.
- Families are allocated houses that are appropriate for their family size.

- More funding is allocated for English language tuition.
- Health promotion activities include resources targeted at those who do not speak English.
- Access to trained interpreters is made available.
- Community members can access trained interpreters whose gender matches that of the patient.
- Family members are supported to resettle in New Zealand.
- Health practitioners are trained to work with culturally diverse patients and to be culturally responsive.
- Health service providers take a more holistic approach when treating people from a refugee background that incorporates the patient's mental health, their history and where they have come from.
- Recognition, among health practitioners, of the skills and experience that people from a refugee background bring to New Zealand.
- More acceptance of diversity among the wider community with people welcoming refugees into their community.
- Better coordination and cooperation between refugee service providers including health and other social service agencies to enable interrelated health issues to be addressed (ChangeMakers Refugee Forum, 2011).

Participants recognised that the health system alone could not address the issues that they had raised or their suggestions on how these issues could be resolved.

One refugee participant summed it all by saying *'They [the health system] have to get help from Housing, from MCLASS from ChangeMakers...anyone who is related to the communities. One hand can't make a sound, two hands make a sound.'* (ChangeMakers Refugee Forum, 2011, .p. 14.).

The Conclusions Drawn from this Study

The conclusions drawn from this study are as follows:

- The majority of the members of the African communities in New Zealand, especially those from refugee background, are not aware and conversant of the concept of the public health and how the system operates within the New Zealand health sector.
- It is not easy for some of the members of the African communities to access health services. It is hard to navigate through the complicated system with a lot of bureaucratic procedures.
- Lack of English language proficiency continues to be a barrier, especially for those from refugee background. There is need to use professional and trained interpreters as opposed to the use of children of refugee parents. The use of small children is culturally inappropriate and unacceptable.
- Spirituality and African traditional beliefs have a great bearing in the health and health promotion within the African communities in New Zealand.
- There is need for New Zealand health professionals to understand the basics of the African cultures in order to be effective in the service delivery.
- African community members do face racism and discrimination from the New Zealand health professionals. In addition, African health professionals also face racism and discrimination from New Zealand main-stream patients.
- There is need to provide houses that are warm, clean carpets so that inhabitants, especially children are not affected, health wise.
- There is still stigma and discrimination associated with HIV and AIDS, within the African communities in New Zealand.

Limitations

I could not itemize and capture all problems mentioned by all the 20 individual community leaders, 10 service providers and focus group members regarding the health promotion challenges faced by the New Zealand-based African communities. In addition all participants talked about the issue of employment as one of the biggest challenges faced by the African communities in New Zealand. However, this issue of employment could not be taken into account as a health promotion challenge but was viewed and considered as a health outcome. Since this issue of employment was so prominent and important to all participants, it could be dealt with separately, in a different setting, for example as a PhD thesis.

The focus group found that the allocated 90 minutes was a short time for them to discuss all the issues. They spent most of the time discussing racism and discrimination. This topic was of great interest to all focus group members.

There are also limitations as regards to the length of the thesis, thus the maximum number of pages stipulated.

References

- Adams, J., McCreanor, T., & Braun, V. (2008). Doctoring New Zealand's gay men *New Zealand Medical Association*, 121(1287), 11-20.
- Alexander, Z. (1999). *Study of Black, Asian and Ethnic Minority Issues* London, United Kingdom: Department of Health.
- American Psychological Association. (2009). *APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation: Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington D.C, USA: American Psychological Association.
- Arabena, K. (2008). *Indigenous Epistemologies and Wellbeing: Universal referent citizenship AIATSIS Research Discussion Paper No.22*. Canberra, Australia: The Australia national University.
- Auckland District Health Board (ADHB). (2011). *Health Needs Assessment of Middle Eastern, Latin American and African people living in the Auckland Region*. .
- Auckland Refugee Council Inc. (2012). *We Are Better Than That New Zealand ? Immigration Amendment Bill (Mass Arrivals of Asylum Seekers)*. Auckland, New Zealand.
- Auckland University of Technology. (2012). *AUT African Students Club:<http://www.ausm.org.nz/wawcs0151706/idDetails=164/Cultural%20clubs>*. Retrieved June 24, 2012, ,
- Auslander, W., Haire Joshu, D., & Houston, C. (2000). The short-term impact of a health promotion program for low-income African American women *Research on Social Work Practice*, 10(1), 78-97.
- Bailey, J., M. (1999). Homosexuality and mental illness. *Arch General Psychiatry*, 56, 883-884.
- Baker, M., McNicholas, A., Garrett, N., Jones, N., Stewart, J., & Koberstein, V. (2000). Household Crowding: A Major Risk Factor for Epidemic Meningococcal Disease in Auckland Children Paediatric. *Infectious Disease Journal*, 19(10), 983-990.
- Banks-Wallace, J. (1998). Emancipatory potential of storytelling in a group. Image. *Journal of Nursing Scholarship*, 30(1), 17-21.
- Banks, C. (2009). Doubled up with stigma: gay men and mental illness in New Zealand *Mental Health MindNet*(12), 1-6.
- Barrett., D. (1996). *From: He Tatai i te Ara, Determining the Path: Guidelines for Developing Maori Health Education Resources*. Druis Barrett. Auckland, New Zealand: Ministry of Health.
- Benoliel, J. Q. (1984). Advancing nursing science: Qualitative approaches. *Western Journal of Nursing Research*, 6, 1-8.
- Bhugra, D., Leff, J., & Mallett, R. (1997). *Incidence and outcome of schizophrenia in Whites*. London, United Kingdom.
- Bonnke, R. (2010). *The Biography of Evangelist Reinhard Bonnke: <http://us.cfan.org/Reinhard-Bonnke-Biography.aspx>*. Lagos, Nigeria: Christ for All Nations.
- Boorse, C. (1977). Philosophy of Silence. *Philosophy*, 44(4), 542-573.
- Bradley, C., & Longino, C. F. (2001). Geographical Distribution and migration. In R. H. Binstock & L. K. George (Eds.), *Handbook of aging and the social sciences* (5th ed., pp. 103-124). San Diego, CA: Academic Press.
- Breaking the Circle of Fear. (2002). *Breaking the Circle of fear: Available via www.scmh.org.uk*. Retrieved June 30, 2010,
- Burnett, A., & Peel, M. (2001). Health needs of asylum seekers and refugees. *British Medical Journal*, 322, 544-547.
- Carl, W. (2009). *Africans - Immigration. Te Ara - the Encyclopaedia of New Zealand; 2009 [updated 04/03/2009; cited 26/04/2011]; Available from:<http://www.teara.govt.nz/en/africans/2>*. Wellington, New Zealand.
- Carr-Hill, R. (2007). Health Promotion: what is desirable, what is feasible? *Critical Public Health* 18, 285-297.

- Centre for Caribbean Health. (2004). *Stroke and Hypertension [online]*. Available from: http://www.kcl.ac.uk/depsta/ccm/CCM_stroke.html Retrieved September 30, 2010
- ChangeMakers Refugee Forum. (2011). *Barriers to achieving good health outcomes in refugee-background communities: A report prepared for Regional Public Health and the Department of Labour*. Wellington, New Zealand.
- Chavunduka, G. (1978). *Traditional Healers and the Shona Patient*. Gweru, Zimbabwe: Mambo Press.
- Chile. (2002). The imported underclass: poverty and social exclusion of black African refugees in Aotearoa New Zealand *Asia Pacific Viewpoint*, 43(3), 355-366.
- Chile. (2007). *Community Development Practice in New Zealand: Exploring Good Practice*. Auckland, New Zealand: AUT Press.
- Chile. (2012). *The Africans in New Zealand. A development perspective (Forthcoming)*. Auckland, New Zealand
- Chile, L. M. (2009). *Culturally Competent Practice: A Training Manual For Professionals working with Refugees, Migrants and People from Diverse Backgrounds*. Auckland, New Zealand: AUT Press.
- Chile, L. M. (2011). *Cross-cultural issues in building health communities*. In R. Scherman & C. Krageloh (Eds.). *Walking the talk: The 2011 collection of oral presentations from AUT School of Public Health and Psychosocial Studies (pp 146-159)* Auckland, New Zealand: Auckland University of Technology.
- Community Alcohol and Drug Services (CADS). (2008). Providing Asian Counselling: www.ndsa.co.nz. *Asian Mental Health Newsletter*, 2(3), 1-2.
- Cook, B. P. (2001). A call for respect and equality for indigenous scholarship in Hawaiian health. *Public Dialogue*, 8(368-374).
- Cousins, J. B. (1997). *A Conceptual Model for Health Promotion*. London, United Kingdom: Oxford Press.
- Cutler, D. M., & Lleras-Muney, A. (2007). *Education and health. National Poverty Center: Policy Brief #92007(1-4)*. Boston, USA.
- Department of Health (UK). (2004). *Choosing Health: Making healthy choices easier. (HMSO)* London, United Kingdom.
- Department of Labour. (2009). *Quota Refugees in New Zealand: Approvals and movements (1999–2008)*. Wellington, New Zealand.
- DeSantos, L. (1997). Building Healthy Communities with Immigrants and Refugees. *Journal of Transcultural Nursing*, 9(1), 20-31.
- Dime, C. A. (1995). *African Traditional Medicine: Peculiarities*. Edo State University Press Ekpoma, Nigeria
- Drayton-Brooks, S., & White, N. (2004). Health promoting behaviors among African American women with faith-based support. *Journal of the Association of Black Nursing Faculty*. , 15(5), 84-90.
- Duken.k. (1998). *Strangers, Ambivalence and social theory*: Ashgate, Hants.
- Durie, M. (2009). *The Māori health model philosophy (Te Whare Tapa Wha) : Toward health based on a holistic health and wellness*. Auckland, New Zealand: Health Promotion Forum of New Zealand.
- Ellis, C., & Berger, L. (2002). *Their Story/My Story/Our Story: Including the Researcher's Experience in Interviews Research*. California, USA: Sages Publishing, Inc.
- Faulkner, A. (2000). *Strategies for Living: Report of user led research into people's strategies for living with mental distress*. London, England: Mental Health Foundation.
- Fergusson, D. M., Horwood, L. J., Ridder, E. M., & Beautrais, A. L. (2005). Sexual orientation and mental health in a birth cohort of young adults. *Psychological Medicine*, 35, 971-981.
- Fernando, S. (2002). *Mental health, race and culture. Second Edition Hampshire: Palgrave*.
- Fouche, C., Hendrickson, M., & Poindexter, C., C. (2011). *"Standing in the Fire": Experiences of HIV-Positive Black African Migrants and Refugees Living in New Zealand*. Auckland, New Zealand: The University of Auckland.

- French Unrest. (2005). *The French Civil Unrest of 2005- Racial Discrimination and Social and Economic Exclusion*. http://www.cbc.ca/news/background/paris_riots/ Retrieved October 1, 2010.,
- Friedli , L. (2000). A matter of faith: religion and mental health International. *Journal of Mental Health Promotion*, 2(2), 7-13.
- Gilbert, P. A., & Khokhar, S. (2008). Changing dietary habits of ethnic groups in Europe and implications for health *Nutrition Review*, 66, 203-215.
- Gushulak. (2007). Healthier on arrival? Further insight into the "healthy immigrant effect". *CMAJ2007*, 176(10), 1439-1440.
- Gyekye, K. (1987). *An Essay on Philosophical Thought: The Akan Conceptual Scheme*. Cambridge. Cambridge University Press.
- Hall, A., & Stewart, R. (1989). Obesity: time for sanity and humanity. *New Zealand Medical Journal*, 102, 134-136.
- Health Promotion Forum of New Zealand. (1997). Passion about health promotion: the health promotion forum-10 years on and growing, 10-13.
- Health Promotion Forum of New Zealand. (2002). Reducing Inequalities in Health, Ministry of Health. *Hauora*, 48.
- Health Promotion of New Zealand. (2004). *What is Health Promotion?*<http://www.hpforum.org.nz/page.php?> . Auckland, New Zealand.
- Health Research Council of New Zealand. (2011). *Health Research Council of New Zealand:* <http://www.hrc.govt.nz/> Retrieved 24 June 2012,
- Higgs, P. (1999). Stratification, Class and Health: Class Relations and Health Inequalities in High Modernity. *British Sociological Association*, 33(2), 275-296.
- Human Rights Campaign Foundation. (2008). *Human Rights Campaign Foundation, Gay and Lesbian Medical Association. 08 Healthcare equality index: Creating a national standard of equal treatment of gay, lesbian, bisexual and transgender patients and their families*. Washington, DC and San Francisco, USA: Human Rights Campaign Foundation and Gay and Lesbian Medical Association.
- Human Rights Commission. (2008). *Human Rights Commission: "To Be Who I Am – Report of the Inquiry into Discrimination Experienced by Transgender People"*, www.hrc.co.nz/transgenderinquiry. Wellington, New Zealand.
- Human Rights Commission. (2010). *Review: Pacific Peoples in New Zealand:*<http://www.hrc.co.nz/home/hrc/newsandissues/reviewpacificpeoplesinnewzealand/reviewpacificpeoplesinnewzealand.php>. Retrieved September 13, 2010,
- Husserl, E. (1931). *Ideas: General Introduction to Pure Phenomenology*. London, United Kingdom: George Allen & Unwin.
- Idowu, B. (1973). *African Traditional Religion: A Definition*: London, United Kingdom
- Immigration New Zealand. (2006). *Immigration Act Review: Discussion Paper*. Wellington: Department of Labour.
- Interagency on AIDS and Development (Canada). (2009). *Prevention Programs In Developed countries: Lessons Learned: A report on Prevention Initiatives used to address HIV and AIDS prevention for Africans, Caribbean and Black Populations in developed countries*. Toronto, Canada.
- Iwu, M. (1982). *African Ethnomedicine*: Snaap Press; 1982. Enugu, Nigeria.
- Jackson G, K. L., Parr A, et al., (1998). *Socioeconomic inequalities in health care: A preliminary analysis of the link between health status and socio-economic status in the North Health region Auckland: North Health*. Auckland, New Zealand: Department of Public Health and General Practice.
- Jackson , J. B., Brown, T. N., & Williams, D. R. (1996). *Racism and the physical and mental health status of African Americans: a thirteen year national panel study on ethnicity*

- Jackson, K. (2006). *Fate, Spirits and Curses: Mental health and traditional beliefs in some refugee communities*. Auckland: Rampart Publishing services.
- James, L. (2006). *HIV Prevention Guidelines and Manual: A Tool for Service Providers Serving African and African Caribbean Communities in Canada*. Toronto, Canada.
- King, M. (2003). *The Penguin History of New Zealand*: Penguin Books Auckland, New Zealand.
- Krieger, N. (2003). Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: an ecosocial perspective. *Am Journal Public Health*, 93, 194-199.
- Krueger, R. A., & Casey, M. A. (2000). *Focus group: A practical guide for applied research (3rd ed)*. Madison, USA: Sage Publications, Inc.
- Laverrack, G., & Labonte, R. (2000). A Planning Framework for Community Empowerment Goals within Health Promotion. *Health policy and planning*, 15(3), 55-62.
- Lockley, J. (2010). *John Lockley: A White South African is an Traditionally, Ancestrally Trained and Initiated Xhosa Sangoma – A Traditional South African Shaman* Retrieved 16 June 2010,
- Lurie, N. (2002). *Measuring disparities in access to care*. Available at: <http://www.nap.edu/openbook/0309085195/html/1.html>. Retrieved 27 July, 2010,
- Marshall, C., & Rossman, G. B. (1999). *Designing Qualitative Research 3rd Edition*: Sage Publications. Thousand Oaks.
- Matheson, A. (2005). Engaging Communities To Reduce Health Inequalities: Why Partnership? *Social Policy Journal of New Zealand*, 26(6), 1-6.
- Miles, M. B., & Huberman, M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook*. California, USA: SAGE Publications.
- Ministry of Health. (1999). *Taking the Pulse: The 1996/97 New Zealand Health Survey*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2001). *Refugee health care: A handbook for health professionals*. Ministry of Health. Wellington, New Zealand.
- Ministry of Health. (2010). *Pacific People's Health*: <http://www.moh.govt.nz/moh.nsf/indexmh/pacifichealth-health>. Retrieved September 13, 2010
- Minkler, M., & Wallerstein. (2003). *Community-Based Participatory Research for Health*. Jossey-Bass, San Francisco
- MSN NZ News. (2012). Homeless families shock minister: State houses sitting unused 'unacceptable': <http://news.msn.co.nz/nationalnews/8527146/homeless-families-shock-minister>.
- National Health Services Executive. (1998). *Tackling Racial Harassment in the NHS* London: NHSE.
- Neuman, W. L. (2000). *Social research methods: Qualitative and quantitative approaches (4 ed.)* Boston, USA: Allyn and Bocon.
- New Zealand African Welfare Service Trust. (2012). <http://nz.search.yahoo.com/search?p=New+Zealand+African+Welfare+Service+Trust+&fr=yfp-t-501&ei=UTF-8> (www.nzawst.co.nz). Retrieved June 12, 2012.
- New Zealand AIDS Foundation. (2009). *Most Communities Affected by HIV/AIDS in New Zealand*. Retrieved 10th August 2010.
- New Zealand Immigration Service. (1987). *Immigration Act 1987 Public Act 1987 No 74* <http://nz.bing.com/search?q=New+Zealand+Immigration+Policy+of+1987&FORM=IE8SRC>. Retrieved 24 June, 2012.
- New Zealand Immigration Service. (1991). *New Zealand Immigration Service*: <http://nz.bing.com/search?q=%28Immigration+Amendment+Act+1991%29.&FORM=IE8SRC>. Retrieved June 24, 2012,
- New Zealand Immigration Service. (2004). *Refugee Voices: A Journey Towards Resettlement*. Wellington, New Zealand.

- New Zealand Immigration Service. (2005). *Immigration Report on Nationals*. Wellington, New Zealand.
- New Zealand Immigration Service. (2006). S4.15 Special Zimbabwe Residence Policy (04/07/2005): Retrieved March 1, 2012, from <http://www.visabureau.com/newzealand/news/30-08-2006/health-requirement-relaxed-for-zimbabweans-in-nz.aspx>. New Zealand Visa Bureau.
- New Zealand Immigration Service. (2008). *Africans Currently in New Zealand- from Selected African Countries as at 13th August 2008 (email dated 19th August 2008)* Wellington, New Zealand.
- New Zealand Immigration Services. (2012). *General Information/Statistics*: <http://www.immigration.govt.nz/migrant/general/generalinformation/statistics/>; Retrieved June 12, 2012.
- Nigerian Television Authority (Writer/Producer/Director). (2004). *News Report on African Traditional Medicine Nigeria*. <http://www.docstoc.com/docs/44695546/An-approach-to-risk-reduction-and-risk-management>.
- NIMHE. (2003). *Inside Outside: Improving mental health services for Black and Minority Ethnic Communities in England*. Leeds, England; NIMHE.
- Obuekwe, C., & Obuekwe, F. (2002). Indigenous methods used for the management of diarrhoea in an urban community in Edo State, Nigeria *Journal of Medical Science*, 1(12).
- Office of Minority Health. (2007). *African American Profile [online]*. Available from: <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=51>. Retrieved October 4, 2010.
- Office of National Statistics. (2003). Census 2001-Ethnicity and religion in England and Wales [online]. Available from: <http://www.statistics.gov.uk/census2001/profiles/commentaries/ethnicity.asp>.
- Omonzejele, P. F. (2008). African Concept of Health, Disease and Treatment: An Ethical Inquiry *The Journal of Science and Healing*, 4(2), 120-126.
- Otago University Epidemiology. (2011). *Ninetieth Quarterly Report of the AIDS Epidemiology Group to the Ministry of Health* Dunedin, New Zealand Otago University.
- Ozekhome, F. (1990). *The Theory and Practice of Traditional Medicine in Nigeria*. Lagos, Nigeria: Okey Chime and Co.
- Parnell W, R. J., Wilson N, et al. (2001). Food security: Is New Zealand a land of plenty? *New Zealand Medical Journal*, 114, 141-145.
- Pearce, N., Foliaki, S., Cunningham, C., & Sporle, A. (2004). *Genetics, race, ethnicity and health*: BMJ. London, United Kingdom.
- Pernice, R., Trlin, A., Henderson, A., & North, N. (2000). Employment and mental health of three groups of immigrants to New Zealand. *New Zealand Journal of Psychology*, 29(1), 24-29.
- Pio, E. (2010). *Longing & Belonging Asians, Middle Eastern, Latin America and African people in New Zealand*. Wellington, New Zealand: Dunmore Publishing Ltd.
- Polit, D. F., & Beck, C. T. (2004). *Nursing Research: Principles and Methods (7th ed)*. Philadelphia, PA, USA: Lippincott Williams & Wilkins.
- Polit, D. F., & Hungler, B. P. (1995). *Nursing Research: Principles and Methods (5th ed.)*. Philadelphia, USA: J.B Lippincott Company.
- Pomare. (1980). *Maori Standards of Health: A Study of the 20-Year Period 1955-75*. Wellington, New Zealand: Medical Research Council of New Zealand.
- Pomare, E., Tutengaeh, H., Ramsden, I., Hight, M., Pearce, N., & Ormsby, V. (1991). *He Mate Huango: Maori Asthma Review: Huia Publications; 1991*. Wellington, New Zealand.
- Powell, A., & Kahn, A. S. (1995). Racial differences in women's desire to be thin. *International Journal of Eating Disorders*, 17(191-195).
- Proposed French Immigration Bill. (2007). *Proposed French Immigration Bill: Africans in France say bill calling for DNA tests for immigrants is racist*:

- <http://www.haaretz.com/news/africans-in-france-say-bill-calling-for-dna-tests-for-immigrants-is-racist-1.230521> Retrieved October 4, 2010.
- Ramsden, I. (1997). Cultural safety: Implementing the concept. The social force of nursing and midwifery. In: Te Whaiti P, McCarthy M, Durie A, eds. *Mai i Rangiatea: Maori Wellbeing and Development*. Auckland, New Zealand: Auckland University
- Ransdell, L. B., & Wells, C. L. (1998). Physical Activity in urban white, African- American and Mexican-American women. *Medicine and Science in Sports and Exercise*, 30(11), 1608-1615.
- Ray, O. (2004). How the Mind Hurts and Heals the Body *American Psychologist*, January(59), 29-40.
- Refugee Migrant Services. (1993). *Refugee Migrant Services, (1993). The Refugee Report*. Wellington, New Zealand.
- Refugee Services. (2012). *Quota Programme*:http://www.refugeeservices.org.nz/refugees_and_new_zealand/quota_programme. Retrieved 29 March, 2012.
- Rosen , E. (2001). *The Influence of Culture on Mental Health and Psychopathology in Japan* Washington,USA.
- Rumball-Smith, J. M. L. (2009). Not in my hospital? Ethnic disparities in quality of hospital care in New Zealand: a narrative review of the evidence. *New Zealand Medical Journal*, 122(1297), 68-83.
- Salmond, C., & Crampton, P. (2000). *Deprivation and health. In Howden Chapman P, Tobias M: Social inequalities in health: New Zealand 1999. Ministry of Health*. Wellington, New Zealand.
- Sashidharan, S., & Francis, E. (1993). *Sain Race and health in contemporary Britain* (Ahmad, W.I) Open University Press: Buckingham.
- Schatzman, L., & Strauss, A. L. (1973). *Field research; strategies for a natural sociology*. California, USA: Prentice-Hall.
- Seedhouse, D. (2004). *Health Promotion: Philosophy, Prejudice and Practice*. Auckland, New Zealand: Wiley.
- Shepherd, J. (1999). A Method In Search Of A theory: Peer Education and Health Promotion *Health Education Research* 14(4), 235–247.
- Simmons, D. (1998). Barriers to diabetes care: lessons from a multi-ethnic community in New Zealand. *Diabetic Medicine* 10 (15), 958-964.
- Sloane, D., Nascimento, L., Flynn, G., Lewis, L., Guinyard, J. J., Galloway-Gilliam, L., et al. (2006). Assessing resource environments to target prevention interventions in community chronic disease control. *Journal of Health Care for the Poor and Underserved*, 17, 146-158. .
- Smith, A. H., & Pearce, N. E. (1984). Determinants of differences in mortality between New Zealand Maoris and non-Maoris aged 15–64. *New Zealand Medical Journal*, 97, 101-108.
- Statistics New Zealand. (2006). *The 2006 New Zealand Census*:<http://www.stats.govt.nz/Census/2006CensusHomePage.aspx>. Wellington, New Zealand: Statistics New Zealand.
- Strauss, A., & Corbin, J. (1998). *The basics of qualitative research: Techniques and procedures for developing grounded theory*: Sages Publications. California, USA.
- The Canadian Public Health Association. (1996). *The Canadian Public Health Association: Action Statement for Health Promotion in Canada (1996)*. Retrieved June 30, 2010.
- The South African Magazine. (2012). The South African: Connecting South Africa and New Zealand:April/ May 2012(026).
- UMR Research. (2009). Mood of the Nation - An annual report on New Zealand's mood, political, economic and social trends from the UMR Omnibus survey. 7(5-7).

- United Nations. (1993). *United Nations General Assembly. Vienna declaration and programme of action*. Paper presented at the meeting of the World conference on human rights, Vienna 14-25 June 1993, Vienna.
- Universal Declaration of Human Rights. (1948). *Universal Declaration of Human Rights (1948)*. <http://www.ohchr.org/EN/UDHR/Pages/Introduction.aspx> : Retrieved 31st January 2012.
- Waa, A., Holibar, F., & Spinola, C. (1998). *Programme Evaluation: An Introductory Guide for Health Promotion*. Alcohol and Public Health Research Unit / Whariki Runanga Wananga Hauora Mete Paekaka, Auckland, New Zealand.
- Waldron, I. R. (2002). *African Canadian women storming the barricades. Challenging psychiatric imperialism through indigenous conceptualisation of mental illness and self-healing*. Unpublished Doctor of Philosophy Thesis. University of Toronto. Toronto, Canada.
- Wilkinson, R., & Pickett, K. (2010). *The Spirit Level: Why Equality is Better for Everyone*. London, England: Penguin Books.
- World Health Organisation. (2005a). *Resource book on mental health, human rights and legislation*. Geneva, Switzerland WHO.
- World Health Organization. (1986). *Ottawa Charter for Health Promotion* Geneva: World Health Organization.
- World Health Organization. (1997). *The Jakarta Declaration on Health Promotion: Health Promotion into the 21st Century* Retrieved May 18, 2010.
- World Health Organization. (1999). *The 52nd World Health Conference on Health Promotion: Amendment of the Definition of "Health"*. Retrieved May 18, 2010,
- World Health Organization. (2005). *The Bangkok Charter for Health Promotion in a Globalized World*. Retrieved 18th May 2010.
- Young, D. R., Gittelsohn, J., Charleston, J., Felix-Aaron, K., & Appel, L. J. (2001). Motivations for Exercise and Weight Loss Among African-American Women: focus group results and their contribution towards program development *Ethnicity & Health*, 6(3/4), 227-245.
- Zimbabwe Association in New Zealand. (2012). <http://www.zimnz.org/index.php?id=17>: Retrieved 24 June 2012. Retrieved
- Zimbabwe Situation. (2000). *Commercial Farmers' Union (CFU) - FARM INVASIONS UPDATE*:http://www.zimbabwesituation.com/august_archive_index.html. Retrieved 2 April, 2012.
- Zimbabwe Situation. (2001). *Farm Invasions in Zimbabwe*:http://www.google.co.nz/search?sourceid=navclient&aq=f&oq=Zimbabwe+FARM+INVARSION+IN+2001+in+New+Zimbabwe.com&ie=UTF-8&rlz=1T4GGLL_enNZ324NZ325&q=Zimbabwe+FARM+INVARSION+IN+2001+in+New+Zimbabwe.com&gs_upl=0I0I0I877913IIIIIIIIII0 Retrieved June 24, 2012,
- Zimbabwe Situation. (2010). *Civic group to fight plans to deport UK Zimbabwean Asylum Seekers*:http://www.zimbabwesituation.com/aug18_2010.html#Z6 Retrieved October 1, 2010.

Appendix A: Individual Participant Information Sheet



Participant Information Sheet (Individual Participants)

Date Information Sheet Produced:

07-02 2011

Project Title

The challenges of health promotion within the African communities in New Zealand An Invitation

My name is Kudakwashe Tuwe. I am doing a Masters in Philosophy (M.Phil) at the Auckland University of

Technology, with the Institute of Public Policy.

You have received this information sheet because you responded to my recruitment and selection process for people to take part in my above research topic or you were given it by someone (for example your community leader) who saw that you qualify to participate and thought you might be interested.

Please note that participation is voluntary and you have the right to withdraw your participation at any given time during this process without any adverse consequences.

Please read this sheet, and if you think you would like to take part, then contact me by telephoning on **09 303 3124 (Business)** or **021 065 9305 (Mobile)** or writing to me: **Kudakwashe Tuwe Po Box 121369 Henderson, Auckland, 0650 New Zealand.** I would like to hear back from you before the end of **May 2011.**

What is the purpose of this research?

The main aim of this study is to find out the health promotion challenges that are facing the growing African communities in New Zealand. Please note that it is only the New Zealand-based African community members who know these issues and how to prescribe the required solutions.

This is the first research of its kind in New Zealand. It is therefore important for members of the New Zealand-based African communities to tell their stories relating to the challenges they have faced on the health promotion delivery system in New Zealand.

Once completed, the results will be presented to the responsible authorities (in New Zealand) with a view of them (authorities) doing something positive after been informed (by this research).

How was I identified and why am I being invited to participate in this research?

The recruitment and selection criteria require that participants meet the following requirements:

- be originally from the continent of Africa,
- be above the age 20 years

- Having been living in New Zealand for at least two years and above
- Be able to communicate effectively in English. Interpretation services will not be available in this research.
- Have either a refugee or migrant background
- Mostly stay in either Auckland, Hamilton and Wellington
- The recruitment process includes public meeting with community leaders and community members.

What will happen in this research?

I will interview each participant for approximately 45-60 minutes. The focus group discussion will be allocated between 60- 90 minutes, for meaningful and informative deliberations. With your permission, I will tape the interview and take notes. After that, I will send you the two interview typed copies for your verification and you are free to make any changes, should you wish to. You have to return one copy and you are free to keep the other one, if you wish to.

I will then analyse all the interviews, and look for relevant themes which are similar and different. In addition, I will also look at information, which will place your lived experiences in the context of the health promotion challenges you have faced or experienced in New Zealand. After putting and consolidating everything together the thesis will be a combination of excerpts from your stories, and a discussion of themes during focus groups.

I will also discuss with you, the theoretical information about this research project processes and the reasons why I had to select the manner in which I have done this study in this particular way.

What are the discomforts and risks?

Please be aware that in the interview and focus group processes you will be talking about your personal lived experiences and this may cause some discomfort and revive past emotions. It is important that you know that by been asked as a participant, to share your experience, thoughts and feelings on the health challenges you have faced may evoke some sad memories, especially for those who may have faced challenges like discrimination, racism, exclusion. This may cause some re-traumatisation and grief, on your part.

Some of the participants who were well-to-do and influential in their home country communities (before coming to New Zealand) may experience a sense of loss and low self-esteem, as they re-tell their experiences in New Zealand. This may cause some embarrassment as their community social status and influence will have been eroded.

As regarding the focus groups some participants may not feel comfortable as a result of group ground-rules set for the smooth running of focus groups and to guide group discussions, such as not speaking over others, laughing at other's contributions, dominating others, which some groups may not be used to. Some participants may feel uncomfortable being required to adhere strictly to these ground rules. However, every effort will be made to ensure that these are minimised or where possible eliminated.

How will these discomforts and risks be alleviated?

In the event of participants feeling embarrassed, re-traumatised or experiencing feelings of discomfort, the interview will be stopped and they will be referred for counselling services provided by the Auckland University of Technology (AUT) at any of the three campuses, Auckland Central, North Shore Campus or Manukau Campus, depending on where they prefer or live.

Please note that you have the right to bring along a support person (including family members) of your choice to the interviews and that you are free not to respond or answer any question(s) that you are uncomfortable with.

As a researcher and interviewer I will remain professional and ensure that you, as a participant, are not pushed and pressed to divulge information that you are not comfortable to discuss. I will not push participants to points that may evoke some adverse past emotions. I will constantly check with my supervisor(s) after each set of interviews for guidance. My supervisor's (Dr Chile) contact details are provided below.

What are the benefits?

Your voluntary participation in this study will give you an opportunity to share your experiences from your point of view. Some people often find it has empowering and invigorating experience. This research project will capture and record health promotion challenges faced by the New Zealand-based African communities and these will be revealed to the responsible authorities with a view of addressing these issues. It is important for policy makers to understand these issues and take them into account when developing relevant policies.

In addition, sharing and hearing other people's experiences will give participants a sense that they were not the only ones facing these challenges.

Findings from this study will be published in academic journals. However, no personal details of individual participants will be used in any publication in order to minimise the possibility of individuals or groups being identified or particular aspects of the data.

How will my privacy be protected?

Pseudo names will be used to protect your privacy, when telling your experiences regarding the health promotion challenges faced by the New Zealand-based African communities. It is also important to note that the information you will supply will be kept in a secure place, under lock and key in a locked building. Following the study, my supervisor is required to keep all the information (you will have supplied) in a secure place for a period of six years, after which it will be destroyed. If you decide to withdraw from the study (before its completion), your information will be immediately destroyed.

It is also important to realise that I cannot guarantee your anonymity as some of your personal story(s) will be quoted in the thesis, and it may be possible that someone who knows you will recognise your story.

In addition, your privacy can be further protected by you choosing a time and place for the interview which suits you.

What are the costs of participating in this research?

The major cost of participating in this study is your time. If it is fine with you, I am happy to interview you in your home. Provided it gives you the privacy and convenience you need.

If it is not possible, we can decide together a venue which you would be comfortable with and I can look into the possibility of arranging transport for you or reimburse you for travel costs incurred to get you to the agreed venue.

What opportunity do I have to consider this invitation?

If you are interested in participating in this project, after going through the information on this Information Sheet, please get in touch with me as soon as possible so that we make arrangements. My contact details are below.

How do I agree to participate in this research?

If you agree to participate in the study, please complete a simple Consent Form (Appendix E) which is attached. Forms can be obtained from me directly or your local community leader(s).

Will I receive feedback on the results of this research?

If you are interested in getting the feedback on the results of this research, please let me know so that I can organise this for you. I can post a full report of the final results or send you on your email- whichever way you prefer.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, whose contact details are as follows:

- Dr Love M Chile, Auckland University of Technology (AUT) Institute of Public Policy (IPP), 350 Queens Street, 2nd Floor, Auckland, New Zealand.
- Email address: Love.chile@aut.ac.nz
- Work Telephone number is 09-921-9999 Ext 8312

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz , 921 9999 ext 8044.

Whom do I contact for further information about this research?

Research Contact Details:

The research details are as follows:

- Name: Kudakwashe Tuwe
- Telephone number 09-303-3124 (Business) or 021 065 9305 (Mobile)
- Email address: ktuwe@yahoo.co.nz

Project Supervisor Contact Details:

The contact details for my supervisor are as follows:

- Dr Love M Chile, Auckland University of Technology (AUT) 350 Queens Street, 2nd Floor, Auckland, New Zealand.
- Email address: love.chile@aut.ac.nz.
- Work Telephone number is 09-921-9999 Ext 8312

Approved by the Auckland University of Technology Ethics Committee on 28th April 2011,
AUTEK Reference number 11/64.

Appendix B: Service Provider Participant Information Sheet



Participant Information Sheet (Service Providers/Organisations)

Date Information Sheet Produced:

07-02 2011

Project Title

The challenges of health promotion within the African communities in New Zealand
An Invitation

My name is Kudakwashe Tuwe. I am doing a Masters in Philosophy (M. Phil) at the Auckland University of Technology, with the Institute of Public Policy.

Your organisation has received this information sheet because I have selected you as one of the organisations that have a direct dealing with some of the members of the New Zealand-based African communities.

Please note that participation is voluntary and you have the right to withdraw your participations at any given times during this process without any adverse consequences.

Please read this sheet, and if you think you would like to take part, then contact me by telephoning on **09 303 3124 (Business)** or **021 065 9305 (Mobile)** or writing to me to **Kudakwashe Tuwe Po Box 121369 Henderson, Auckland , 0650 New Zealand**. I would like to hear back from you before the end of **April 2011**.

What is the purpose of this research?

The main aim of this study is to find out the health promotion challenges that are facing the growing African communities in New Zealand. Since your organisation is one of the service providers for the members of this community, your participation in this research will contribute key and important information

This is the first research of its kind in New Zealand. It is therefore crucially important for members of the New Zealand-based African communities to tell their stories relating to the challenges they have faced on the health promotion delivery system in New Zealand.

Once completed, the results will be presented to the responsible authorities (in New Zealand) with a view of them (authorities) doing something positive after been informed (by this research). As a participating service provider organisation, you will get a copy of the final findings

How was I identified and why am I being invited to participate in this research?

Your organisation has been selected simply because you are a service provider to some of the members of the New Zealand-based African communities.

What will happen in this research?

I will interview a representative of your organization for approximately 45-60 minutes. With your permission, I will tape the interview and take notes. After that I will then give you two copies for your verification and you are free to make any changes, should you wish to. You have to return one copy and you are free to keep the other one, if you wish to.

I will also discuss with you the theoretical information about this research project processes and the reasons why I had to select the manner in which I have done this study in this particular way.

What are the discomforts and risks?

Please be aware that the interview may involve talking about personal lived experiences of some of the community members and this may cause some discomfort on your part.

How will these discomforts and risks be alleviated?

As a researcher and interviewer I will remain professional and ensure that you, as a participating organisation, you are not pushed and pressed to divulge information that you are not comfortable to discuss. I will constantly check with my supervisor(s) after each set of interviews for guidance. My supervisor's (Dr Chile) contact details are provided below.

What are the benefits?

Your voluntary participation in this study will give you an opportunity to share your experiences from your point of view, as a service provider.

This research project will capture and record health promotion challenges faced by the New Zealand-based African communities and these will be revealed to the responsible authorities with a view addressing these issues. It is important for policy makers to understand these issues and take them in to account when developing relevant policies.

What compensation is available for injury or negligence?

I do not anticipate any injuries or negligence's but however, in the unlikely event of a physical injury as a result of your participation in this research, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation (ACC), providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

Pseudo names will be used to protect your privacy, when telling your experiences regarding the health promotion challenges faced by the New Zealand –based African communities.

It is also important to note that the information you will supply will be kept in a secure place, under lock and key in a locked building. Following the study, my supervisor is required to keep all the information (you will have supplied) in a secure place for period of six years, after which it will be destroyed. If you decide to withdraw from the study (before its completion), you information will be immediately destroyed.

What are the costs of participating in this research?

The major cost of participating in this study is your time. If it is fine with you, I am happy to interview you at your organisation. Provided it gives you the privacy and convenience you need.

What opportunity do I have to consider this invitation?

If you are interested in participating in this project, after going through this information on this Information Sheet, please get in touch with me as soon as possible so that we make arrangements. My contact details are below.

How do I agree to participate in this research?

If you agree to participate in the study, please complete a simple Consent form (Appendix E) which is attached. Forms can be obtained from me directly.

Will I receive feedback on the results of this research?

If you are interested in getting the feedback on the results of this research, please let me know so that I can organise this for you. I can post a full set of the final results or send you on your email- whichever way you prefer.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, whose contact details are as follows:

Dr Love M Chile, Auckland University of Technology (AUT) Institute of Public Policy (IPP), 350 Queens Street, 2nd Floor, Auckland, New Zealand.

Email address: Love.chile@aut.ac.nz

Work Telephone number is 09-921-9999 Ext 8312

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Whom do I contact for further information about this research?

Research Contact Details:

The research details are as follows:

Name: Kudakwashe Tuwe

Telephone number 09-303-3124 (Business) or 021 065 9305 (Mobile)

Email address: ktuwe@yahoo.co.nz

Project Supervisor Contact Details:

The contact details for my supervisor are as follows:

Dr Love M Chile, Auckland University of Technology (AUT) 350 Queens Street, 2nd Floor, Auckland, New Zealand.

Email address: love.chile@aut.ac.nz.

Work Telephone number is 09-921-9999 Ext 8312

Approved by the Auckland University of Technology Ethics Committee on 7th June 2011, AUTEK Reference number 11/64.

Appendix C: Consent Form for the Researcher (Interviews)



For use when interviews are involved- Individual Participants.

Project title: The challenges of health promotion within the African communities in New Zealand

Project Supervisor: Dr Love M Chile

Researcher: Kudakwashe Tuwe

- I have read and understood the information provided about this research project in the Information Sheet dated 27/02/2011.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes No

Participants' signature:.....

Participants' Name:.....

Participants' Contact Details (if appropriate) :.....

Date:.....

***Approved by the Auckland University of Technology Ethics Committee on 7th June 2011
AUTEK Reference number 11/64***

Note: The Participant should retain a copy of this form.

Appendix D: Interview Questions for Community Leaders

Interview Questions for Community Leaders

Topic: The challenges of health promotion within the African communities in New Zealand.

1. Please describe to us what you know about the health promotion delivery system in New Zealand?
 - **Probing/ Prompt Question(s):** *Your knowledge and experience about how the health system meets the needs of clients/ patients/ people who need health services*

2. What has been your personal experience with the health promotion delivery system in New Zealand?
 - **Probing/ Prompt Question(s):** *When you or a member of your family needed health care, how did you find the experience?*
 - – *Pleasant?*
 - – *Difficulty?*
 - – *challenging?*

3. Please explain to us what you understand by health promotion?

4. Please describe your experience of health promotion in New Zealand
 - **Probing/ Prompt Question(s):** *Has anybody spoken with you about how to access health service?*
 - *Has anyone talked to you about how to prevent illnesses like colds, flu, flu injections, cardiovascular diseases (CVD) diabetes, stroke and heart attack?*

5. In your experience, how effective is health promotion?
 - **Probing/ Prompt Question(s):** *How have you been involved in health promotion activities?*
 - *Have seen any advert on TV, Newspapers, fliers, handbills?*
 - *Has anyone come to speak at your community meetings about health promotion or health issues?*
 - *Information from your General Practitioner (GP) or any other health provider?*

6. How effective is this for you as an African?
 - **Probing/ Prompt Question(s):** *How does this meet your cultural, social, spiritual needs as an African?*

7. What do you think service providers need to better meet the health promotion needs of Africans communities in New Zealand?
 - **Probing/ Prompt Question(s):** *Cultural awareness?*
 - *Social contexts*
 - *Beliefs*
 - *Spirituality?*

8. Are there any other things or issues that service providers need to do better meet the health needs of African communities in New Zealand?

9. Are there any other issues that we have not covered in this discussion that you want to raise or discuss?

Thank you for your participation.

Demographic Data

Your Age Range (years): (Indicate by an "X" or tick)

- 20-30
- 30 -40
- 40-50
- 50-60
- 60+

Sex:

- Male
- Female

How long have you lived in New Zealand:

- 2-5 years
- 5-10 years
- 10-15 years
- 15-20 years
- 20 + years

Education:

- Primary
- Secondary/College
- Tertiary/ University

Profession:

- Engineering/ IT
- Education
- Health
- Banking/ Finance
- Hospitality/ Entertainment
- Arts/Dancing/ Music
- Students
- Other (please specify).....

Country of origin:

Immigration status when entered into New Zealand? :

- Refugee
- Migrant
- New Zealand born

Date:.....

Appendix E: Interview Questions for Service Providers

Interview Questions for Service Providers (Organizations like Refugee Services, Auckland Regional Migrant Services (ARMS), Refugees as Survivors (RAS) and District Health Boards (DHBs))

Topic: The challenges of health promotion within the African communities in New Zealand.

1. Please describe to us the services that you provide for clients?
2. What proportion of your clients would be of African origin or “Africans” generally?
3. Please explain to us the ways that you think your services meet the needs of African clients?
 - **Probing / Prompting Questions:** *Cultural needs?*
 - *Social needs?*
 - *Beliefs?*
 - *Refugee background?*
4. In what ways do you address health promotion needs of your African clients?
5. What specific challenges do you face in meeting the health promotion needs of your African clients?
6. From your experience, how effective do you think health promotion works with African clients and African communities generally?
7. What do you think service providers need to do in order to better meet the health promotion needs of Africans communities in New Zealand?
 - **Probing/ Prompt Question(s):** *What do you know?*
 - *What do they do?*
 - *Networks?*
8. Are there any other things or issues that service providers need to do better meet the health needs of African communities in New Zealand?
9. Are there any other issues that we have not covered in this discussion that you want to raise or discuss?

Thank you for your participation.

Date:.....

Appendix F: Research Safety Protocol

Researcher Safety Protocol

Topic: The challenges of health promotion within the African communities in New Zealand

As the researcher, I will make sure that I have researched and have a basic understanding of the cultural values, traditions and beliefs of the participant(s) before conducting the interviews. I will also ensure that these cultural values are respected all the time during and after the interviews. In order to ensure that the interview venues for both individual interviews and focus groups are free and conducive, these will be conducted in places where participants feel free and comfortable. These places include Community Halls, Community Meeting Rooms or offices.

In order to ensure that I am safe, all the individual interviews and focus group discussions will be held during the day, especially if the venue is the participant(s)' house. To further create a professional and conducive environment, no interviews will be held in my office or my house.

At times participants may request that interviews be carried out in their houses. Under such circumstances, I will put in place a plan that will safely guide my security. The plan will operate as follows:

- All scheduled interview times, including dates, travel times and specific venues (physical addresses) will be detailed in the plan
- This schedule will be given to my wife or a close friend whom I will closely be working with
- I will communicate, through a phone call or text, with my wife/ colleague just before the start and as soon as I finish the scheduled interview
- If my wife or colleague does not hear from me, between 10- 15 minutes, after the scheduled interview, she will then call me on my mobile to check on my safety
- If I do not respond to the call, she (my wife/ colleague) will then have to physically come to the scheduled venue/ location and check on my security circumstances.

Participants will be informed and reminded of their right to bring along a support person of their choice, should they choose to. However, this support person will not be permitted to respond to the interview questions.

Appendix G: Confidentiality Agreement (Transcriber)



For someone transcribing data, e.g. audio-tapes of interviews.

Project title: The challenges of health promotion within the African communities in New Zealand

Project Supervisor: Dr Love M Chile

Researcher: Kudakwashe Tuwe

- I understand that all the material I will be asked to transcribe is confidential.
- I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: 

Transcriber's Name: Kudakwashe Tuwe

Transcriber's Contact Details (if appropriate):

P. Po Box 121369, Henderson, Auckland, 0650, New Zealand.

Date: 7 February 2011

Project Supervisor's Contact Details (if appropriate):

Dr Love Chile (IPP Department)

350 Queens Street 2nd Floor,

Auckland, New Zealand.

Approved by the Auckland University of Technology Ethics Committee on 7th June 2011 AUTEK Reference number 11/64.

Note: The Transcriber should retain a copy of this form.

Appendix H: Glossary

1. **ACLI 1** -During the research interviews participants from the community (community leaders) were coded according to the area/ city they came from. For example ACLI 1 means Auckland Community Leader Interview 1.
2. **WCLI 6-** mean Wellington Community Leader Interview 6 and so on
3. **HCLI 4-** means Hamilton Community Leader Interview 4
4. **SPI 2** - means Service Provider Interview 2. The service providers were not grouped according to their domiciled cities but were allocated numbers 1-10.
5. **FGI** - means Focus Group Interview