Exploring young African migrant women's conceptualisation of their health, healthcare experiences, and improvement of services in Aotearoa New Zealand

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2022

A thesis submitted to Auckland University of Technology in
fulfilment of the requirements for the degree of
Doctor of Philosophy

ABSTRACT

The increasing diversity of the Aotearoa New Zealand population has noticeably impacted on healthcare service provision, access, and utilisation, with health service underutilisation more prevalent among young immigrants. The research presented in this thesis explored the shared experiences and insights of young African migrant women between the ages of 16 and 35 years regarding Aotearoa New Zealand youth healthcare services. This objective was pursued by creating a platform for an open and creative dialogue for the participants to rewrite their narratives and reposition their knowledge to interact or negotiate with mainstream knowledge on equal terms; as well as challenge the shapes and forms of discrimination and segregation, barriers to access and engagement with services, and the prospect of what must be the betterment of their wellbeing.

I applied a decolonising theoretical framework in line with African epistemology. The philosophical teachings of these theories are vast; in this study, I focused on the key tenets that reflect the research context, the participants' life worlds and my positionality. The decolonising process involved asking how my research would: 1) challenge dominant ideologies; 2) ensure collective community validity of knowledge; 3) reflect the significance of race and racism and their interconnectedness with gender; and 4) empowered the participants for social change which suited the population being studied, whose culture and traditions are passed down orally. Data were collected by using storytelling sharing circles – a focus group method common in Africa contexts and practiced in research amongst Indigenous people for generations in various parts of the world. Findings were thematically analysed with a decolonising lens to ensure minimal misinterpretation of findings or loss of meaning. A triangulation approach was employed which used field notes involving observation and in-depth reflection to evidence meaning and aid in the understanding of contextual information, encounters, and information gathered during individual storytelling, and the storytelling circles.

Sixteen young African women of African origin and identity participated in the main study. The research encountered hurdles in the collective and collaborative research processes. Eight participants were interviewed individually to capture data behind the unforeseen challenges. Only four of the 16 participated until the end of the research project. They developed a video artefact, which openly discussed their culture, ways of thinking and behaviour, and how these influenced their access to and use of youth health services, and their recommendations. Four common themes emerged: (1) making meaning of our health and wellbeing; (2) young African women's experience and views of Aotearoa New Zealand health services; (3) participants' shared prosperity and aspirations for positive health outcomes; and (4) barriers to democratic participation and collective action.

The findings show a visible epistemological tension—both in the application of African philosophical principles in conducting research and contesting and contrasting the participants' cultured bodily expression or embodiment against the mainstream biomedical narratives perpetuated by Aotearoa New Zealand's services providers. The concepts of 'embodiment' and 'embodied belonging' provided a more nuanced understanding of how migration, exclusion, and marginalisation contribute to shape health-related inequities for young African women's lives; the conditions of their existence and bodies which do not just tell stories but hold histories; and how their struggle for integration sought to regain health and sustain their wellbeing which cannot be divorced from religion and spirituality, and their social positioning as young African Black migrant women.

These findings have implications for research, policies, and clinical practice. For instance, the study's findings provide an evidence-based definition of health and wellbeing for young African migrant women to combat a 'one-size-fits-all' definition which has implications for the design of a model of care for this group. The study also unearthed different social factors operating concurrently and, therefore, accounts for a dimension of non/belonging and its effects on the domain of health, illness, and healthcare delivery for migrants. In this research, the discourse of African philosophy demonstrates its ability to serve as a guide for research with other marginalised groups and Indigenous people because it addresses issues pertinent to most formerly colonised (and collective) societies.

Key words

Young African migrant women; health and wellbeing; healthcare services; African epistemology; decolonising methodology; embodiment; Aotearoa New Zealand.

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ATTESTATION OF AUTHORSHIP

I hereby declare that this is my own work and that, to the best of my knowledge and belief, it does not contain material previously published or written by another person, nor material which has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made.

Signed:

Date: 4 April, 2022

ACKNOWLEDGEMENTS

My heartfelt thanks for the Vice-Chancellor Doctoral Scholarship which gave me the opportunity to pursue my doctoral studies for the betterment of my people in Aotearoa New Zealand, and my academic and professional growth. Words fail to express my gratitude. I also extend my warm gratitude to many people who have contributed their time, skills, and expertise. Firstly, I would like to acknowledge my supervisors—Dr Sari Andajani-Sutjahjo and Professor Eleanor Holroyd—for the unlimited support, coaching, and the dedication to see me through a challenging but rewarding phase of my life. A year ago, I would never have believed that there is light at the end of the tunnel. Many thanks to the Student hub, in particular Emilliana Faapoi, who assisted my family and I, emotionally and financially, during the first wave of the COVID-19 outbreak in Aotearoa New Zealand.

My appreciation is also extended to David Parker who pitched in to proofread and format my research, giving me the much-needed time to recover the years I have lost being away from my partner—Nicholas—and our three little babies, Nate who recently turned six years of age, Briony who is four years of age, and Blessen who is 16 months.

My utmost sincere gratitude to the participants who took part in the research. Your precious time and valuable participation cannot go without being acknowledged. Without you, this research project would not be possible.

Last but not least, my fond thanks to my husband Nicholas for being a father and mother to our children in the last four years. The mental, emotional, and physical anguish you embraced to see me cross the finish line—I will be forever grateful. I thank my mother for her emotional and spiritual support all the way from another part of the world.

Lastly, I glorify my Heavenly Father. Without His blessing, favour, grace, and love for me, all this would have been just a dream.

GLOSSARY

African migrant	See Section 1.6 on key definitions used in this study.
African gate keeper	One who has control of and/or regulates access to the community.
Aotearoa	Māori term used for New Zealand.
Biomedical	The most widely accepted model of healthcare that underlies the theories and practices of modern medicine.
Culture	The ideas, customs and social behaviour of a particular people or society.
Dominant	Ruling, governing, or controlling; having or exerting authority or influence.
Epistemology	Part of a philosophy which deals with knowledge and knowing.
Eurocentric	Ways of thinking which are rooted in European value systems and European ways of knowing the world.
Identity	The sense of self of an individual; the way he/she sees himself/herself.
Ideology.	The narrative and ideas through which dominant social actors maintain their control over marginalised sectors of the world.
Māori	Indigenous Polynesian people of mainland New Zealand (Aotearoa).
Marginalisation	The condition of being situated at the peripheries of mainstream society, without access to basic resources.
Narrative	The process of making a story and the story itself which is generated in the process.
Pākehā	Generally, a Māori-language term for New Zealanders primarily of European descent.
Patriarchy	Hierarchical organisation of the social structures which privilege masculine norms and ideals and rewards masculine values.
Ubuntu	An African philosophy described as the capacity in an African culture to express compassion, humanity, dignity, reciprocity and mutuality in the interests of building and maintaining communities with just and mutual caring.

CHAPTER ONE: INTRODUCTION

As the movement of people occurs increasingly across the globe, receiving western countries face a huge challenge to understand and address the healthcare needs of ethnic minority groups. This study focuses on young African migrant women in Aotearoa New Zealand and aims for recognition of this ethnic group as a significant population in Aotearoa New Zealand's development with unique healthcare needs.

This chapter presents the background to the study, its significance and rationale as a research topic. The first section outlines four major trends in the last decades influencing this research. These trends are: (i) the mass influx of mixed migrants from Africa to Aotearoa New Zealand; (ii) the lack of health research on young African women migrants in Aotearoa New Zealand; and, subsequently, (iii) the lack of policies, programmes, and services sensitive to African youth migrant health; and (iv) the use of Eurocentric worldviews to inform research methodologies which may not be relevant to the cultural and traditional customs of migrant populations. In the second and third sections, I discussed the rationale and significance of the research, its aims and scope. My research was situated in Auckland for reasons described later. I also provide a brief discussion on the potential research contribution to Te Tiriti o Waitangi and scholarship on African young migrant women's health and wellbeing. The fourth section includes an overview of Aotearoa New Zealand's healthcare system and particularly that part that is relevant to migrant youth health. In the fifth section, I summarise the decolonising theoretical perspectives and the tenets of African epistemology used in this study. In the sixth section, I include key definitions used throughout the thesis. In conclusion, I give an overview of the thesis structure.

1.1 Trends Influencing the Study

In this section I present four major trends to support my argument for doing this research.

1.1.1 Migration and Resettlement of African Populations in the Global North

Today, 244 to 258 million people have moved across their country's borders (Crea et al., 2018; Issop Migration Working Group, 2018).[1] Young people account for over 12% of the migrant population, representing the largest mobile population in human history (United Nations Department of Economic and Social Affairs, 2019). Half of the young international migrants are women and girls, making migration a feminist issue (Fleury, 2016; Global Migration Group, 2014; International Organisation For Migration, 2017; Kanengoni, Andajani-Sutjahjo, & Holroyd, 2018; United Nations Department of Economic and Social Affairs Population Division, 2017b).

From 2000 to 2017, there had been an increase of Africans from the African continent by 68% compared to those migrating from the Asian region (62%); Latin America and the Caribbean (52%) and those from Oceania (51%) (United Nations Department of Economic and Social Affairs Population Division, 2017a). See Figure 1. Although African migration remains overwhelmingly within the continent, since the late 1980s there has been an increasing diversification of emigration out of Africa to Europe, North America, the Gulf and Asia (Flahaux & De Haas, 2016; United Nations Department of Economic and Social Affairs Population Division, 2017a). Unlike the general interpretation of the *dark and gloomy*[2] African continent, and African migration being driven by poverty, violence and underdevelopment, indeed most Africans migrate for family, work or study (Mlambo & Mpanza, 2019; Outlaw Jr & Jeffers, 2017; United Nations Economic Commission of Africa, 2017). Studies also found one of the unique migration drivers peculiar to young African girls and women to include 'finding a safe haven' from unfavourable cultural practices like female genital mutilation (Allotey, Manderson, & Grover, 2001; Elamin & Mason-Jones, 2020; Odukogbe, Afolabi, Bello, & Adeyanju, 2017; Said et al., 2018), forced marriages and social stigma and condemnation (de Leon Siantz, 2013; Fleury, 2016; International Organisation For Migration, 2017; Jolly & Reeves, 2005).

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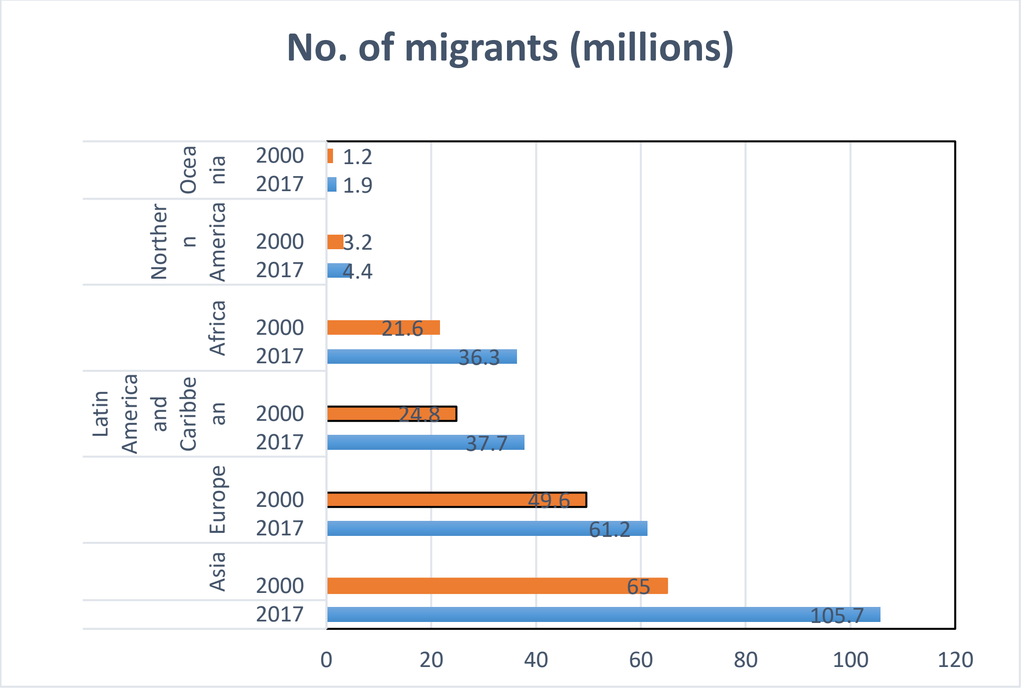
[1] The discrepancies in the figures provided by different studies are possibly due to the use of variations in the categorisations and definitions of migrants in different tools used in reporting migration data by the studies and/or countries (Rechela, Mladovsky, & Devillée, 2012).

[2] The under-developed state of the continent—an outcome believed to derive from post-colonialism—including civil unrest, political strife, lack of basic services, inadequate human capital investments, poverty, youth unemployment, and lack of essential resources, are the push factors (Mlambo & Mpanza, 2019; Outlaw Jr & Jeffers, 2017; United Nations Economic Commission of Africa, 2017); as well as unfavourable cultural practice, like female genital mutilation (Said, Conn, & Nayar, 2018).

Figure 1. Number of international migrants by region of origin in 2000 and 2017 globally



Source: United Nations (2017).

Western countries are the most preferred destinations with the top five destinations being: the United States (16.1 million), France and Germany (3.3 million each), Canada (2.3 million), and the United Kingdom (1.9 million) (International Organisation For Migration, 2014; Woetzel et al., 2016). Between 2000 and 2017 there has been an increasing attraction to countries in the Pacific (Australia and New Zealand) (International Organisation For Migration, 2018).

Mass influx of mixed migrants from Africa to Aotearoa New Zealand

Aotearoa New Zealand shares a long history with Africa, being the first country in the world to accept refugees under 'Medical/Disabled' category during the late 1980s and early 1990s (New Zealand AIDS Foundation, n.d.; Stephens, 2017). Since the early 2000s, Aotearoa New Zealand immigration policies have recognised the benefits associated with migration for both the sending and receiving countries (United Nations Department of Economic and Social Affairs Population Division, 2017a). Kanengoni and colleagues (2018) found that each immigrant contributed about $2,653 to the government, which is 15 times higher that of $172 contributed by each New-Zealand-born individual. This is mirrored in the older age structure of the native-born population, with 47% of this group in the economically active band in 2013, versus 60% for migrants (Krupp & Hodder, 2017). Woetzel et al. (2016) argue for migrants to be able to contribute up to $1 trillion annually to the Aotearoa New Zealand economy, if the 20 to 30% wage gap between the migrants and those of comparable native-born workers was reduced.

African migration to Aotearoa New Zealand: Immigration policies and resettlement

History states that the first Black African to set foot on Aotearoa New Zealand's soil was a servant of Captain Furneaux who was part of Captain Cook's second voyage in the 1770s (Walrond, 2015). Recorded in the 1916 Aotearoa New Zealand census, under the term 'Race Aliens', were 95 Americans, six born in Africa (four Ethiopians and two Egyptians). By 1972, 266 Black Africans had completed courses under the Colombo Plan. Although most returned, a handful settled in Aotearoa New Zealand, married and started families (Walrond, 2015). The Colombo Plan, according to McLintock (1966), aimed to foster Aotearoa New Zealand's relations with then underdeveloped countries to protect the developed countries from the animosity of underdeveloped countries which they believed would be dangerous, should low living standards foster the growth of communism within the underdeveloped countries.

Before 1986, the Aotearoa New Zealand government believed that White Africans could adapt and adjust easily into the Aotearoa New Zealand society due to similarities in cultures and traditions (Nakhid et al., 2016). However, in 1986, a review of the Aotearoa New Zealand immigration policy resulted in the move away from only accepting White people from Africa to anyone who met a specific criterion in education, business, skill set, age or asset requirement (Beaglehole, 2013). This implied the Aotearoa New Zealand Immigration policy had remained an unofficially 'White immigration policy'.

In 1991, there was another milestone in Aotearoa New Zealand migration policy, marked by the amendment of the 1987 Act regarding the Refugee Convention. As a result there was an influx of roughly 3,000 refugees from the Horn of Africa (Somalia, Ethiopia, Eritrea, Djibouti, & Sudan) (Adelowo, Smythe, & Nakhid, 2016). Most of those refugees who arrived in the early 1990s were escaping from the devastating economic hardship in Africa caused by political unrest and the famine of 1992 (Walrond, 2015). In 1997, the annual global quota system of 800 refugees was established, which was amended to 750 places (Human Rights Commission, 2010). This quota has since increased to 1500 in 2022 (Office of the Minister of Immigration, 2022). By 2004, 44 out of 55 nationalities that make up the African continent were represented in Aotearoa New Zealand. Most were from South Africa (41,676), followed by those from Zimbabwe (8,151), Somalia (3,200), Egypt (2,000), Kenya (1,512), and Ethiopia (966) (Ministry of Social Development, 2008; Walrond, 2015).

Between 2001 and 2006, 60% of the Aotearoa New Zealand working population was immigrants (International Migration Settlement and Employment Dynamics, 2011), suggesting the Aotearoa New Zealand economy and development were becoming increasingly fuelled by migrants' contributions. This is believed to have been further accelerated by the introduction of key policies that targeted certain categories of immigrants, like international students as prospective skilled migrants (Hawthorne, 2014; International Migration Settlement and Employment Dynamics, 2011). Between 2007 and 2010, a 'Skilled Migrant Category' visa was introduced. This visa selected potential skilled migrants who had particular skill categories that matched with the identified needs and opportunities in Aotearoa New Zealand (International Migration Settlement and Employment Dynamics, 2011; Ministry of Social Development, 2008). This move was also intended to balance the remaining ageing population and the exodus of over 63,000 New Zealanders either on a permanent or long-term basis due to the attraction of the larger economy and labour market particularly in Australia and the UK (International Migration Settlement and Employment Dynamics, 2011).

Therefore, since the year 2007, Africans from the African continent have been able to enter Aotearoa New Zealand through various pathways, including the pathways of skilled migrants and international university students (Adelowo, 2012; Kanengoni et al., 2018). Categories for permanent residency include the family stream and temporary visas which include but are not limited to work, partnership work, and essential skills (Ministry of Business Innovation and Employment, 2017a). South

Africa is the only African country which continues to feature in the top five sending countries of immigrants to Aotearoa New Zealand (Immigration New Zealand, 2017).

Although the Immigration Survey Monitoring programme describes refugees and migrants as satisfied with their settlement and integration experiences and their ability to participant in the labour market (Ministry of Business Innovation and Employment, 2021), Adelowo (2012) found resettlement challenges for young African migrant women in the areas of employment, reunification with family members, housing, racism and segregation. This trend in migration and related issues is likely to continue in the future and, as such, the importance of positioning Africans in Aotearoa New Zealand as it relates to their health and wellbeing cannot be emphasised enough.

1.1.2 Deficit of Health Research on Young African Migrant Women in New Zealand

Knowledge, publications and data sets on the health and healthcare issues of young African women from the African continent in Aotearoa New Zealand are scarce (Kanengoni et al., 2018; Ministry of Health, 2017a, 2017b), suggesting young African immigrants to be the least-studied immigrant group. Historical and current trends in youth health studies have been heavily focused on Māori (Clark, Crengle, Sheridan, Rowe, & Robinson, 2014; Clark et al., 2011; Clark et al., 2013; Edwards, McCreanor, & Moewaka-Barnes, 2007; Saewyc, Clark, Barney, Brunanski, & Homma, 2014); Pasifika (Teevale et al., 2016; Teevale, Denny, Nosa, & Sheridan, 2013; Teevale, Denny, Percival, & Fleming, 2013; Teevale et al., 2012), and some Asian peoples (Ameratunga, Tin Tin, Rasanathan, Robinson, & Watson, 2008; Parackal, Ameratunga, Tin Tin, & Wong, 2011; Rasanathan et al., 2008). International literature attributes the exclusion or marginalisation of Africans to the complicated historical, political, and professional sensitivities around race and inclusion (Nyashanu & Serrant, 2016; Serrant-Green, 2011; Viruell-Fuentes, Miranda, & Abdulrahim, 2012); and the unsuccessful appeals to decision-makers to obtain data on them due to the challenges in reaching and engaging with these groups (World Health Organisation, 2018).

Aotearoa New Zealand studies have widely held the view that African migrants are part of the “Black” category, along with other phenotypically similar groups like Latin Americans and those from the Middle East (Kanengoni, Andajani-Sutjahjo, & Holroyd, 2020; Mortensen, 2007; Perumal, 2011). Migrant and refugee women and children continue to be left out in Aotearoa New Zealand's recent health reforms (Abbas et al., 2022). This approach either overlooks data on this group or make it difficult to utilise research data in critical healthcare decisions targeting African young migrant women. This study, therefore, seeks to conduct research and publish findings that advance the healthcare needs of young African women migrants.

1.1.3 The Lack of Youth Migrant Health Sensitive Policies, Programmes, and Services

As a follow-on to the above trend, the deficit of research on African youth health has led to the omission of this group and other ethnicities from policies and strategies. For instance, the recently launched 2019 Child and Youth wellbeing strategy focuses on the voices of Māori and Pacific young people, disabled young people, rainbow youth, and rural young people (Department of the Prime Minister and Cabinet, 2019), suggesting the voices of youth migrants to be less critical (more discussion on this can be found in section 1.4.1). This study is therefore both critical and timely as it comes in the wake of the 2030 Agenda for Sustainable Development call to *Leave No One Behind*, in which governments are encouraged to integrate the health needs of migrants and refugees into national plans, policies, and strategies.

1.1.4 The Use of Non-Relevant Research Methodologies with Migrant Communities

It is becoming increasingly important for researchers to critically reflect on and use research approaches that have a positive impact on the health outcomes of non-western ethnic groups. This trend therefore contests the effectiveness and relevance of the western mode of knowing on shaping the knowledge in health of young women whose values, beliefs, and culture are embedded in African traditions. This study has identified and implemented the appropriate epistemology to challenge the Eurocentric values, norms and interpretation of reality imposed onto African contexts and, in this study, honour the knowledge and experiences of the young African migrant women, and their insights, ideas, and aspirations to inform healthcare services, policies, and strategies to the betterment of their health and wellbeing. Empowered with a critical and de-colonial apparatus, the participants would advance in developing resilience towards legacies of oppression by working collectively to produce and implement knowledge as informed by their African worldview; and disseminate and position their own pools of knowledge to enable interactions with other systems of knowledge on equal terms. More on this can be found in Chapter Three.

These four trends give a background to the study and jointly support the rationale and significance of the proposed research.

1.2 Rationale and Significance of the Study

I have previously reported that African migrant youth are overlooked in youth health policies (Kanengoni et al., 2018). Young African migrant women represent a specific category of migrant youth who face triple forms of discrimination based on their gender, age, and migrant status (Global Migration Group, 2014); and the interplay of race, ethnicity, culture, and traditions (Ministry of Youth Affairs, 2002; Mortensen, 2011b). While there is substantial international research on various aspects of the health and wellbeing of young African migrant women, as well as published and practical experiences from trans-Tasman links with long-established migrant and refugees' programmes (Kanengoni et al., 2018), the healthcare experiences and needs of young African migrant women in other countries or continents cannot be assumed to be the same with those in Aotearoa New Zealand. For instance, youth migrant health policies or frameworks operating in other countries are not being implemented in Aotearoa New Zealand.

In addition, the categorisation of Africans varies across countries (Australian Bureau of Statistics, 2019; Statistics New Zealand, 2018; UK Office for National Statistics, 2017) which may affect health and healthcare access. For instance, the Australian Bureau of Statistics (2019) and the UK Office for National Statistics (2017) classifies all residents into cultural and ethnic groups according to geographical origin (for example, for Africans, that will be North African or Sub-Saharan Africa); whereas the Aotearoa New Zealand Government aligns its definition within African philosophy discourse to describe Africans as having place of origin in sub-Sahara

Africa (Ikpe, 2010; Statistics New Zealand, 2018). However, it differs in the sense that African philosophy does not identify Africans in the diaspora and neither does it include Afro-American/West Indians. They both exclude countries in the northern parts of the African continent (e.g., Algeria, Egypt, Libya, Tunisia, and Morocco), yet Figure 2 show these countries make up the African continental crust.[3] This African description continues to be used in the analysis of census data by most state sector and health sector data users, making Somalians and Ethiopians the largest identifiable African groups in Aotearoa New Zealand (Nakhid, 2018).

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[3] Ethnicity coding in New Zealand documents African nationalities from Zimbabwe and South African as 'European' regardless of the colour of skin (Statistics New Zealand, 2006). It may be that many African-born people moving to New Zealand, prior the 1990s were not of African ancestry; rather, they were the children of European-origin parents who had moved to South Africa and Zimbabwe. This trend has continued in New Zealand such that South Africans are classified separately from other African nations (Statistics New Zealand, 2013b).

Figure 2. Map of African continent

Source: Google.

As the African population continues to grow in Aotearoa New Zealand, healthcare inequities are likely to increase, as identified in studies of other ethnic communities in Aotearoa New Zealand (Kennedy et al., Akhtar, Heydon, & Norris, 2022; Cassim et al., 2022; 2021; Shrestha-Ranjit, Patterson, Manias, Payne, & Koziol-McLain, 2020). These inequities are discussed in section 1.4.2. This study therefore sought to make an original contribution to knowledge on the concept of health and wellbeing for young African migrant women and how their experiences of inequities in healthcare can be addressed. This was done by giving voice to young African migrant women to provide a nuanced understanding of the relationships between migration, the social, cultural and political complexity of young African migrant women, and how these complexities explain their cultured bodily expression or embodiment against the perpetuation of mainstream biomedical narratives. The thesis endeavours to provide policy recommendations on migration and youth health related issues that promote equitable health outcomes for migrant youth with similar collective and traditional cultures to African ethnic groups. This study also acknowledges Te Tiriti o Waitangi (the Māori text) which established the terms and conditions of all Tauiwi (an exclusive term for non-Māori) settlement in Aotearoa.

1.2.1 Study Contribution to Te Tiriti o Waitangi

Te Tiriti O Waitangi is a declaration of independence negotiated between the British Crown and hapū (subtribes) in 1840 stating Rangatira (chiefs) agreed to the Queen having a governor to exercise kāwanatanga (governance) over British people and their friends/allies; with Māori to retain their Tino Rangatiratanga (powers of full chieftainship) (authority and self-determination) over the whenua (land) and taonga (treasured things); and with Māori granted the same rights and privileges of British subjects while maintaining their religious and cultural freedom (Healy & Murphy, 2012). It deepened the relationship between the treaty partners and granted the British the rights to govern Tauiwi. Despite the successive colonial governments breaches of te Tiriti through active policies of colonisation, assimilation, and neo-liberalism (Waitangi Tribunal, 2019), it remains central to public policy (Cabinet Office, 2019), ethical public health practice (Public Health Association, 2007), and the striving for equitable outcomes for all citizens; and it is embedded in public health competencies, curriculum and practice (Public Health Association, 2007).

This study recognises the primacy of Māori as the Indigenous people of Aotearoa and recognises the obligations which necessitate careful attention to the ethnic health inequities facing Indigenous people of Aotearoa and other ethnic minority groups and urgency for proactive measures (Marriott & Sim, 2014). That said, the relationship between Africans from the African continent communities and Māori are still unfolding as the local African community grows. This is an under-researched area that needs further development and is beyond the scope of this study. However, Africans and Māori have a shared experience of colonisation, systemic racism and state violence. For instance, Indigenous activists based in South Africa and Aotearoa have particular long-standing connections through their shared collaboration in the anti-apartheid movement as it came to prominence in the notorious 1981 Springbok rugby tour (Johnson, 2009). Colonial oppression often impedes solidarity between colonised communities.[4] Under the Declaration of Indigenous People's Rights (United Nations, 2007), there are shared collective rights between Indigenous Africans and Māori. This, too, is a limitation of this study in that this solidarity was not more deeply explored.

1.2.2 Contribution to Scholarship on African Young Women's Health and Wellbeing

The academic contributions of this thesis are linked to the following three peer-reviewed articles and conference presentations: Kanengoni (2020), Kanengoni et al. (2020), and Kanengoni et al. (2018); and conference presentations at the AUT Annual Doctoral conference (20 November 2019) and 42nd Annual African Studies Association of Australasia and Pacific (26-27 November 2019), Dunedin, New Zealand. The conference paper was entitled *"Hard to reach but not out of reach": Understanding collaboration opportunities with young African female migrants in healthcare research in New Zealand.* They stand as dissemination strategies and the translation of research with social and cultural impact into health practice, into young women's future lived experiences with clinical encounters and their bodies.

In addition, some benefits or contributions were derived from this research by the participants, the researcher, and the wider community. Those benefits are described in Appendix B.

1.3 Aim and Scope of the Study

This research is believed to be one of the pioneer studies documenting and publishing the healthcare experiences and needs of young African migrant women in Aotearoa New Zealand. The study aimed to produce evidence-based recommendations for policies and youth healthcare services that will contribute to the health and wellbeing of young African migrant women. A platform was created to allow for an open and creative dialogue to explore the shared understanding of the young African migrant women's experiences, insights, ideas, and aspirations to inform services, policies, and strategies to better their health and wellbeing. The specific research questions were:

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[4] Personal communication with Associate Professor Heather Came (AUT), a prolific publisher on the application of Te Tiriti o Waitangi on 01/09/22.

1. How do young African migrant women create meanings of their health and wellbeing within the intersections of their gender, social, cultural, political, and traditional context?
2. What are young African migrant women's views and experiences of the Aotearoa New Zealand youth healthcare delivery system?
3. What are the best strategies for enabling youth female migrants to contribute to existing health, social, or youth services?
4. What are the best ways to implement the strategies identified in answering the above question?
5. How do young African migrant women participate in the research process and build collective knowledge and social transformation, and what are the inherent limitations?

This research acknowledges the complexity and difficulties in defining migrants. Thus, I allowed the participants to self-identify their migrant status to avoid being trapped into the debate on migration definition. However, the study excluded female youth who self-identified as refugees. Whilst it may be argued that refugees have existing concerns of poorer health outcomes, spanning mental health, general wellbeing, and social care needs than migrants (International Organization for Migration, 2020), I argue that a lot of work, research, and organisations or programmes have been designed with the mandate of meeting the needs of refugees. Although it is still work in progress, refugees have defined health and social services (Kennedy, 2016; Mahony, Marlowe, Humpage, & Baird, 2017; Marlowe, Bartley, & Hibtit, 2014), whereas migrant youth fall under mainstream services that may have ignored the specific cultural or social needs and context of migrant communities (Ministry of Youth Affairs, 2002; Mortensen, 2011b).

I also acknowledge that the health of a migrant is largely influenced by various stages of migration: pre-departure, transit and arrival, and the stay in the host country (International Organization for Migration, 2018). This study concentrated solely on the arrival and stay phases, to allow a focus on the long-term health and wellbeing of young African women in Aotearoa New Zealand. Subtypes of migrant groups were stated where necessary.

Sixteen young African migrants of African of African origin and identity aged between 19 and 36 years were recruited. They represented eight countries: Zambia, Zimbabwe, Jamaica, South Africa, Democratic Republic of Congo, Nigeria, Tanzania, and Ghana. They have linguistically and ethnically diverse backgrounds. Their length of residence in Aotearoa New Zealand at the time of the data collection ranged from 9 to 20 years – a short enough time to identify health vulnerabilities but long enough to allow for health deterioration (the healthy immigrant effect[5]) and the subsequent use of youth health services. I applied a decolonising lens to Braun and Clarke's (2012) thematic analysis approach to ensure the participants' voices were put first to ensure no misinterpretation of findings or loss of meaning of their realities (Chilisa, 2012; Kovacha, 2010; Tuhiwai Smith, 1999) and how others might perceive them (Brown & Gilligan, 1992).

1.3.1 Area of Study

Aotearoa New Zealand is home to 16,890 Africans (8,619 males; 8,265 females), making up 0.4% of the total population (Statistics New Zealand, 2018). Although this number is likely to be underestimated (Tuwe, 2012), Auckland has the highest African migrant population in Aotearoa New Zealand. Approximately 47% of African migrants live, study, and work in Auckland (McClure, 2016; Ministry of Business Innovation and Employment, 2017c; Statistics New Zealand, 2018). I chose Auckland as an appropriate location to conduct my research.

Demographics of Africans in Aotearoa New Zealand

African migrants are a relatively young population with a median age of 26.5 years (Statistics New Zealand, 2018), compared to the international median age of 39 years (United Nations Department of Economic and Social Affairs Population Division, 2017a). African migrants' median age is similar to the Pacific and Māori populations, which have a median age of 23.4 and 25.4 years, respectively (Statistics New Zealand, 2018), as detailed in Table 1.

Table 1. Median age of dominant ethnic groups in comparison with Africans

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[5] The "Healthy Immigrant Effect" (HIE) suggests that immigrants have a health advantage over the domestic-born which vanishes with increased length of residency (Elshahat, Moffat, & Newbold, 2021).

Ethnic group	Population	Median age
European New Zealand	3,297,864	41.4
Māori	775,836	25.4
Pasifika	381,642	23.4
Africans	16,890	26.5

Source: Statistics New Zealand (2018).

People who identified with European ethnic groups are generally older, with a median age of 41.4 years (Statistics New Zealand, 2018).

1.4 Aotearoa New Zealand Healthcare System: Policies and Programmes

In Aotearoa New Zealand, the primary healthcare is the first point of access into the health system for migrants (Goodyear-Smith & Ashton, 2019). Established in 1938, the Aotearoa New Zealand health service operates as a universal, tax-funded system that provides free services for its citizens and permanent residents (Goodyear-Smith & Ashton, 2019). Aotearoa New Zealand generally spends less per capita on healthcare than other countries. In 2013, Aotearoa New Zealand spent $US3,328, which is less than the Organization for Economic Cooperation and Development (OECD) average (US$3,453) or Australia (US$3,866), but more than the United Kingdom (US$3,235) (Cumming, 2017).

The system is made up of three main components: (i) public health services which provide and shape policies to promote areas that make a difference to lifelong health, such as immunisation and the management of outbreaks of infectious diseases, such as COVID-19; (ii) primary healthcare, which is the entry level into the health system and it includes a broad range of activities and services from health promotion and prevention to the treatment and management of acute and chronic conditions; and (iii) secondary healthcare, which is often hospital-based and requires a referral (Goodyear-Smith & Ashton, 2019). Most primary healthcare (privately owned general practitioners) have partial public funding and therefore waiver the fee for a regular daytime consultation for eligible children under 14 years. The waiving of fees is also applicable on a standard prescription and sometimes for eligible families (Goodyear-Smith & Ashton, 2019).

As of 1 July 2022, the 20 District Health Boards (DHBs) which are spread across the country's regions (see Appendix A) sit under one national authority—Health New Zealand—to fund and run the health system with aims to improve service delivery and increase positive health outcomes for all. This reformed health service structure has a new Māori Health Authority, an independent voice with power to commission health services to improve Māori health outcomes (Ahuriri-Driscoll, Lovell, Te Kawa, Te Ata o Tū McDonald, & Mathias, 2022).

Prior to 1 July 2022, and the creation of Te Whatu Ora (Health New Zealand), each DHB was responsible for ensuring the provision of health and disability services to populations within its defined geographical area. Each DHB received public funding from the Ministry of Health based on categories such as the total number of patients, their age, socio-economic status, ethnicities, and needs of individuals and communities (Minister of Health, 2016).

The following section reviews the Aotearoa New Zealand youth health sector. I will start by critically discussing the 2002 and 2019 Aotearoa New Zealand national youth development strategies and the impacts on youth health services and outcomes.

1.4.1 Aotearoa New Zealand National Youth Health and Development Strategies

The first Aotearoa New Zealand national youth development strategy was established in the year 2002. It set out to: "(1) ensure a consistent strengths-based youth development approach; (2) develop skilled people to work with young people; (3) create opportunities for young people to participate actively and engage; and (4) build knowledge on youth development through information and research" (Ministry of Youth Affairs, 2002, p. 8). Closely linked to the strategy, an 'Agenda for Children,' a parallel strategy focusing on issues for the 0-17 age group, was simultaneously rolled out. It aimed at "improving the life of our children" (Ministry of Social Development, 2002, p. 6).

In the same year, 2002, a youth health action strategy was implemented to set out actions that government would take in partnership with other youth health stakeholders, outlining co-developed strategies to improve the health of young people in Aotearoa New Zealand (Ministry of Health, 2002). This strategy further advocated for more school-based health clinics and more opportunities for the participation of young people in health sector decision-making.

In 2009, an extensive review of the youth health strategies was conducted to identify good practice in youth development programmes and assess the continued relevance of existing programmes (Ministry of Youth Development, 2009). The review established that youth development was still in its infancy, with limited knowledge of where successful intervention lay. For instance, the application of knowledge within the sector appeared variable at best, with a lack of a common language or a shared understanding of terms, concepts, ideas and knowledge of youth development.

By 2011, several youth health initiatives were introduced, with some approaches lacking adequate local assessments or evidence-based research (Youth Health Workforce Working Group, 2011). The repercussions of such initiatives resulted in poor youth health outcomes (Pollock, 2018; UNICEF, 2017). In 2011, a working group was established to focus on youth-centred health services and workforce needs by 2020 (Youth Health Workforce Working Group, 2011). Subsequently, a new Child and Youth Wellbeing strategy was launched in August 2019.

Child and Youth Wellbeing Strategy 2019

In 2019, the Child and Youth Wellbeing strategy was designed with a Programme of Action, which draws on evidence about what works and focuses on the urgent needs (Department of the Prime Minister and Cabinet, 2019). Between October and December 2018, an engagement process included multiple meetings, focus groups, and child and adult surveys which were conducted in informing the strategy and, this time, included recent migrants and refugees (Department of the Prime Minister and Cabinet, 2019).

When the Programme of Action was launched in August 2019, the initiative brought together more than 75 actions and 49 supporting actions led by 20 government agencies to include increase support for mental wellbeing, address racism and discrimination, and increase sense of belonging and cultural connections, to name a few. These actions were supported by NZ$3.5 billion in funding. Over the next one to five years (2019-2024), the Programme of Action sets out a platform for related policies, initiatives, programmes to achieve the vision of Aotearoa New Zealand to be the best place in the world for children and young people (Department of the Prime Minister and Cabinet, 2019, p. 4).

The 2019 Child and Youth Wellbeing strategy’s six high-level and interrelated wellbeing outcomes reflected what children and young people said were important. These were: (1) to be loved, safe, and natured; (2) have what they need; (3) be happy and healthy; (4) learning and developing; (5) accepted, respected, and connected; and (6) involved and empowered. These outcomes endorse the social, economic, and environmental factors needed for child and youth wellbeing. The Programme of Action has current information on progress, new focus areas, and investments that support child wellbeing and reduce poverty (Department of the Prime Minister and Cabinet, 2019). For instance, the 2020 budget included the Government response to COVID-19 ensuring continuing services for children and youth during the pandemic and to improve their wellbeing.

On the youth healthcare front, the strategy aimed to increase access by offering lower-cost primary healthcare and to increase support for mental health (Department of the Prime Minister and Cabinet, 2019). Since the announcement of the change of the Aotearoa New Zealand healthcare structure to Te Whatu Ora on 1 July 2022, it remains unclear how the youth healthcare strategy will be affected.

Migrant youth contribution to strategies and policies

The migrants and refugees’ involvement in the planning and design of the 2019 Child and Youth Wellbeing strategy saw them communicate their needs and expectations. These were: (1) for their cultures to be respected and welcomed; (2) recognition of the strengths, knowledge, and global connections they bring to Aotearoa New Zealand; (3) recognition of health needs and expectation that they will be met; (4) recognition of the existence of tensions in navigating intergenerational and intracultural issues and the provision of better support for them and their families; and (5) help to access services and navigate systems to deal with trauma and conflict or with cultural differences (Department of the Prime Minister and Cabinet, 2019). A budget was provided for work to understand the needs of diverse communities in order to develop future violence prevention programmes in Māori communities, and work with refugee and migrant communities in culturally appropriate ways to increase their wellbeing and diminish harm (Department of the Prime Minister and Cabinet, 2019).

Given limited social policies, programmes and studies that consider the contexts and needs of migrant youth, migrant youth are likely to experience higher rates of poverty and health inequalities than mainstream youth (Marlowe et al., 2014; Minister of Health, 2016; Ministry of Business Innovation and Employment, 2017b; Murdoch, 2017; Stephens, 2017). This context therefore calls for the government to embrace the UNCHR (2009) recommendations that facilitates the smooth integration of migrants and refugees in a collaborative process of participatory and community development approaches like "engaging local communities, institutions, and refugees alike in the design, implementation, and evaluation of integration policies and programs" (UNCHR, 2009, p. 7).

Next, I turn to the discussion on youth healthcare services in Aotearoa New Zealand. I describe why they are important; how they are accessed, and how youth utilise them.

Youth healthcare services

In Aotearoa New Zealand, youth healthcare services are primarily designed to provide healthcare for young people aged 8 to 24 years. Several studies (Auckland District Health Board, 2010; Ministry of Health, 2002, 2018; Youth Health Workforce Working Group, 2011) list the main domains of youth health services:

1) Family. Programmes are provided to support families in dealing with young people's physiological and psychosocial developmental needs.

2) Educational institutions, through health clinics provided at secondary school and tertiary institutes in collaboration with GPs, primary health services, and DHBs. School health services, for example, deliver services to all children and young people enrolled in schools with the highest proportion of students from low socio-economic communities (decile 1, 2 and 3), teen parent units, and

alternative education facilities. The service includes universal health, disability and youth development checks; individual health services when these are sought by a young person or as the result of a Registered Nurse contacting a young person; timely referrals to specialist services as appropriate (e.g., sexual health services, nutrition, weight management, and active follow-up of referrals to improve access); and health promotion activities.

3) The communities such as youth councils and advisory groups. These form part of the structure of the youth healthcare services, focusing on the promotion of active participation and development of young people in the community.

4) Primary healthcare. This includes GPs, public health nurses, and family planning services that offer youth-focused interventions like Young Mums Midwifery service (Counties Manukau DHB) which provides maternity care for young women who have additional social and psychological issues that may impact on their life when they are pregnant.

5) Hospital-based and specialist health services that provide youth-friendly services such as Youth Alcohol and Other Drugs and Mental Health services.

(6) Youth health-specific healthcare services.

(i) Why youth healthcare services are important

Historically, Aotearoa New Zealand mortality statistics have shown 10- to 24-year-olds to be the only age group not to have had a significant reduction in death rates until the early 2000s (Safekids Aotearoa, 2015). This is perhaps owing, in part, to free or subsidised government health services for children having a cut off at 15 years of age, leaving those 16 years and above to be serviced by adult-targeted services without acknowledgement of their unique and complex health issues and determinants which differ from adults (Safekids Aotearoa, 2015). Historically and recently, published studies show ongoing health problems among youth to include: high rates of mental illness, including suicide and self-harming; teenage pregnancies, abortion, and sexually transmitted infections (STIs); injuries associated with violence and traffic accidents; addictions and family violence (UNICEF, 2017). These studies support the need for and importance of youth healthcare services in Aotearoa New Zealand.

(ii) How youth access current healthcare services

Youth healthcare services are made accessible by offering walk-ins, telehealth and/or 0800 lines for youth needing counselling, or assistance in accessing community resources such as Youth Line and referrals to appropriate services or programmes (Ministry of Health, 2002). Services are free of charge for those eligible; yet, there are some barriers for young people accessing services, such as cost (transportation and waiting period), confidentiality and privacy (Ministry of Health, 2002). However, information on most youth health services are accessible in print, audio, or electronic formats (Ministry of Health, 2002). Some of these services also include information provided in ethnic languages, including Te Reo Māori, Hindi, Arabic, Farsi, Bengali, Urdu, and Mandarin. Other services are culturally specific like the Muslim Wellbeing Service and Aotearoa New Zealand Chinese Youth Trust.

(iii) How youth utilise current healthcare services

The use of youth health services by young people relates to illnesses that arise in adolescence, for example infections and acne. However, the burden of disease is more strongly associated with youth-specific behaviours like being more impulsive and taking more risks than adults; and the establishment of patterns of behaviour that persist into adulthood, for example, cigarette smoking and substance abuse (Fleming & Elvidge, 2010).

Young people often utilise a range of healthcare providers such as school health, family planning and GPs. Most young people say the main place they get healthcare is from a family doctor, medical centre or GP clinic.

The studies found varying levels of healthcare service uptake, and Māori and Pacific young people in particular depended on healthcare location and cost; however, the most common barriers reported by young people are issues such embarrassment, not wanting to make a fuss, or concerns about confidentiality (Fleming & Elvidge, 2010; McKinlay, Morgan, Garrett, Dunlop, & Pullon, 2021). Many young people report that they have had difficulties getting help for problems or were unable to access healthcare when they needed it. Young people are often reluctant to raise sensitive health issues and prefer to be asked rather than raising sensitive issues themselves (Fleming & Elvidge, 2010; McKinlay et al., 2021). Undisputed evidence also claims internet health information sites to be most frequented for topics including diet, STIs, and contraception, among many other health issues (Chester & Montgomery, 2008; Percheski & Hargittai, 2011).

The Aotearoa New Zealand health system generally performs well, but there remain significant inequities in access and health outcomes (Chin et al., 2018; Goodyear-Smith & Ashton, 2019; Solano & Huddleston, 2020), and these are more pronounced for migrant and refugees (Field, McClunie-Trust, Kearney, & Jeffcoat, 2020) as documented next.

1.4.2 Access and Availability of Migrant Health Services in Aotearoa New Zealand

The 2020 Migration Integration Policy Index reported the actions government has taken to build health systems which are inclusive and responsive to people of diverse cultural backgrounds (Solano & Huddleston, 2020). Of importance here is that Pacific and Māori health models have been adapted to serve migrant communities (Huddleston, Bilgili, Joki, & Vankova, 2015), implying these health models to have been centred on commonalities of the different ethnic cultures. However, migrant health is only a priority in the Auckland Regional Settlement Strategy (Migrant and Refugee Health Action Plan) (Waitemata and Auckland District Health Boards, 2017). Service responsiveness at local level also shows discrepancies (Mortensen, 2011b). For example, the Avondale-Roskill ward in Auckland where Africans predominantly live in is the most medically deprived ward in Auckland, with a disproportionately high rate of hospital admissions (Kanengoni et al., 2020).

Aotearoa New Zealand has primary healthcare as the initial point of access into the health system (Goodyear-Smith & Ashton, 2019), and enrols refugees as soon as they enter Aotearoa New Zealand (Richard, Richardson, Jaye, & Stokes, 2019). Yet, there is constrained access to healthcare such as the lack of cultural sensitivity or appropriateness in the delivery of healthcare to refugees and migrants (Field et al., 2020; Jayan & Dutta, 2021; Park, Loy, Lillis, & Menkes, 2022; Shrestha-Ranjit, Patterson, Manias, Payne, & Koziol-McLain, 2017; Shrestha-Ranjit et al., 2020). Perceived racial experiences and discrimination when interacting with the health system has also been reported to hinder access to healthcare (Akhtar et al., 2022;

Cassim et al., 2022; Shrestha-Ranjit et al., 2020). Further, the difficulties of finding information to navigate the health system were also noted as a big problem amongst migrants and refugees (Akhtar et al., 2022; Jayan & Dutta, 2021; Park et al., 2022; Shrestha-Ranjit et al., 2017). Migrants with limited English proficiency are severely impacted in terms of access and acceptability of interpreter services (Cassim et al., 2022; Kennedy et. al., 2021; Park et al., 2022; Shrestha-Ranjit et al., 2017, 2020). The quality of interpreters was found to vary, due to there being no accreditation system in place for interpreters in Aotearoa New Zealand (Ji, Taibi, & Crezee, 2019).

It has commonly been viewed and recommended that migrant health policies that seek to achieve health equity would recruit ethnically diverse migrant health workers (Field et al., 2020; Richard et al., 2019). A review on this is provided next.

Migrant healthcare professionals in Aotearoa New Zealand

Aotearoa New Zealand employs foreign, international or overseas trained doctors and nurses at relatively high rates compared to other OECD countries (New Zealand Productivity Commission, 2021). International medical graduates (IMGs)[6] make up 43% of Aotearoa New Zealand's specialist workforce, and dependency on IMGs is greater in the provinces, but has started to decline in recent years as the number of domestically trained doctors increased faster than the prior years (New Zealand Productivity Commission, 2021; OECD, 2019). Thirty percent of nurses employed by District Health Boards (DHBs) are migrants (New Zealand Productivity Commission, 2021). New Zealand draws most international migrants from English-speaking OECD countries (see Table 2) mainly to fill gaps in its ageing health workforce (International Migration Outlook, 2015; Ministry of Health, 2016). Data reveal that these migrants integrate the easiest (Beaglehole, 2013; Nakhid et al., 2016). However, they are the least likely to stay compared to overseas trained doctors from Africa, the Middle East, and Asia (Ministry of Health, 2016). The reason behind the low retention is due to the effect of the on-going shortage of medical skills on the workloads, wellbeing, and productivity of the senior doctors employed by DHBs (Ministry of Health, 2016).

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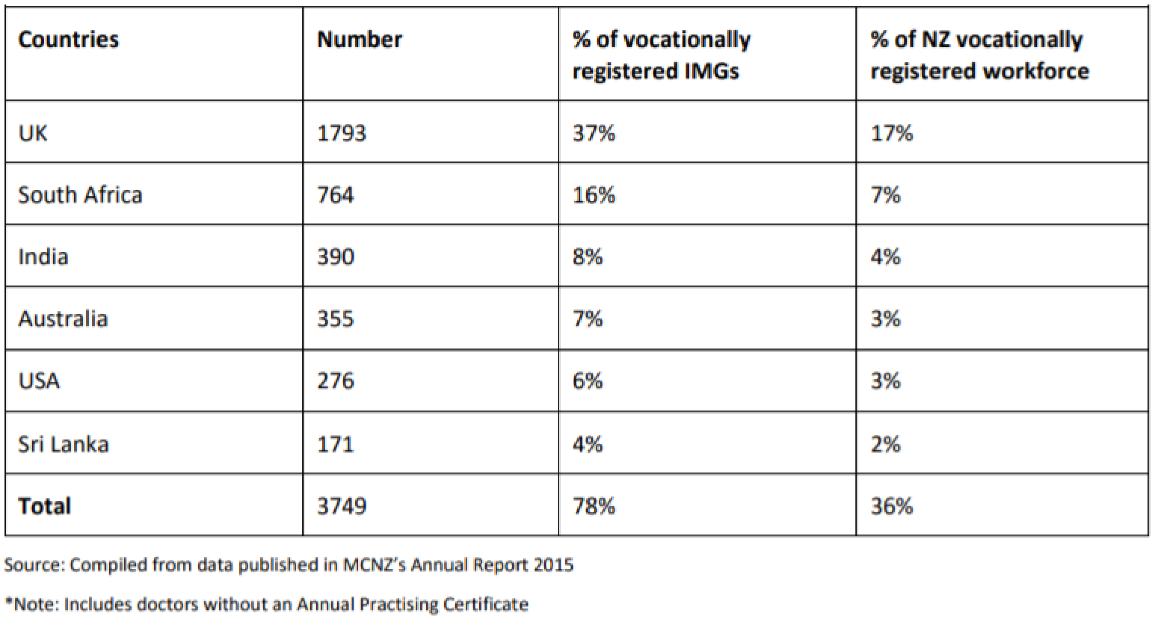
[6] An International Medical Graduate (IMG), previously known as an overseas trained doctor, is a doctor who obtained his or her primary medical qualification in a country other than New Zealand.

Table 2. Top six countries from which Aotearoa New Zealand sources health professionals



Countries	**Number**	**% of vocationally registered IMGs**	**% of NZ vocationally registered workforce**
UK	1793	37%	17%
South Africa	764	16%	7%
India	390	8%	4%
Australia	355	7%	3%
USA	276	6%	3%
Sri Lanka	171	4%	2%
Total	3749	78%	36%

Source: Compiled from data published in MCNZ's Annual Report 2015

*Note: Includes doctors without an Annual Practising Certificate

There is a code of conduct in recruiting international health workers which prevents targeted recruitment from developing countries (WHO, 2010). Whilst the WHO reported the African region to be suffering from the emigration of health professionals to OECD countries (Dumount & Lafortune, 2017), many of them still fail to practise in Aotearoa New Zealand (Health Central, 2018; Russell, 2018; Thomas, 2018). Recognition of foreign qualifications, in particular from non-English speaking countries, remains a problem for migrant health workers and continues to cause tensions between the recruitment policies that ensure high standards and quality in healthcare delivery (Health Central, 2018; Ministry of Business Innovation and Employment, 2019; Russell, 2018; Thomas, 2018) and the control of the inflow of foreign-trained workers (Tam, Edge, & Hoffman, 2016).

1.5 Decolonising Theoretical Framework of the Study

Chapter Three details the decolonialising process of enquiries that is shaped by African epistemology, personal positioning and the lived experiences of young African migrant women in Aotearoa New Zealand context. I engage with the works of McDougal (2014), Ani (2013), Udefi (2014) and Anyanwu (1983) to show how African epistemology serves as a decolonial tool which is explained by Anyanwu (1989, p. 60) as "disrupt[ing] the traditional ideas about how the human being perceives the world by establishing its ontological and epistemological perspectives which have been historically disregarded or purposefully marginalised". I identify and apply central tenets governing the assumptions, beliefs, and attitudes of African epistemology to frame the decolonising process and identification of decolonising strategies within the scope of this research. Guided by Tuhiwai Smith (1999) and Chilisa (2012), I apply the decolonial apparatus to these tenets by asking myself how my research would: 1) challenge dominant ideologies; 2) ensure collective community validity of knowledge; 3) reflect the significance of race and racism and their interconnectedness with gender; and 4) empower for social change.

I hoped the participants would be equipped with the knowledge, means and methods for determining and investigating what they believed as the valid representation of their knowledge and beliefs which could be mythical or beyond common-sense, but could improve equitable access to healthcare services.

1.6 Key Definitions Used in the Study

Culture remains, for many, a vague but dynamic concept, which Napier et al. (2014) stated can be sometimes overtly expressed, sometimes not openly defined. For instance, some studies view culture as implying shared understandings and practices, based on understandings, which make sense of beliefs held in common with others from the same ethnic group (Viruell-Fuentes et al., 2012; Williams & Deutsch, 2016). However, Williams and Deutsch (2016) argued against using an ethnic label (e.g., African) as people may have distinctive life experiences that yield different cultural beliefs and norms. Napier et al. (2014) further stated that culture does not equate solely with ethnic identity, nor merely refer to groups of people who share the same racial heritage. In this study, culture is a category of inquiry that is crucial to the experience of health and wellbeing, and the provision of healthcare (Chukwuneke, Ezeonu, Onyire, & Ezeonu, 2012; Napier et al., 2014). In this study, culture will be understood as a set of practices and behaviours defined by customs, habits, language, and geography (migrants from Africa) that are shared by African individuals.

The much-disputed question on **'**Who is an **African**' has been an on-going debate for decades, making it difficult to define an **African** migrant. The definition of a **migrant** mirrors the current struggle in differentiating between a migrant who leaves his/her country because of the effects of climate change, political instability of the country, persecution, conflicts, economic woes, or a combination of these reasons; and those who that are forced to leave to alleviate significant hardships that arise with natural disasters or extreme poverty, or migrate in search of means of survival or wellbeing that does not exist in their place of origin. However, according to the International Organization for Migration (IOM) (2019), a **migrant** is

> any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is.

However, as this study takes a decolonising approach in conducting research, it recognises identity narratives to decolonise stereotypes and deficit literature about indigenous people by reporting powerful stories that give back to the people, confidence and pride in who they are, their histories and their culture (Tuhiwai Smith, 1999). Identity narratives provide information about one's physical space, cultural location, ecological connection and relationships to others and to the living and the non-living (Tuhiwai - Smith, 1999) . Through African ontologies of connectedness and relatedness to the living and the non-living, research participants come to develop awareness of oneself and of belongingness and of their responsibilities to one another and to the environment (Chilisa, 2012). Narratives can be at individual level or at community level. Therefore, the terminology of African migrant adopted in this research context is a person who self-identifies as African with a link and or connection to African heritage; voluntarily or involuntarily moves out of the African continent, for whatever reason; and conforms to African philosophical ideologies, social practices, and the way in which worldviews are discovered and practised. This clarification of the term African migrant, therefore, sheds light on my application of the term and how it aligns with the theoretical frameworks chosen for this study.

The meaning of '**youth**' varies in different societies globally where its terminology changes with demographic, financial, economic, socio-cultural settings, individual personality and choices. There is no fixed age that defines this group of people whose onset is also defined by the biological features of puberty, ending with a series of social role transitions that are now far less linear and fixed than previously. For instance, the WHO (2011) defined young people, mainly using the term adolescents, as individuals ranging from 10 to 24 years, whilst with the United Nations (n.d.), for statistical purposes, defines ‘youth’ as people between the ages of 15 and 24 years, without prejudice to other definitions used by Member States. The different youth terminologies and contradictions in how data are reported at local, national, and global levels is one practice that makes youth and their health invisible. In keeping with the African philosophy underpinning this research, the African Youth Charter definition was adopted. The Charter defines youth based on Africa’s development realities to be persons between 15 and 35 years of age (African Union, 2006).

The term **indigenous** is complex and surrounded with controversy. It can be conceptualised differently across society; that is, whether the term refers to issues such as race, ethnicity, tribal identity, cultural identity, or other types of identity. It has been universally understood as people who have “a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them” (United Nations Department of Economic and Social Affairs Division for Social Policy and Development, 2004, p.2). In other works, the term has been used to collectivise and politicise colonial struggles shared among First Peoples globally (Tuhiwai - Smith, 1999). This study applies the collectivist usage of the term as being a name, a face, a particular identity that struggles with the interest and ways of knowing of the West (Tuhiwai - Smith, 1999); and adopts Le Grange’s (2001) description of indigenous knowledge in an African context as African history, African cultural heritage, and African customs as developed in direct response to the physical and social realities in that part of the world. It can also be described as a third space which focuses on the voices of those disadvantaged based on their gender, race, age, ethnicity, health, and socio-economic status (Chilisa, 2012) or “an interstitial space in which local knowledge traditions can be reframed, decentred by enabling all knowledge traditions to work together” (Turnball, 1997, p. 560).

The terms **health system** and **healthcare system** are used interchangeably as they both refer to the group of health service providers, healthcare institutions, and resources that deliver the healthcare services to meet the health needs of target populations (Goodyear-Smith & Ashton, 2019; WHO, 2014).

This study adopts the definition of **racism** by Kubota (2019, p. 712) to mean the "discourse, knowledge, and social practices by means of inferiorisation, denigration, marginalisation, and exclusion, to construct and perpetuate inequities" (p. 712). There are three levels, similar in their focus and approach, which demonstrate how racism and health outcomes intersect each other in the delivery of healthcare, with several pathways to health. This study recognises three levels as defined by Priest and Williams (2018): first, internalised (intra-personal) describes attitudes, beliefs or ideologies often founded on the premise of purportedly inborn superiority and inferiority that may be held by individuals of dominant groups and/or oppressed ones. Second, interpersonal racism refers to racism between people, with varying degrees of frequency and intensity, including manifestations from racially motivated assault to verbal abuse, ostracism, and exclusion. Third, systemic racism, also known as institutional structural inequality, encompasses the manufacturing of, control of, and access to material, informational, and symbolic resources within societal institutions, laws, policies, and practices that disadvantage less empowered groups while, at the same time, serving to advantage the dominant group.

1.7 Thesis Structure

This thesis is made up of nine chapters. Chapter One has introduced the argument, foci, and aim of the research. It also serves as the first part of the literature review which includes important background and contextual information, as well as an introduction to the theory and methodology applied in the study. This chapter outlined the peer-reviewed articles that came out of this research study and concluded with the study's contribution to youth health and public health, and an overview of the thesis structure. Chapter Two serves as the second, and final, part of the literature review aimed at identifying the gap in the current literature and framing the research questions. Chapter Three centres on the theoretical and paradigmatic stance of key decolonising theoretical perspectives and African epistemology underpinning the conceptual framework exercised in the research. Chapter Four is a progression from Chapter Three where storytelling sharing circles are applied to collect data in the study.

The chapter also focuses on the recruitment of young African migrant women and the challenges to their participation and collaboration in the research.

Chapters Five, Six, Seven, and Eight present the study findings. Chapter Five presents in-depth discussions around participants' interpretation of health and wellbeing informed within the intersections of their gender, social, cultural, political, and traditional/historical contexts as young African women living in Aotearoa New Zealand. Chapter Six presents a multi-voiced account of what the participants and I thought and experienced with our co-constructed exploration of youth healthcare services to address young African migrant women's views and experiences of Aotearoa New Zealand's youth healthcare services. Chapter Seven narrates the formulation of creative problem solving, which the participants understood to be relevant and viewed as best suited to improving their health and healthcare experiences, limitations and complexities in collecting data and following through with proposed actions. Chapter Eight, therefore, presents these complexities and offers insights into values and ethical standards that promote inclusion, long-term participation, and collaboration. The chapter further reflects on African knowledge and belief systems and how these elements fit, or not, within the life worlds of the participants in light of the results. In Chapter Nine, I discuss the findings in relation to the wider literature to also include the study's limitations, general recommendations and the conclusion.

CHAPTER TWO: LINKING MIGRATION AND YOUNG AFRICAN WOMEN’S HEALTHCARE IN AOTEAROA NEW ZEALAND

2.1 Introduction

This chapter serves as the second and final part of the literature review aimed at reviewing the literature to address the specific research questions of the study. In the second section, I overview the accepted meaning and understanding of health and wellbeing. I further draw out the potential differences in how health and wellbeing are generally defined by mainstream youth as compared to African migrant youth. I go on to appraise literature on social determinants of health and explain the link between migration and youth healthcare services. Owing to there being very little specific research on the views and experiences of healthcare provision for young African migrant women in Aotearoa New Zealand, the third section reviews international literature including practical experience from trans-Tasman links with long-established migrant programmes. I also use my peer-reviewed published articles as a resource (Kanengoni, 2020; Kanengoni et al., 2018; Kanengoni et al., 2020).

2.2 The Concept of Health and Wellbeing

There has not been any absolute agreement on the definition of health. The medical literature has heavily criticised the WHO’s (1948) definition. Departing from a single criterion of the absence of illness or infirmity, the WHO’s (1948) definition encompasses the existence of other states of complete physical, mental, and social wellbeing, making health impossible to realise. Jadad and O’Grady (2008) concurred that the requirement for complete health would leave few people healthy at any given time. Other critics, like Callahan (1973), argued the WHO definition to be: (1) hopelessly vague; and (2) unintentionally contributing to the medicalisation of society. This definition gives power to the medical profession to be the only one to declare an individual healthy, suggesting the writers of the WHO definition to have had a medical background. Callahan (1973) also saw the potential for misuse of the definition in the hands of Savonarola-style moralists, who would simply reframe their agendas in the language of “mental and social wellbeing”. Therefore, he suggested a simpler definition of health just to mean ‘physical health’. He based it on the premise that the appearance of a physically healthy body is a powerful one and, used carefully, it can be an indication of the kind of wholeness and adequacy of function one might hope to see in other areas of life.

Regardless of the WHO definition maintaining a place of prominence in official documents, according to Sartourius (2006), two other definitions seem to be also accepted and used: (1) health to be the state that allows an individual to adjust and self-manage in the face of social, physical, and emotional challenges (deducing the absence of disease or infirmity) and; (2) health to be a state of balance, an individual's ability to establish stability within self and between self and individual's social and physical environment.

The concept of wellbeing is derived from the 1986 Ottawa Charter description of health[7] by the WHO (1986) which defines it as a positive rather than neutral state, implicitly linking health with wellbeing. Unlike the existing disputes on the definition of health, a substantial number of studies are unanimous on this definition (Dodge, Daly, Huyton, & Sanders, 2012; Dooris, Farrier, & Froggett, 2018; Harttgen & Klasen, 2009; Sfeatcu et al., 2014). Although studies use different terminology to describe wellbeing, the term is used synonymously with quality of living. Further, because of the proven relationship between health and wellbeing, it is safe to assume health to be comparable to the concept of wellbeing. Therefore, this study will use the ideas of health and wellbeing synonymously, to mean one and the same thing, throughout this thesis.

Of note are how these different definitions of health and wellbeing are dominated by Eurocentric concepts and may be a generalisation of westernised societies and those with similar cultures and traditions. The above-mentioned writers appear to apply these concepts equally to Indigenous societies and migrant youth, yet the following section show these concepts to differ when seen through a migrant youth and young African migrant woman's lens.

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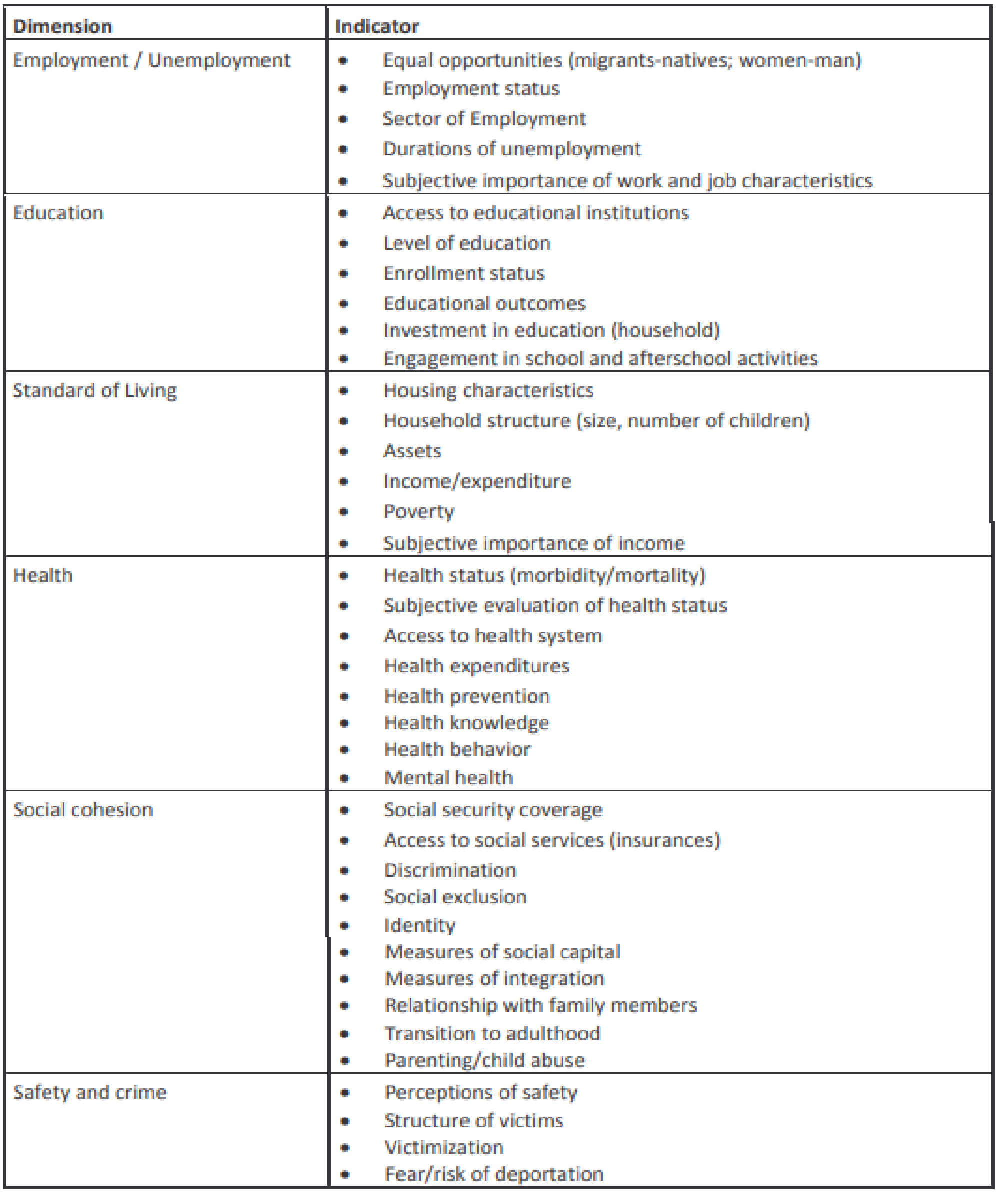
[7] Health is a resource for everyday life, not the objective of living.

2.3 The Concept of Health and Wellbeing for Migrant Youth

Migration is an important life event with changes that may affect the health and wellbeing of a migrant over a life course. Drawing on available data, particularly for the first and second generation migrants, Nolan (2009) and Harttgen and Klasen (2009) found immigrant youth health and wellbeing intimately tied to their socio-economic status and success. In turn, their success and how they relate to society are essential elements of health and wellbeing. In Table 3, Harttgen and Klasen (2009) provide a list of core dimensions and their indicators of health for assessing migrant youth health and what 'health and wellbeing' means to them.

Table 3. Health and wellbeing dimensions and indicators of migrant youth

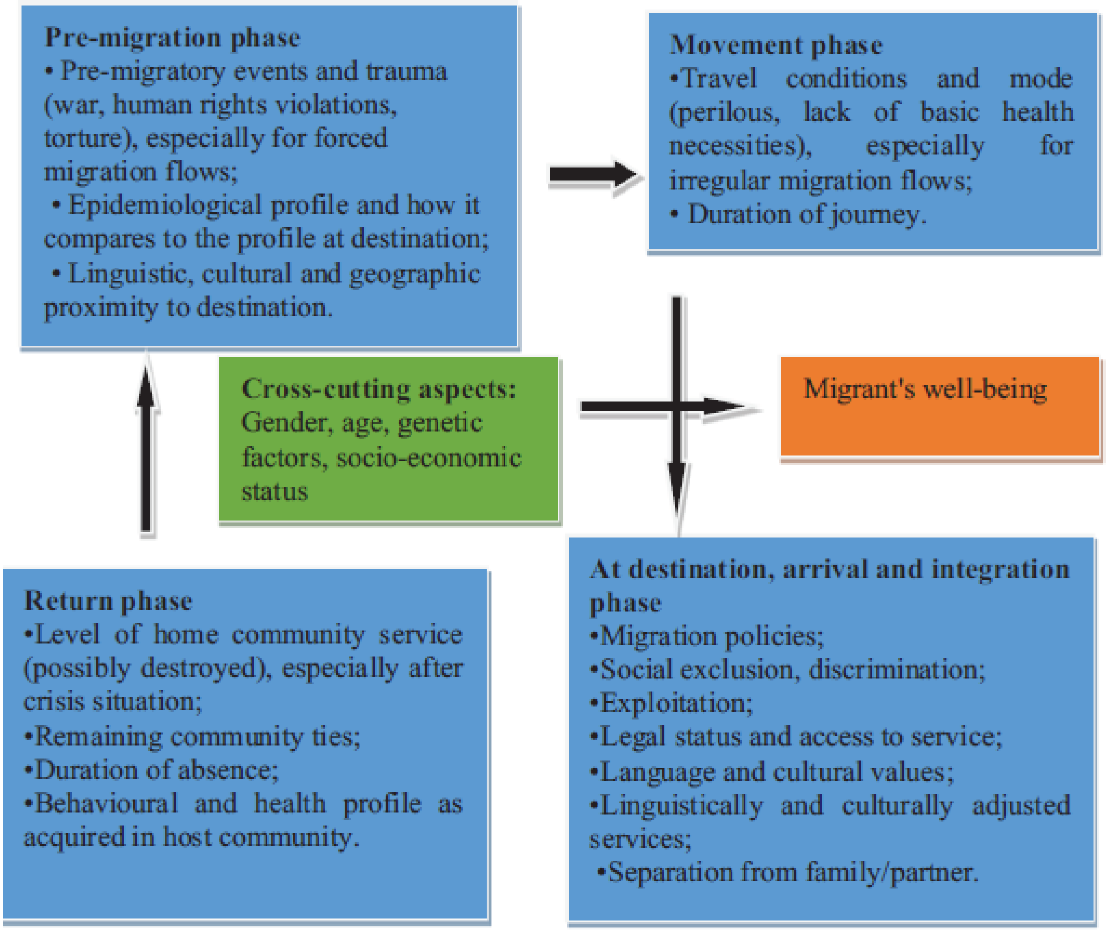


Dimension	Indicator
Employment / Unemployment	• Equal opportunities (migrants-natives; women-man) • Employment status • Sector of Employment • Durations of unemployment • Subjective importance of work and job characteristics
Education	• Access to educational institutions • Level of education • Enrollment status • Educational outcomes • Investment in education (household) • Engagement in school and afterschool activities
Standard of Living	• Housing characteristics • Household structure (size, number of children) • Assets • Income/expenditure • Poverty • Subjective importance of income
Health	• Health status (morbidity/mortality) • Subjective evaluation of health status • Access to health system • Health expenditures • Health prevention • Health knowledge • Health behavior • Mental health
Social cohesion	• Social security coverage • Access to social services (insurances) • Discrimination • Social exclusion • Identity • Measures of social capital • Measures of integration • Relationship with family members • Transition to adulthood • Parenting/child abuse
Safety and crime	• Perceptions of safety • Structure of victims • Victimization • Fear/risk of deportation

Source: Harttgen and Klasen (2009, p. 36).

Though similar to indicators identified by UNICEF (2007) in 21 developed countries (which include, additionally, material deprivation, health and safety, family and peer relationships, behaviour/lifestyles and risks, and subjective wellbeing), these dimensions and indicators differ in their awareness of the role migration has on the health and wellbeing of migrant youth. The health and wellbeing of migrants vary greatly at all stages of migration; that is, at the pre-migratory, movement, arrival and integration, and return phases. As this study's focal point is on the 'destination, arrival, and integration' phase, Figure 3 shows other dimensions that affect the health and wellbeing of migrants, include migration policies, discrimination, exploitation, access to services, language and cultural barriers, and separation from family.

Figure 3. Social determinants of migrant health at all stages of the migration process



Source: International Organization for Migration (2018).

In the next section, I explore further the dimension of health and its related indicator of access to healthcare services.

2.3.1 The Concept of Health and Wellbeing for Young Migrant African Women

Chapter One, section 1.4.2, and discussions earlier in this chapter used migration phenomena as the starting point for analysis to understand concept of health and wellbeing. However, literature in medical anthropology has highlighted how illness and help-seeking are embedded within social and moral worlds, even as the terrain has shifted from a focus on ‘traditional’ healing to the ‘indigenisation’ of biomedicine in African settings (Read, 2014). Religion and spirituality form one socio-cultural layer that interacts with health, poses specific health risks, and enables the health beliefs and practices of Africans which simultaneously define their health and wellbeing (Ajima & Ubana, 2018; Asare & Danquah, 2017; Kanengoni, 2020; Omonzejele, 2008), as illustrated in the following section.

Religion and spirituality

Religion and spirituality have been found to provide meaning and value, and provide comfort, hope and connectedness amid social, ill health and economic woes (Arrey, Bilsen, Lacor, & Deschepper, 2016; Asare & Danquah, 2017). For example, in the responses to HIV illness, a Belgian study of 44 immigrant participants (42 women were practicing Christians and two were Muslims) who had migrated from 15 countries in sub-Saharan Africa found strong faith and belief in God and spiritual/religious coping with illness and treatment (Arrey et al., 2016). One-woman summarised the participants’ beliefs: “*I strongly believe in God and I always say that a miracle will happen. You must always hope and science has progressed a lot. We hope that one day we will be free of this illness*”. Peculiar to the studies by Babatunde-Sowole, DiGiacomo, Power, Davidson, and Jackson (2020) and Babatunde-Sowole, Power, Jackson, Davidson, and DiGiacomo (2016) is the role of religion and spirituality as a factor of cultural resilience in the maintenance of overall wellbeing for Western African migrant women in Australia and East, Central, and Northern African migrant women in the UK respectively. These studies highlight how these women’s hopefulness arising from religion and faith appears to nurture resilience and overall wellbeing when faced with significant health and social challenges including racial discrimination and marginalisation, employment difficulties, and micro-aggressions that seem to dominate the experiences of African migrants in their receiving countries. It is worth noting how levels of acculturation, integration or assimilation in the host culture may determine the levels of resilience which inform their pathway to health and wellbeing (Wu et al., 2018).

Cultural, social, and biological factors also intersect to play a role in the interpretation of experiences of pain, illness, disease and care in healthcare settings, as illustrated in the next section.

2.3.2 Healthcare Needs for Young African Women from Africa

Empirically rich and conceptually nuanced interpretations of how cultural, social, and biological factors influence human experiences of pain, illness, suffering, and the understanding of healthcare needs in the formulation of health institutions have been widely published in the field of medical anthropology (Foucault, 1975; Halloran, 2019; Helman, 2007; Kaunda-Khangamwa et al., 2020; Krieger, 1987; Manderson, Cartwright, & Hardon, 2016; Mkhwanazi, 2016; Napier et al., 2014; O'Neil, 1989). For example, Mkhwanazi (2016) used ethnographic research to explore the failure of circumcision in Swaziland, a story that evokes a time when medical missionaries, military doctors, and anthropologists worked hand in hand with colonial officials to pacify, civilise, and subjugate whole populations. In Malawi, an ethnographic study was conducted by Kaunda-Khangamwa et al. (2020) to understand the roles of multiple services for creating a pathway for resilience for adolescents suffering from HIV and their complex needs. These studies demonstrated the use of biomedicine in African settings is governed by cultural health beliefs which affect how people think and feel about their health and health problems, from whom and when they seek healthcare, and how they respond to recommendations for lifestyle change, healthcare interventions, and treatment adherence.

The above-mentioned studies also offer theoretical insights into suffering and recovery as a social experience; it takes us to intersecting social factors, such as cultural discourses and practices that shape biological needs, gender and socio-economic status to mention a few. When placed in western societies, the notions of racism and marginalisation further increase inequities in accessing healthcare. Culture, gender, socio-economic status, racism and marginalisation are discussed seriatim.

Culture

Cultural discourses and practices shape the elements and norms in perceptions of the body, personhood, embodiment and healthcare needs (Foucault, 1975; Halloran, 2019; Krieger, 1987; Lorenzo, 2008; Manderson et al., 2016; Napier et al., 2014). For instance, the alteration of the physical, mental, and genetic constitution of African bodies by cultural practices during slavery have been reported (Halloran, 2019; Krieger, 1987; Wilson & Grim, 1991). Halloran (2019, p. 55) suggests the passing on of "cultural trauma of slavery through successive generations and the comparatively poor physical and psychological outcomes among contemporary African Americans especially as these outcomes persist even when economic disadvantage is taken into account". Napier et al. (2014) concurs, stating that ancestral practices, environmental stimuli or exposures, such as dietary changes to turn on and off biological and genetic processes, create new forms of illness and health (p.1633).

Gender norms, both those that are perceived and those that that differ from those of the healthcare providers, also elicit health professional failures to understand a patient's health concerns, as demonstrated next.

Gender and young African women

Gender norms in African societies have been linked to reduced help-seeking behaviour across a range of health services, predominantly felt in the sexual and reproductive area (Agu, Lobo, Crawford, & Chigwada, 2016; Allotey, Manderson, Baho, & Demian, 2004; Botfield et al., 2016; Botfield et al., 2018; Dune & Mapedzahama, 2017; Dune, Perz, Mengesha, & Ayika, 2017; Hawkey, Ussher, & Perz, 2021; Rade, Crawford, Lobo, Gray, & Brown, 2018). In rural Mali, women who actively sought healthcare exposed themselves as shameless, risking their moral social status, but they preferred to build social and symbolic capital by meeting the moral ideal of the 'good woman' (Read, 2014). The cultural embeddedness of moral systems in African migrant communities demonstrates different cultural systems have different standards for behaviour and different expectations for relationships that are played out in healthcare systems. This manifests when accessing information and services for safer sex and in the low uptake of reproductive and sexual health services (Dune & Mapedzahama, 2017; Dune et al., 2017; Kanengoni, 2020; Ministry of Social

Development, 2008). For instance, one study in Aotearoa New Zealand identified social and cultural norms which make an open discussion about sex and sexuality difficult and, consequently, create barriers to accessing sexual health services, including experiences of stigma and discrimination (Kanengoni, 2020). Another study found low uptake in reproductive and sexual health services amongst African and refugee migrant women in Victoria, Australia; these women perceived the services as hostile and unforgiving of cultural differences and the complexities of exercising reproductive rights in a space of evolving power relations within families and communities (Allotey et al., 2004). This was supported by Read (2014), in their systematic review which found Africans migrants perceived people outside their own culture would be unable to understand their specific needs and would not be in a position to help them navigate through the differences in culture. Unfortunately, the repercussions often come with a wide range of sexual and reproductive health issues including, but not limited to, unplanned pregnancies, abortion, unmet need for contraceptives, STIs, sexual and gender-based violence, and sexual abuse as observed amongst African migrant women in Australia (Dune & Mapedzahama, 2017; Dune et al., 2017).

The contextual delivery of healthcare is also meets with medical dilemmas bound to broad culturally based practices like female genital mutilation as found in Australia, Europe, USA, and New Zealand (Allotey et al., 2001; Elamin & Mason-Jones, 2020; Said et al., 2018). For instance, the practice is traditional, and the process has been empowering for young African migrant women under those circumstances, yet while well-meaning, the legislation in receiving countries does appear specifically to target the culture, leaving open the possibility of a racially discriminatory interpretation, even in the delivery of healthcare in New Zealand (Said et al., 2018). Other indirect costs to immigrant African women's health that have been reported are women's reluctance to present for antenatal care, non-use of gynaecological services and lack of treatment for urinary and reproductive tract infections (Allotey et al., 2001).

Racism and power inequality in the doctor–patient consultation

Relations of inequality and power during the doctor–patient consultation between White health professionals and African patients are presented as "artificial dialogues"

(Konadu, 2008). According to Konadu (2008), this discourse is shaped by the power relations historically situated, in the broad and multi-layered scope of colonial encounters, between Africans and Europeans (Konadu, 2008). This power imbalance between a physician and patient also features in the decision-making in treatment during doctor–patient consultations such as those found in America (Puddifoot, 2019; Singer & Baer, 2018). The dominance of biomedicine further reinforces ideologies concerning women’s ability to handle their emotions and make rational decisions to effect and/or enable reporting, communication, and treatment (Manderson et al., 2016; Singer & Baer, 2018).

In Aotearoa New Zealand, systemic racism has been found to be embedded in individual experiences of different treatment plans offered based on the assumption of families’ motivation and the capacities of the family to take care of themselves (Bécares, Cormack, & Harris, 2013; Harris et al., 2012a; Harris et al., 2012b; Harris et al., 2013). For example, when a Pākehā, a Māori, a Pasifika person and an Asian person present with the same set of symptoms, a better treatment plan is offered to a Pākehā (Harris et al., 2012a). The New Zealand study by Adelowo (2012) argues that the implicit bias and the assumption of adverse social factors affecting African women in New Zealand emanate from the elements of colonialism, racism and political ideology, manifesting in the form of verbal abuse, discrimination, and marginalisation. Other studies in Aotearoa New Zealand have also confirmed how racial/ethnic minorities face bias and institutional and personally mediated racism with associated serious health consequences (Chin et al., 2018; Harris et al., 2018).

Socio-economic status

The relationship between income and the health of African migrant populations was reported globally (United Nations Department of Economic and Social Affairs Population Division, 2017a) to include Aotearoa New Zealand (Kanengoni, 2020; Perumal, 2011; Statistics New Zealand, 2013a; Tuwe, 2018). These studies found African migrants to have low-wage occupations that negatively impacted their health and wellbeing due to economic insecurity and financial stress, creating cost barriers to health-seeking behaviours (Kanengoni, 2020; Perumal, 2011; Statistics New Zealand, 2013a; Tuwe, 2018). Africans’ ability to look for work and secure employment is dependent on their English proficiency and/or accent, dress, country of qualification, and the number of work experience years in Aotearoa New Zealand (Tuwe, 2018). These studies collectively depict a perpetuating downward cycle of health and employment disadvantage for Africans living in Aotearoa New Zealand.

2.4 Summary

This chapter demonstrates the existence of different definitions of health and wellbeing which, while dominated by Eurocentric concepts, differ across cultures and one's migrant status. For example, from a migrant youth lens, one's socio-economic status is a vital role in constructing the meaning of health and wellbeing. Further, religion and spirituality are one socio-cultural layer that interacts with health and poses specific health risks and enables the health beliefs and practices of Africans while simultaneously defining their health and wellbeing. This chapter also analyses the insights of medical anthropology as an agent of mediation in health systems. It provides a nuanced understanding and interpretation of how cultural, social, and biological factors influence human experiences of pain, illness, disease, suffering and healing in different settings, and how they are important in meeting the healthcare needs of diverse ethnic population groups. For instance, the use of biomedicine in African migrant settings is governed by culture, gender relations and socio-economic status, which determine biological healthcare needs and, in turn, when suffused with notions of racism and marginalisation in western societies, increase inequities in access and engagement with healthcare.

CHAPTER THREE: DECOLONISING THEORETICAL FRAMEWORK

3.1 Introduction

In this chapter, I examine decolonising theoretical perspectives and their solidarity with the construction of African epistemology. This chapter details the decolonialising process of enquiry that is shaped by African epistemology, personal positioning and the lived experiences of young African migrant women in Aotearoa New Zealand context. I resonate with Chilisa (2012) and Tuhiwai - Smith (1999) who elegantly explain the decolonising framework "as the process of conducting research in such a way that the worldviews of those who have suffered a long history of oppression and marginalisation are given space to communicate from their frames of reference" (Chilisa, 2012, p. 14), and the strategies that are not "concerned so much about the actual technique of selecting a method but more with the context in which research problems are conceptualised and designed, and with the implications of research for its participants and their communities" (Tuhiwai - Smith, 1999, p. ix).

This chapter is composed of four sections. After the introduction, in the second section I examine and reflect on my positioning in this research, how my personal and embedded 'collective' identity as an African young migrant woman influences my research interest. I also reflect on my research participants' worldviews – how being young African migrant women would shape their health concerns and how these interact with the 'other' system of knowledge of the western worldview. I further engage with the works of McDougal (2014), Ani (2013), Udefi (2014) and Anyanwu (1983) to show how African epistemology serves as a decolonial tool which is explained by Anyanwu (1989, p. 60) as "disrupt[ing] the traditional ideas about how the human being perceives the world by establishing its ontological and epistemological perspectives which have been historically disregarded or purposefully marginalised".

I therefore identify four central tenets I deem to be applicable and important actions toward transforming our colonised views and holding alternative knowledges as they relate to the research context: 1) a challenge to dominant ideologies; 2) collective community validity of knowledge; 3) the significance of race and racism and their interconnectedness with gender; and 4) empowerment for social change. In the third section, I examine the translation of each of these tenets to redressing and reflecting colonising practices in knowledge acquisition. I further present the choice of using the storytelling sharing circles as the data collection method which, in various forms and adoptions, have been used in research with Indigenous populations such as those with the First Nations in Canada (Lavallée, 2009) and in Africa (Chinyowa, 2001). The fourth section concludes this chapter.

3.2 My Reflection

In January 2018, I was working as a youth health worker with one of the district health boards in Auckland. In the first two months of my employment, I was made aware of the disparities in the provision of healthcare access and engagement with youth. For example, in my induction training and subsequent workshops to build my capacity in working with young people, I noted the training manuals had limited regard to the diverse ethnic groups and cultures, beyond the mainstream European New Zealander and, to some extent, the Māori and Pasifika communities. Being a female, a migrant of African descent, born and raised in Zimbabwe, I found it challenging to resonate with how the system worked for African communities. For example, I was trained to recognise young people to have full autonomy of their body and health without the parents' consent yet, as Africans, one's health – and more so for young people – was a family issue; that is, no decisions would be made without consultation with the rest of the family. I wondered if African youths' needs were being met and to what extent their health needs were being addressed. Subsequently, I developed a curiosity to further explore relevant health policies, programmes or directions that addressed the needs of my young women peers. This became my research interest.

During the first six months of my doctoral study, I started looking into published literature on immigrant health in Aotearoa New Zealand (Kanengoni et al., 2018). Most articles published in this topic were heavily dominated by studies on communicable diseases, and most of the studies had women as their participants. I wonder whether women of migrant backgrounds, compared to their men counterparts, were more vulnerability to ill health. With regard to the research methodologies, most of the literature was informed by western paradigms, such as discourse analysis (Kanengoni et al., 2018). Literature on African youth health was scarce and almost non-existent, except for studies on police encounters with African youth in Aotearoa

New Zealand (Nakhid, 2018; Nakhid et al., 2016). This insight reinforced my motivation and curiosity to study African young migrant women's health.

Having lived and studied in Aotearoa New Zealand in 2012 to 2014 and returned in late 2017, I have also been aware of the public commitment and policy advocacy in improving the health equity for the Tangata Whenua, Māori Indigenous population of Aotearoa New Zealand. I was also aware of the public health directions and discussions that focus on the Pacific people living in Aotearoa New Zealand. As a Zimbabwean migrant woman, I can relate well with the discussion on the concern and worldviews of the Indigenous communities in understanding their health and explaining their health needs and services that are relevant to their cultural context and their worldviews. I can see that being the frontier of my own cultural heritage and invited to engage in actions that empower me to make an informed decision regarding my health, would be something I aspire for.

Next, I reflect on my journey in embracing myself as a researcher.

3.2.1 My Positioning

In my determination to embark on research exploring the experiences of young African migrant women and their health aspirations, I examined theories or frameworks on African philosophies, African beliefs and African knowledge system. I asked myself how comfortable I am in my knowledge about African worldviews; and if there was only 'one' 'singular' African worldview? How comfortable would I be in speaking to my indigenous knowledge systems, and my feelings? I appreciated this process of self-reflection as pivotal in my research journey (Franks, 2016). I have been schooled in the mainstream school system in Zimbabwe. I continued my graduate studies in Aotearoa New Zealand. My knowledge and awareness of any indigenous theories or African epistemology was limited. This awareness, however, became the catalyst of wanting to learn from other young African migrant women of various ethnic groups within the African continent, or those who embraced their African migrant identities, and how my research participants would explain their identities and to what extent their unique context of migration influenced their views on health, life and health needs. See Chapter Eight. Indeed, there was a possibility of the participants having diverse explanations and worldviews in reflecting on and explaining their health beliefs, interpreting illness and disease and the means for recovery and striving in life.

In pursuit of more grounded evidence on the cultural and traditional standpoint of African migrant youth in Aotearoa New Zealand, I came across a New Zealand ethno-cultural youth study which was part of an International Comparative Study on identity, acculturation and adaptation (Ward, 2008). It was carried out with 8,000 adolescents and young adults coming from 13 nations. In New Zealand, it surveyed 1445 New Zealand adolescents aged 12-19 years; 510 national youth (396 New Zealand Europeans, 114 Māori) and 935 immigrant youth (145 Chinese, 188 Koreans, 147 Samoans, 102 Indians, 111 Britons, 101 South Africans). The findings revealed migrant youth to have a strong connection with their cultural, social, and religious roots, and this applied across generations. Ward (2008) further reported on the existence of strong ethnic identity; youths' frequent contact with peers of the same cultural or ethnic backgrounds, and youths' preference to maintain cultural heritage which all remained stable across generations. Ward's study affirmed and empowered me to give research participants the space to communicate from their socio-cultural frame of reference. I noted Ward's research was conducted 14 years ago, and therefore I questioned if it was still relevant at the time of my research (data collection was conducted in 2019-2020). Various African-based researchers concur that African culture is fluid and contested and, at times, elusive (Buntu, 2013; Ikpe, 2010; Mazrui, 1963; Outlaw Jr & Jeffers, 2017). This further reinforced my interest to explore the state of African worldview and the application, if any, of an African socio-cultural knowledge system amongst migrant African young women in Aotearoa New Zealand.

I chose to engage in African epistemology as a form of epistemic decolonisation. It is a form of epistemic decolonisation because "it helps Africans conceptualize, interpret and apprehend reality within the context of Africans' cultural or collective experiences" Anyanwu (1983, p. 60). It calls for in-depth reflection on the discourse around colonialism, race and racism as the major reasons to decolonise Western European knowledge. In the next section, I discuss African epistemology and how it informs the decolonising process that I undertook in my research.

3.2.2 African Epistemology

Epistemology, in general, refers to the nature, status, and production of knowledge and the assumptions and fundamentals that govern wisdom of the knowledge (Harding, 1987; Kaphagawani & Malherbe, 1998). For Bernal (2002), the concept of epistemology goes beyond a "way of knowing" to a "system of knowing" that is linked to the worldview of an individual within his or her socio-cultural situation and interpretation of his or her world. Thus, developing an epistemological stance is universal to the human species, but knowledge acquisition arises among cultures. African epistemology is therefore "an approach to knowledge that includes Africans, (1) conceptions of the meaning of knowledge; (2) means used to gain knowledge; (3) criteria for assessing the validity of knowledge; and (4) role that knowledge plays in human existence" (McDougal, 2014, pp. 237-238). In finding whether African epistemology is the best-fit epistemological framework to guide the decolonial process and application of decolonial strategies, I learnt African philosophy is confronted with the problem of establishing its own unique African order of knowledge in the light of Africa's colonial legacy; and that there is an ongoing debate on the existence and nature of indigenous African epistemology (Ani, 2013; Higgs, 2010). I resorted to identifying various African thinkers, activists and scholars to see commonalities shared in the efforts to explain the philosophy behind African epistemology. I found the works of McDougal (2014), Ani (2013), Udefi (2014) and Anyanwu (1983) very insightful and useful.

In Udefi (2014)'s paper, "*The Rationale for an African Epistemology: A Critical Examination of the Igbo Views on Knowledge, Belief, and Justification",* using the views of the Igbo community in Nigeria, he disrupted the traditional ideas about how the human being perceives the world by establishing African ontological and epistemological perspectives. He prepositioned African epistemology as

> using African categories and concepts as provided by African cultural experience without a recourse to Western or alien conceptual framework ... abstracted from the collective worldview of Africans and leaning essentially on such materials as myths, folklores, proverbs, folk wisdom etc. (p. 108)

He therefore viewed epistemology as "an inclusive or holistic epistemology that also consists of non-empirical means of knowing and perceives non-empirical sources of knowledge as valid methods" (p. 239). Ani's work built upon Udefi's standpoint to contend African forms of knowledge are acquired from "intuitive, religious and mythological means" (2013, p. 298), dismissing mainstream western ways of knowing. As an African scholar based in Nigeria, Ani demonstrates these dimensions to have meaning to African indigenous knowledge in the face of the limitations of mainstream scientific epistemological traditions (2013, pp. 308-309).

Religious knowledge and spirituality

The existence, reality, and way of life of people in Africa depends on an invisible supernatural world, where an individual seeks and expresses meaning and purpose in their experience and their connectedness to self, others, nature, and to the higher powers which were found across various African nations like Ghana, Zimbabwe and Nigeria and cultures like Shona, Ndebele and Igbo (Ani, 2013; Mbiti, 1990; Ngara, 2007). This worldview gives foundation, meaning, and the fundamental purpose and destination of human life to an African. Therefore, African knowledge systems reflect the primacy of spirituality (i.e., connection to higher divine powers and gods), the relationship between the physical (i.e., earth, water, air), as well as interconnectedness with all things (Ani, 2013).

Intuitive knowledge

As noted earlier, in many African cultures, knowledge is perceived to be natural intellect – the use of reason, rational processes, and the natural senses to arrive at knowledge – decolonising the traditional western concept of mind's conformity to reality (Ani, 2013; Nkulu-N'Sengha, 2005). For instance, Nkulu-N'Sengha (2005) highlights how for centuries Africans have tamed livestock, understood seasonal and weather patterns for sowing and reaping crops, surviving amongst human dangers and educating their children without the interference of the Westerners' views of themselves as being the source of civilised existence.

Mythological knowledge

Mythical knowledge gives Africans access to the region of reality that lies beyond the reach of science (Jaki, 2000); an empirical world of space and time to account for some of the most fundamental problems of life and existence (Ani, 2013; Mbiti, 1969; Ngara, 2007). Ani (2013) refers to the definition of myth by Ruch and Anyanwu (1984, p. 35) as “a complex set of signs, both verbal and gestural, which aim at accounting for some of the most fundamental problems of life and existence”. Thus, reality lies beyond the comprehension of human minds (Ani, 2013). Ani (2013) uses an example of the origin of the universe to explain this dimension of knowledge. He asserts science has failed to explain the origin of the universe as scientists ‘cannot go outside the universe’ to observe the whole of it and give a supreme objective and genuine knowledge about it, suggesting that defining the whole by the knowledge of some part of reality is inherently ‘mythological’. Mythical knowledge thus gives humans the reason for hoping when it seems that all hope based on rational or scientific judgement is lost (Ruch & Anyanwu, 1984). Through myth, African people access the region of reality that lies beyond the reach of science. A recent study shows mythical knowledge is alive and well in modern society. For example, the Shona people in Zimbabwe still believe in “ancestors who carry petitions; ancestors that lie in the deep and unknown recesses of the past” (Mahohoma, 2020, p. 4). In times of drought, the Shona believe nature spirits and ancestors control rainfall. According to Mahohoma (2020), the Shona has places and times where they perform a sacrificial rain dance to the ancestors, either for the ancestors to transmit petition to the unknown or act upon them directly. The ceremony is not only about asking for rain, but also cleansing the land of evil which may have been responsible for the drought.

I am also in solidarity with the teaching of another Nigerian-born philosopher (Anyunwu, 1983; Anyanwu, 1989) who, nearly 40 years ago, affirmed that African philosophy:

> Invites people to take a stand on the issue of reality as experienced by Africans. This experience of an African reality gives rise to a sense of commonality in an expression of an indigenous African epistemology which finds countenance in certain general themes in African philosophy, one of these being, the discourse of community in Africa, also referred to as communalism (Anyanwu, 1989, p. 127).

When applied to research, African epistemology allows “the African to conceptualize, interpret and apprehend reality within the context of African cultural or collective …to enforce action for social change” (Anyanwu, 1983, p. 60). In the same light, McDougal (2014) aptly asserts forms of knowledge acquisition prosper on African-oriented principles: interdependency and reciprocal interaction. According to McDougal (2014), the purpose of knowledge in an African sense of the word is to affirm beingness by advancing the condition of being ‘a collective’. This culminates in the holistic understanding of reality which is expressed by Mbiti (1969) as, ‘I am because we are, and since we are, therefore I am’, as opposed to the western, I/You relationship which emphasises the individual. This, Mbiti (1970, p. 109) concludes, is the central point in the understanding of the how African cultures and people view men, women and relationships, and explain their world.

Summarising the thinkers mentioned above, I understood the following epistemological constructs to be centred in African epistemology or philosophy, to include a commitment to: (a) communalism – knowledge is the product of collective social processes which depend on collective responsibility and collaborative action which are well reflected in people’s social interactions, customs and traditions; (b) being purpose driven and participatory; (c) liberating the people, to transform the mindset of Africans to appreciate their indigenous form of knowledge; and (d) shifting structures of oppression and marginalisation for social justice.

I had to also challenge myself to reflect on my ‘own and subjective’ assumptions of African worldview and knowledge system. In my research, I continue to wonder how participants’ knowledge and feelings and appreciations were also shaped by their personal and unique story of the migration journey and the context of host culture as opposing or reinforcing the migrant’s worldview. I kept a reflective journal and assist me in understanding my prior assumptions, beliefs, and attitudes of African epistemology. I examined how my beliefs were aligned, or not, with the participants’ beliefs and the framing of their stories and knowledge they offered in this research. Through this dialogic process within myself and with the participants, I learnt to contest and expand theories and the system of knowledge produced collectively in this research in light of the findings.

In the next section, I discuss the decolonising strategies through the four central tenets identified in African epistemology.

3.3 Decolonising Strategies

Decolonising epistemology seeks to remove all remnants of racism and colonialism in ways of knowing (Chilisa, 2012; Tuhiwai - Smith, 1999). I found Chilisa (2012) and Tuhiwai - Smith (1999) interesting for understanding more on this matter. Their work connected to the core aim and illustrated the methodologies which I aspired to implement in this study, doing away with the assumption that Africans were intellectually incapable of knowledge production, to repositioning African knowledge to enable the interaction and negotiating with other systems of knowledge—the mainstream knowledge.

I start with a quotation from a book, *Indigenous Research Methodologies*, written by Bagele Chilisa, an African female anthropologist from Botswana (Chilisa, 2012), who describes decolonisation "as the process of conducting research in such a way that the worldviews of those who have suffered a long history of oppression and marginalisation are given space to communicate from their frames of reference" (p.14). She further states the decolonising process to include creating and using various strategies to liberate the 'captive mind' from 'oppressive conditions' that continue to silence and marginalise the voices of the non-western societies that encountered European colonisation; and the restoration and development of cultural practices, thinking patterns, beliefs and values that were suppressed but are still relevant and necessary.

More locally, the pioneer of decolonising methodologies, Tuhiwai - Smith (1999) describes the process of looking through the eyes of the colonised, not only giving them the voice, but to stop the dying – of people, of culture, of ecosystems. Her book, *Decolonizing Methodologies: Research and Indigenous Peoples* is written for Indigenous researchers, and related projects. Split in two distinct parts, the first part of the book shows imperial legacies of western knowledge and the ways in which those legacies continue to influence knowledge institutions to the exclusion of Indigenous peoples and their aspirations, as described by one section of the first chapter titled ''On Being Human'':

> One of the supposed characteristics of primitive peoples was that we could not use our minds or intellects. We could not invent things, we could not

> create institutions or history, we could not imagine, we could not produce anything of value, we did not know how to use land and other resources from the natural world, we did not practice the ‘‘arts’’ of civilization. By lacking such values, we disqualified ourselves, not just from civilization but also from humanity itself. In other words, we were not “fully human;” some of us were not even considered partially human. Ideas about what counted as human in association with the power to define people as human or not human were already encoded in imperial and colonial discourses prior to the period of imperialism covered here. Imperialism provided the means through which concepts of what counts as human could be applied systematically as forms of classification, for example through hierarchies of race and typologies of different societies. In conjunction with imperial power and with ‘science’, these classification systems came to shape relations between imperial powers and indigenous societies. (Tuhiwai Smith, 1999, p. 25).

I was more drawn to the second part of the book which helped me develop the decolonising strategies which allowed the centring of the concerns and worldviews of young African women so that they understand themselves through their own assumption and perspectives (Tuhiwai - Smith, 1999). The strategies are not “concerned so much about the actual technique of selecting a method but more with the context in which research problems are conceptualised and designed, and with the implications of research for its participants and their communities” (Tuhiwai - Smith, 1999, p. ix)

I used the central tenets governing the assumptions, beliefs, and attitudes of African epistemology identified in section 3.2.2 to frame the decolonising process and identification of decolonising strategies within the scope of this research. Guided by Tuhiwai - Smith (1999) and Chilisa (2012), I applied the decolonial apparatus to these tenets. I asked myself how my research would: 1) challenge dominant ideologies; 2) ensure collective community validity of knowledge; 3) reflect the significance of race and racism and their interconnectedness with gender; and 4) empower for social change. To achieve this frame of thinking entails praxis; that is, under each tenet, I describe the research context and also question the principles of knowledge and understanding that regulate western society, re-evaluate the practices, methods, approaches, tools of data collection, modes of analysis and dissemination of results so that research promotes epistemic justice and is respectful to the participants (Chilisa, 2012). In this sense, praxis is a critical pathway that leads to ongoing and intentional action.

3.3.1 A Challenge to Dominant Ideologies

How knowledge has been produced and acquired has been restricted to the theoretical, scientific of philosophising of the West (Chilisa, 2012; McDougal, 2014; Tuhiwai - Smith, 1999). This disregards the foundation of western "discoveries" in science and technology on diverse worlds, such as Africa, Asia, Latin America, and indigenous knowledge (Tuhiwai - Smith, 1999). Enlightenment, commonly referred to as modernity, has empowered these diverse worlds to assume and transform knowledge according to its own tradition of knowing; contending that knowledge means different things from culture to culture and time to time (Foucault, 1966; Tuhiwai - Smith, 1999). African epistemology sets to disrupt the traditional ideas about how the human being perceives the world by establishing its ontological and epistemological perspectives which have been historically disregarded or purposefully marginalised, in order to transform the mind set of Africans to appreciate their indigenous form of knowledge (Anyanwu, 1989).

Earlier, in section 3.2.2, I mentioned three main dimensions that support systems of knowing and understanding that counter the dominant Eurocentric epistemology: religious knowledge and spirituality, intuitive knowledge and mythological knowledge (Ani, 2013). In my own engagement with African communities in my home and in Aotearoa New Zealand, I had observed knowledge as a spiritual quest that began with a prayer before a meeting or a ceremony, regarding spirituality as a legitimate way of gathering information and coming to know as also reported by Chilisa (2012). Thus, as a form of decolonisation of Western European knowledge, African epistemology was intended to help participants to reclaim the right to think within their scope of religion and spirituality and theorise from those points of reference as the means (as well as the premise) of knowing which underpin and validate all else.

3.3.2 Collective Community Validity of Knowledge

In section 3.2.2, I endorsed the works of African scholars (Mbiti, 1969; McDougal, 2014; Udefi, 2014), and highlighted the importance of research with Africans recognising and prioritising the historical contextualisation of collective responsibility of knowledge construction and its validation as legitimate frames of reference for conducting research and identifying solutions to problems. Acquisition of knowledge prospers on African-oriented principles: interdependency and reciprocal interaction to achieve much more than the potential of any individual. Therefore, African thought processes are intuitive and participatory as opposed to the I/You relationship of the philosophising of the West which emphasises the individual (Chilisa, 2012; Tuhiwai - Smith, 1999). Smith's (1999) seminal text on *Decolonizing Methodologies* advocates collaborative and reflexive ways of knowing, a decolonial lens which advances the critical and emancipatory thinking of the researched. This culminates in the holistic understanding of African reality which is expressed by Mbiti (1969) as, 'I am because we are, and since we are, therefore I am'. Following the argument of Anyanwu (1983), and subsequently his fellow thinker McDougal (2014), I therefore planned the development and acquisition of knowledge to take place in a participatory manner, recognising the life experiences of young African women as unique individuals but (I assumed) being part of a collective. This was further supported by using sharing storytelling circles described later, in section 3.3. I hoped this decolonising strategy would sensitise the participants to the existence of dominant discourses and the influence of dominant groups in the assumptions made in the dominant research pedagogy of the individualistic mode of knowledge construction. Connecting first-hand experiential knowledge to the collective would be the bridge that holds these two together, fostering meaning-making in a shared space, allowing participants to learn to cultivate their collective voice and empower themselves and others.

3.3.3 The Significance of Race and Racism and Their Interconnectedness with Gender

Colonial history centres Euro-western knowledge systems to privilege White male domination, therefore restructuring the meaning of national and ethnic identities into race and racism, and gender and gender roles, which has diminished women's autonomy (L. Harris & Watson-Vandiver, 2020; Tuhiwai - Smith, 1999). In my day-to-day observations and experience, I recognised and experienced the multiple layers of oppression young African migrant women in Aotearoa New Zealand go through and how this is also followed by various forms of marginalisation in particular race and gender which have also been reported elsewhere (Adelowo, 2012). African epistemology acknowledges the contribution of racial and gender perceived domination and discrimination, especially as these overlap, interlock, and intersect with systems of oppression and exploitation which affect the life worlds and lived experiences of African Black women (Bassey, 2007). It aims to redress inequality by revealing and responding to the oppressions and privileges that result when peoples' identities or positions intersect with each other, and with social structures. It is therefore impossible to decolonise epistemological traditions of the West without considering the intersectional effects of gender and racial oppression texts.

(i) Gender

The desired and undesired qualities of women, for example as mothers, daughters and wives, are founded on western social constructed institutions of marriage and family (Tuhiwai - Smith, 1999). Yet, prior to colonisation, women's position, like the eldest aunty in the family in an African society, as studied in countries like Zimbabwe and Nigeria, was a position of authority and power even over male dominance (Montoya, 2008; Presbey, 2021; Walia, 2018). These gender distinctions and hierarchies were visible in the Aotearoa New Zealand African communities. It situated young African migrant women in a patriarchal and religious society with clear principles about expected moral behaviour. For example, parenting practices place strict control over their daughter's activities outside the house including going to parties, spending time with friends after school, but not on their sons, as reported both locally (Kanengoni, 2020; Ministry of Social Development, 2008) and internationally (Suárez-Orozco & Qin, 2006). Consistent with Suárez-Orozco and Qin (2006) is the study by Le Espiritu (2001) that reported Filipino migrant males were not being subjected to the same strictness and ideal ethnic compass as their female siblings. It created a learned hopelessness, even for opportunities that may create positive change in their lives, like participating in this study. For example, during the recruitment phase, one young African woman had concerns about consenting to participating in the research, and remarked: "*but why should I be talking about it?*" (Aed).[8]

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[8] Aed is a young African woman who had been approached to participate in the study, but she refused. She is added in the thesis as part of my reflection to show culture and religion suppressed young African women from participating in perceived sensitive research topics.

(ii) Race and racism

Young African women's experiences, including my own, on racial awareness were categorised by feelings of identity negotiation and isolation in society (Ani, 2013; Anyanwu, 1983; Chilisa, 2012; McDougal, 2014; Udefi, 2014). True to the description by Tuhiwai - Smith (1999) of western racial and en-gendering of the Other, from my own experience and the experience of my network of African women and communities, young African women are likely to be confronted with day-to-day negotiations and contentions that arise with their 'Blackness' in a society. Within my social network, anecdotes include the detention of a Black young woman, who is a Aotearoa New Zealand citizen, in an airport overseas, due to being seen as 'being not like the commoner New Zealander, which represents the wider racially oppressive attitudes globally. The Blackness accounts for the ways in which the participants live and where they live. It explains the kinds of debates that prohibit – or allow – equity in health and other social support.

3.3.4 Empowerment for Social Change

Empowerment is one of the distinct features of research for social change with African communities (McDougal, 2014; Anyunwu, 1989; Udefi, 2014). The role of African knowledge and belief systems forms a nexus with liberating strategies and collective problem-solving and social transformation (Anyanwu, 1989). Empowerment, as gathered earlier from Chilisa (2012), liberates the 'captive mind' from 'oppressive conditions' that continue to silence and marginalise the voices of the non-western societies that encountered European colonisation; and restores and develops cultural practices, thinking patterns, beliefs and values that are suppressed but are still relevant and necessary to inform the delivery of culturally appropriate healthcare services. Further, the participants' strengths, capacities, resourcefulness, and resilience would potentially foster the engagement of individuals, communities, and societies for social action (Anyanwu, 1989).

In this study, I was open to the assets that each participant brought to the research, including, to name a few, their individual strengths, attributes, social power and connection, and experiences. At the conceptual level, I hoped the participants would be equipped with the knowledge, means and methods for determining and investigating what they believed to be the valid representation of their knowledge and beliefs which could be mythical or beyond common sense. I also anticipated that each of them would share their unique way of conceptualising reality and justifying the knowledge they produced.

3.3 Indigenous Interview Methods

There are fairly well-established rules and codes which draw from a western archive of knowledge systems and values that inform how interviews should be conducted. In this study, I applied storytelling sharing circles.

3.3.1 Storytelling Sharing Circles

Storytelling, which is synonymous with sharing circles, is based on the ideal of participants' respect for each other, togetherness, and the sharing of ideas. It is an example of a focus group method, a method which is common and practiced in Africa contexts and amongst Indigenous people for generations in various parts of the world, and its effects on research practice has been noted in many studies with Indigenous populations in Canada, Australia, Zimbabwe and African communities in Aotearoa New Zealand (Chinyowa, 2001; Drawson, Toombs, & Mushquash, 2017; Geia, Hayes, & Usher, 2013; Kovacha, 2010; Lavallée, 2009; K. Tuwe, 2016). For instance, a study with First Nations in Canada, Lavallée (2009, p. 28) uses the term 'sharing circles' to describe this method of inquiry "as gathering stories through sharing circles". She further compares them to "focus groups in qualitative research where researchers gather information on a particular topic through group discussion" (pp. 28-29), and when applied as an Indigenous focus group, the technique allows a collective and equal opportunity to be heard, which is not of concern in western-based focus groups (Chilisa, 2012). For example, the dominant research pedagogy in western knowledge construction emphasises on individualistic mode of philosophising (Chilisa, 2012; Tuhiwai - Smith, 1999).

Storytelling is also an important aspect of Australian Aboriginal and Torres Strait Island. Termed 'yarning', Aboriginal storytelling ranges from the "informal brief conversations or that 'knowing' look that elicits an emotional response, to the more formal ways of storytelling that have prescribed outcomes attached to it" (Geia et al., 2013, p. 15). In Zimbabwe, Chinyowa (2001, p. 1) describes African storytelling as a “powerful pedagogical tool for communicating the people’s knowledge and wisdom using genres such as storytelling, music, song, dance, poetry and drama”. He further stated storytelling not only communicates people’s philosophy but also play an intrinsic role in human pedagogy. Positioning storytelling in Aotearoa New Zealand, Tuwe (2016) argues African oral traditional paradigm of storytelling as an effective and suitable social research methodology, especially for topics which deal with Africans as participants. His view is shared by other PhD scholars who have used African storytelling with Africans in the diaspora: Adelewo (2012) in Aotearoa New Zealand and Banks-Wallace (1998) in the USA. The art/act of storytelling therefore varies depending on individual cultures and ethnic experiences as well as background.

In this study, I employed the storytelling sharing circles as it suited the population being studied, whose culture and traditions are passed down orally. More will be described in Chapter Four**.**

3.4 Conclusion

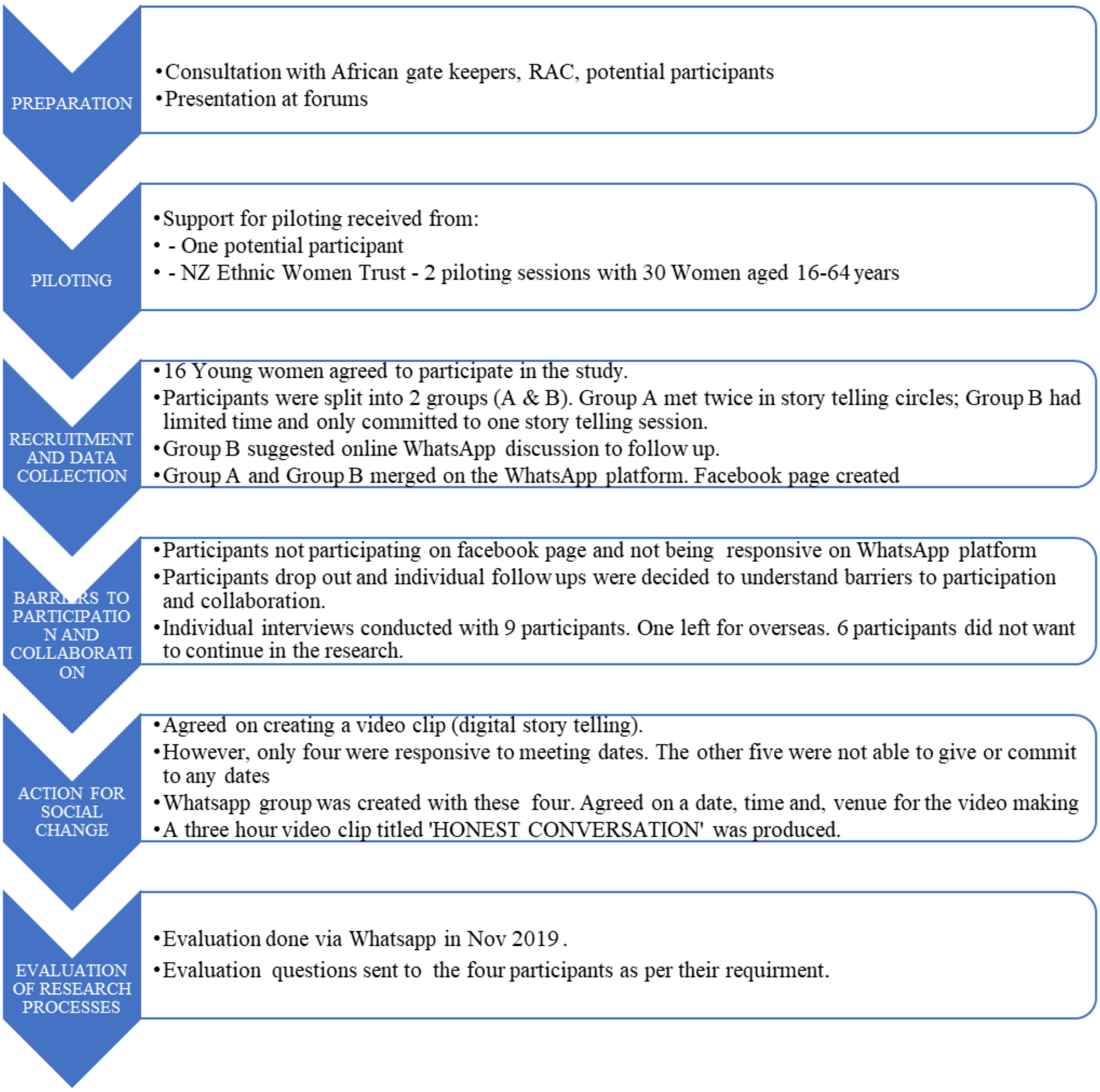
This chapter centred on the theoretical and paradigmatic stance exercised in the research. I described my approach to decolonising methodology, which was characterised by my own positioning and personal experiences as a female and a recent migrant of African descent, and my reflections and observations of young African women’s life worlds during my interactions in the field. I found African epistemology to be the appropriate epistemology to provide a cultural, traditional, racial, and gender-based platform for young African women. This chapter illustrated engaging in African epistemology as a form of decolonisation of Western European knowledge which required the ability to reflect critically on African knowledge systems to help in the decolonisation processes and strategies. In refining assumptions, beliefs, and attitudes of African epistemology to suit the research context, the choice of the decolonial apparatus to operationalise theory was made to afford participants the opportunity to collectively construct knowledge and develop defensible positions and strategies that address circumstances that influence, determine, or disadvantage them. The chapter also appraised the use of storytelling sharing circles as a relevant method for this research, one that offers cultural space to share experiential knowledge.

CHAPTER FOUR: RESEARCH METHODOLOGY

4.1 Introduction

This chapter has been foregrounded by Chapter One, which gave the background and rationale of this study and located the study within Aotearoa New Zealand context. Chapter Two critically analysed the global landscape of migration of young African women and gave an overview of the youth health system and related youth health policies. Chapter Three refined the study’s epistemological standpoint along with the decolonising theoretical perspective on the conceptual framework that governed the study. This current chapter represents the methodological journey critical to my research. Having decided to set myself up for a challenge as a novice researcher in African research and decolonising methodologies, in this chapter I detail my progress in that space with the realisation that I stand to contribute to, and advocate for the use of African research paradigms. Figure 4 illustrates the six steps of my research preparation and data collection.

Figure 4. Research processes flow chart



- Consultation with African gate keepers, RAC, potential participants
- Presentation at forums

- Support for piloting received from:
- - One potential participant
- - NZ Ethnic Women Trust - 2 piloting sessions with 30 Women aged 16-64 years

- 16 Young women agreed to participate in the study.
- Participants were split into 2 groups (A & B). Group A met twice in story telling circles; Group B had limited time and only committed to one story telling session.
- Group B suggested online WhatsApp discussion to follow up.
- Group A and Group B merged on the WhatsApp platform. Facebook page created

- Participants not participating on facebook page and not being responsive on WhatsApp platform
- Participants drop out and individual follow ups were decided to understand barriers to participation and collaboration.
- Individual interviews conducted with 9 participants. One left for overseas. 6 participants did not want to continue in the research.

- Agreed on creating a video clip (digital story telling).
- However, only four were responsive to meeting dates. The other five were not able to give or commit to any dates
- Whatsapp group was created with these four. Agreed on a date, time and, venue for the video making
- A three hour video clip titled 'HONEST CONVERSATION' was produced.

- Evaluation done via Whatsapp in Nov 2019 .
- Evaluation questions sent to the four participants as per their requirment.

I follow the order of the flow chart in documenting my research journey; that is, I begin by reflecting on my experiences in entering the community, followed by piloting the research instruments, then recruitment and data collection. These are followed by the data analysis process, and the justification of methods used to ensure research rigour. I close the chapter with a summary.

4.2 Fieldwork

This section outlines how I engaged with the community, and piloted and the modified the research instrument, the recruitment processes and associated challenges.

4.2.1 Entering and Connecting with the African Community

I presented my proposed study at the first African Health Forum on 15 June 2018 hosted by New Zealand AIDS Foundation for the African community and those who worked with the community. The aim of my presentation was to consult on the relevance of the research in the community. I also sought community validity to remedy shortfalls of community trust, participant enrolment, and uptake of research findings (Ahmed & Palermo, 2010; Fregonese, 2018; Holzer, Ellis, & Merritt, 2014). Unfortunately, I did not receive any feedback on my presentation. Afterwards, I continued to attend African events and presented my proposal where possible. At one event, I received harsh criticism from some parents on my research topic and was questioned as to why I was even pursing a doctorate. These same parents were resistant to having their daughters participate in my research. More on this is explained in Chapter Seven.

This setback did not deter me from engaging with African leaders who were essentially the gatekeepers.[9] I also intended to invite them to join my research advisory committee (RAC) and facilitate access to and collaboration with the community members, which can be daunting, if not fully prohibitive, for researchers who have no link or connection to the community (Gibson & Abrams, 2003). Though I am an African, as a recent immigrant I was well aware of being seen as an outsider. Initially, I started my PhD research journey assuming that as an African immigrant scholar, studying my ethnic community in the diaspora, I would get instant access to the community. My knowledge would allow me to see young African women's situations more clearly. In Chapter Three, I noted my position as often shifting between insider and outsider due to varied contextual issues. How then to navigate the complexity of the 'insider' and 'outsider' concept (Burns, Fenwick, Schmied, & Sheehan, 2012; Kerstetter, 2012; Liamputtong, 2010; Obasi, 2012) was crucial. This complexity has a bearing on credible data and knowledge production issues described throughout the fieldwork section.

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[9] One who has control over and/or regulates access. They also stand as navigators of information (Gallo, Weijer, & White, 2012).

Partner/gatekeeper engagement: Formulation of the RAC

The proposed RAC was to be made up of six to eight members, including four young African women and two to four African leaders (who had insight on African community's youth health). I wished the members to be females as they were likely to know more and understand the young African women's plight. They were to assist in the examination and the relevance of the study as it developed, including the research aims; link me with potential participants; and advise on the recruitments of participants, venues, appropriate social etiquette, ethics, and norms that needed to be adhered to. The terms of reference for the advisory committee are provided in Appendix F. The advisory group members were recruited informally through my social and professional networks. One young African woman and three African leaders (two females and one male) volunteered to be part of the committee. It appeared impossible to have the potential committee members convene for a meeting due to conflicting times in their availability. I resorted to being guided by informal discussions in an individual capacity by some of the members. Ideas were shared and I aligned myself towards advice and guidance that was more affiliated to the principles guiding African research. For example, my initial data collection plan required participants to be part of a collective to share their stories. I was advised that due to the availability of potential participants, it would be easier to meet one-on-one as per their schedules.

There were also concerns around the possibility of the young people finding the research topic sensitive and being unwilling to share openly with their peers. The advisors were doubtful that the young people would divulge their health issues in a group setting and recommended it would be ideal to conduct an anonymous survey. I maintained the collectivist approach (storytelling sharing circles) of collecting data. This decision was also informed by the pilot group, where collective inquiries had allowed for richer data discussion and in-depth dialogue.

I embarked on piloting the research interview guides. I approached two African community-based organisations to assist with participants. One worked with African youth – New Zealand African Welfare Service Trust – and the other which works with African women – New Zealand Ethnic Women's Trust (NzEWT). NzEWT offered their support including the venue. NzEWT is based in Mount Roskill, Auckland.

4.2.2 Pilot Project

The pilot aimed to examine the relevance of the research questions, data collection procedures, and effective means of data analysis to bring about participation and ownership (Van Teijlingen & Hundley, 2002).

Pilot study participants

The NzEWT mobilised pilot participants, who in turn were told to bring one or two people to come and participate. This approach was used as it was difficult to know who would commit to coming. The pilot study was undertaken with 30 participants. I recruited one of the pilot participants, Am, aged 24, fluent in both English and their mother tongue, to be my research assistant. She was a student, pursuing her master's degree. I was aware of the skills and knowledge she would bring to the table, like the facilitation of storytelling circles.

Thirty women attended the first of the two group discussions on 9 March 2019. I was surprised by their enthusiasm. Almost all participants were of refugee and Muslim background, coming from Somalia. I was very humbled by their support. Not only young women came but older women of 64 years. About half of these participants met the pilot study inclusion criteria of aged 16-35years. I allowed the older participants to contribute as a way of showing respect and gratitude. However, most of these participants had come to Aotearoa New Zealand in their youth, and were at some point, able to recall their early migration experiences at younger ages, retrospectively. Table 4 shows the demographic profile of the pilot group.

Table 4. Demographic profile of pilot participants in the first group discussion

Pseudonym	**Age (Years)**	**Years in Aotearoa New Zealand**	**Nationality**	**Socio-economic status**
Ar	51	20	Somalia	Not disclosed
Na	22	20	Kenya	Not disclosed
Sa	63	23	Somalia	Not disclosed
Dh	61	2	Somalia	Not disclosed
Ma***	44	8	Somalia	Not disclosed
En***	37	13	Yemen	Not disclosed
Qa	50	23	Somalia	Not disclosed
Ado	23	20	Tanzania	Marketing officer
Ami	24	19	Somalia	Student/Grant manager
Me***	50	22	Ghana	Community health worker
Sa		16	Somalia	Not disclosed
Mar	50	23	Somalia	Not disclosed
Ka	45	7	Somalia	Not disclosed
Fa	34	22	Somalia	Caterer
Ho	24	7	Somalia	Not disclosed
Fad	68	19	Somalia	Director of Women’s Trust
Ra	40	9	DRC	Not disclosed
Mary	28	8	DRC	Not disclosed
Jo	17	8	DRC	Not disclosed
Joy	16	2	DRC	Not disclosed
Mari	28	2	DRC	Not disclosed
Muh	40	10	DRC	Not disclosed
Hin	35	8		Not disclosed
Fai	33	8	Somalia	Not disclosed
Nim	42	0.75	Somalia	Not disclosed
Maria	30	20	Somalia	Not disclosed
Eno	37	13	Yemen	Not disclosed
Marya	64	8	Somalia	Not disclosed
Ham		4	Somalia	Not disclosed

***Participants who were not refugees

Pseudonyms were used to protect identity of all the participants throughout the thesis.

Piloting the interview guides

In Chapter One, I stated the main research aim sought the shared understanding of young African migrant women's experiences, insights, ideas, and aspirations to inform services, policies, and strategies to better their health and wellbeing. The research questions were:

1. How do young African migrant women create meanings of their health and wellbeing within the intersections of their gender, social, cultural, political, and traditional context?
2. What are young African migrant women's views and experiences of the Aotearoa New Zealand youth healthcare delivery system?
3. What are the best strategies for enabling youth female migrants to contribute to existing health, social, or youth services?
4. What are the best ways to implement those strategies identified in answering the above question?
5. How do young African migrant women participate in the research process and build collective knowledge and social transformation, and what are the inherent limitations?

The discussions were divided into two parts. In the first part, participants were asked to share their understanding of health and wellbeing and whether or not these two health concepts were similar or different. The second part focused on the strengths and weaknesses around the services they most frequented, and their aspirations for meaningful healthcare. Participants were offered choices of drawing, mind mapping, and using word arts to visualise and express their answers. From my observations, and in addition to the pilot participants' responses, I noted and actioned the following points (my responses are in italics):

- Observation: A few participants appeared to be confident in their understanding of health and wellbeing and could differentiate between the two concepts.
  I told them that it was not a test exercise and there was no wrong or correct answer. I was here to understand what health and wellbeing meant to them or

how I could better articulate those concepts in my research questions and guidelines.

- Observation: Participants' discussions around the health delivery system tended to centre on the general practitioner.
  I was made aware that my question on participants' accessing health services would be dominated by discussion regarding their visits to the general practitioners. The New Zealand health system has been set up to have the general practitioner as the first port of call. I had to remove the question. For example, one of the main research questions was: 'Which healthcare services do young African women use the most?' The idea was to understand the common health issues amongst this population from the healthcare services they use.

- Observation: Participants struggled with writing and speaking in English.
  I identified one participant with English literacy in each group to lead the discussions and write down the points. I also introduced a few tools to better express their opinions, like magazines to cut out pictures that could help them communicate and blank sheets of A3 paper on which to stick the pictures or draw (refer to Chapter Six for the drawings).

Unfortunately, due to the horrific event of the Christchurch (massacre) on 15 March 2019, the second session, which had been organised for 16 March 2019, had to be cancelled on suspicion of further attacks on migrants, and especially attacks being targeted towards those of Muslim background. We postponed the second session to 4 May 2020; however, only the 10 participants listed in Table 5 attended, possibly due to fears about safety following the March 2019 massacre.

Table 5. Demographic profile of pilot participants for second group discussion

Pseudonym	Age (Years)	Years in Aotearoa New Zealand	Nationality	Socio-economic status
Me	50	22	Ghana	Community health worker
Sa		16	Somalia	Not disclosed
Mar	50	23	Somalia	Not disclosed
Ka	45	7	Somalia	Not disclosed
Fa	34	22	Somalia	Caterer
Ho	24	7	Somalia	Not disclosed
Fad	68	19	Somalia	Director of a Women's Trust
Ra	40	9	DRC	Not disclosed

The session started with a reflection on the results of the first session. These 10 women offered much rich information, including personal experiences with the healthcare delivery system, which was not found in the first session. Having a relatively small group I was able to develop better personal interaction with everyone. I also observed a power imbalance which had not been apparent in the first session. My response to addressing the power dynamics is written italics.

- Observation: Dominant participants in the discussions, such as Fa and Fad, were noticeable. Not only did I sense power dynamics between the participants, but also with me. I observed Fad to be mainly in control of determining the direction of the discussions.
  I decided to go around the table and encouraged the participants to write down their thoughts to promote inclusion. I also kept on reiterating that I was a student, a recent migrant as well, who wanted to learn from them as a means to balance the power dynamics.

However, the pilot group reinforced five essential themes within the questions asked: (1) their meaning making of health and wellbeing revolved around family; (2) discrimination; (3) perceptions of health services focusing on interactions with the general practitioners and health services; (4) equal opportunities in education and training in health; and (5) action-based strategies for problem-solving. Here, the participants suggested making a video which spoke on racism in healthcare institutions and its effects on their health and wellbeing. I was introduced to Tia as the lady who had volunteered to assist with the filming of the documentary for the pilot study. Unfortunately attempts to engage with the NzEWT Director to commence this project were unsuccessful.

Modifying my interview guide

My meetings with the pilot group rendered the need to modify the following:

(i) Using lay language and fluidity in questioning approach

Observing the group interactions, I was aware that many of them just gazed with no reaction. In considering their English literacy, I was not sure if it was the use of words that may have appeared big to them. The research assistant helped by interpreting on my behalf using what she believed was lay language. However, the questions lacked coherence and flow. I fine-tuned the interview guide to elicit quality data.

(ii) Encouragement of interesting discussions

The discussions did not appear to be exciting or motivating. This could have been due to many factors like communication barriers and partial engagement and lack of attention in the discussions. I considered introducing icebreakers, which would provoke interesting stories, alongside drawing and or developing artefacts. Basic English literacy was a criterion that had to be met.

(iii) Dealing with a big group of participants was a hindrance to the storytelling technique

The advantages that come with the storytelling method could not be fully utilised by many participants. I noted time constraints and people not paying attention to one’s story to be some of the limitations. I decided to reduce the overall number of participants in each group session. Each session would have five to eight participants.

Findings from engaging with the African community including the pilot group were critical in informing my ethics application to conduct research.

4.2.3 Ethical Considerations

The study obtained an ethical clearance from the Auckland University Technology Ethics Committee (AUTEC) (reference number **18/372**). The protocol established a set of ethical principles that informed the research to include the participation, partnership, and protection of the participants. Those who were to participate in my research were depicted as being vulnerable in the sense of being migrants and females who belong to a marginalised ethnic minority community. Therefore, formalised agreements were prepared that outlined conditions that promoted the principles of participation, partnership, and protection of the potential participants and included the right to withdraw from participation. The agreements also mirrored Ubuntu ethics, a comprehensive African belief system of morals that guides research and practice in African communities (Seehawer, 2018; Ujomudike, 2015). Here, Ubuntu promoted human dignity, compassion, and justice as the three important moral values in their social order, with respect for human dignity as a major element of Ubuntu ethics. The spirit of respectfulness for human dignity acknowledged the privilege of information that would only be shared within the storytelling circles. Therefore, confidentiality was highly regarded given the small population of the African community, which had the propensity for idle talk on issues that violates the community's moral codes. Every participant, therefore, had to sign a consent and confidentiality form.

4.2.4 Recruitment of the Study Participants

An invitational flyer was developed and distributed at African community centres, churches, food shops and African community-based organisations, to African leaders of different ethnic based groups, and on social media platforms mostly frequented by African youth. My contact details were on the flyers to enable potential participants to call, text, or email me directly to express interest to participate. The principal participants were young African female migrants who met the following criteria: 1) aged between 16 and 35 years; 2) currently living in Auckland; 3) have accessed social or youth health services in the past or would like to share the aspirations of their health and wellbeing; 4) Black race – targeting young Black African female migrants was undertaken on the premise that African Black minorities have a different cultural outlook and lived experiences compared to their White African counterparts who may have similar culture and traditions to the White majority (Auckland Council, 2017);

and 5) have basic English literacy, as English would be the common language amongst all the participants. Exclusion criteria included female youth who self-identify as refugees.[10]

The flyer also provided information on incentives and honouring participation like a light meal and $20 gift/fuel voucher per person in each session attended. It was noted by the gatekeepers that appreciation and acknowledgment of participants' contributions ought to be honoured (Kanengoni, 2020). During the informal discussions with the advisory group, I was advised to include food and music to attract participants. The vouchers were given as a token of appreciation and to acknowledge the relationship and respect for their participation and the support I received in this research. It signified my commitment as a researcher to use the data purposefully. This way of showing gratification is in line with ways of doing in most African cultures. Some potential participants inquired about the incentives to participate. Details of incentives to participate are discussed in Chapter Eight.

A couple of days after posting my flyers, one young African woman by the name Ku (pseudonym) responded. Three months later, with no other respondent, I started my snowball sampling approach, also known as the chain referral sampling approach (Penrod, Preston, Cain, & Starks, 2003). When carefully planned and executed, this sampling technique offers a reasonable method for accessing potential participants that are particularly hard to reach. Ku volunteered to introduce me to potential participants within her social networks. I had observed some researchers to efficiently recruit participants by approaching people in their circles where trust had already been established. I therefore anticipated the snowballing method to resolve some trust issues between myself and the potential recruits. I also utilised the "chain referral" approach in recruiting participants. This meant that, through Ku, I was given an entry point to potential research respondents.

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[10] Defined as someone who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of [their] nationality and is unable, or owing to such fear, is unwilling to avail [themselves] of the protection of that country; or who, not having a nationality and being outside the country of [their] former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (The UN Refugee Agency, 1951, p. 14).

I found the engaging and recruitment process to be mentally and emotionally exhausting. It required extensive time and effort to connect with diverse individuals, to get their consent and commitment to participating. I wondered if this difficulty in recruiting was related to two of many other things that hindered active participation in the research. First, it could be due to the participants not easily trusting outsiders. Second, it might have been due to my exhaustion and not getting support from my participants. Finally, 16 young African women with a migrant background gave consent to participate in the study. The number of participants of migrant background recruited was determined by challenges in recruiting and, to a lesser extent, data saturation, where recruitment stops when little new information is being added (Glaser, 1992; Kuzel, 1992). The following section gives an overview of the participants' demographics.

Demographic profile of the participants

All participants were first-generation immigrants, meaning they had been born in African countries and immigrated to Aotearoa New Zealand before or during their early teen years (Rumbaut, 2004; Zambrano, 2010). Their length of residence in Aotearoa New Zealand at the time of data collection was between 9 and 20 years. The participants represented eight nationalities: Zambia, Zimbabwe, Jamaica, South Africa, Democratic Republic of Congo, Nigeria, Tanzania, and Ghana, showing linguistically diverse backgrounds. The participant from Jamaica strongly identified as a descendant of Africa and only one participant was married. The participants also had different migration journeys ranging from accompanying their parents searching for greener pastures to those who came under humanitarian aid. They also came from diverse socio-economic and educational backgrounds. Each had a very different life story to tell. Despite their diversity, all identified as raised as Christians. In their narratives, I observed how Christian values conflicted with seeking sexual and mental healthcare (see Chapter Five). I also observed that they shared similar values and beliefs in ways they presented and made meaning of their experiences as young Black African women of migrant communities in Aotearoa New Zealand.

Fifteen participants were able to join the group discussions. One opted for a one-on-one meeting due to travel plans. The 15 participants were divided into two storytelling sharing circles (groups) of eight and seven participants, depending on availability. I will call these groups A and B. Table 6 describes the participants' demographic profiles.

Table 6. Demographic profile of participants

Storytelling circle	Pseudonym	Age (Years)	Years in Aotearoa New Zealand	Nationality	Socio-economic status
Group A	Muk*	24	16	Zambia	Professional /Artist
Group A	Tof	21	15	Nigeria	Healthcare worker/ student
Group A	Gaga*	25	17	Zimbabwe	Coordinator
Group A	Du*	23	15	Nigeria	Health worker
Group A	Nku*	28	9	Zimbabwe	Accountant
Group A	Ku*	25	10	Zimbabwe	Healthcare worker
Group A	Kud*	24	10	Zimbabwe	Healthcare worker/ student
Group B	Oya*+	36	11	Nigeria	Caregiver
Group B	De	20	10	Jamaica	Caregiver
Group B	Ame	20	14	South Africa	Hairdresser
Group B	Gra*	23	13	Ghana	ECD teacher
Group B	Deb*	23	18	DRC	Health worker/ student
Group B	Gai	29	14	DRC	Professional
Group B	Fei	19	12	DRC/ Nigeria	student
Interview	Pa	24	15	Zimbabwe/ Botswana	Migrant

* Denotes those who participated in the individual interviews.
+ Denotes participant who was married at the time of the study.

4.3 Data Collection Methods

I identified storytelling sharing circles as the best fit as the data collection tool. Following the unforeseen non-engagement and lack of participation of young African migrant women in the active implementation of the identified strategies, I sought to hear their stories at an individual level through individual storytelling. Other complementary data collection tools are also discussed.

4.3.1 Storytelling Sharing Circles

It is a method built for collective knowledge and shared experiences (Kanengoni, 2020; Tuwe, 2018). It applies oral storytelling techniques in the form of poems, songs, testimonies, or a combination of visual materials like artefacts and symbols that have meaning to the Africa culture (Chilisa, 2012; Tuwe, 2016). These activities are implemented through a structural topical guideline with the aim of exploring participants' hopes and aspirations and what they want to change in their lives. In this study, they allowed participants to give voice to their own experiences and provided them with autonomy to choose what to discuss as it relates to their health and wellbeing and their experience with the healthcare system in Aotearoa New Zealand.

As mentioned earlier, two storytelling sharing circles were formed, with a total of four group sessions conducted. The sessions were conducted in accordance with the principles of African research which emphasises participants working collectively to achieve goals which are more significant than the potential of any individual. At the end of each session, a recap and reflection were undertaken, highlighting key themes discussed.

4.3.2 Individual Storytelling

Section 4.4.4 and further findings in Chapter Eight highlight the challenges met in the participating and collaborating of the participants. I used an individual approach to storytelling to understand the complexities and barriers that arose amongst the participants in collectively implementing their chosen strategy for social change. Stories shared individually are often used to better understand how a specific health strategy is working, or not, and why (Palacios et al., 2015). I also viewed individual storytelling as providing a safe venue for the participants to express their feelings, emotions, experiences, and perceptions that would otherwise go unheard (Hesse-Biber, 2012; Palacios et al., 2015). I was then able to understand the meaning being shared by listening carefully to what was said and unsaid.

4.3.3 Complementary Data Collection Tools

The use of field notes involved observation while taking both emic and etic notes. Januszka, Lora, Wollard, and Rocco (2013) explained emic notes as describing what is being observed directly, whereas etic notes consist of writing feelings about what is being observed. An example of emic note-taking was recording the number of participants in the sharing circles. Etic notes about the same participants in the sharing circles were about how I felt the participants looked cautious and uncomfortable. This observation included in-depth reflection to increase the richness and quality of findings. Through observation, which was characterised by actions such as having an open, non-judgmental attitude, being interested in learning more, and being open to the unexpected in what is known (Kawulich, 2005), I was able to reflect and reduce potential bias. Therefore, field notes served to show evidence that gave meaning and aided in understanding the contextual information, encounters, individual storytelling, and the storytelling sharing circles (Phillippi & Lauderdale, 2017). Additionally, the field notes facilitated preliminary coding and increased rigor and. See sections 4.5 and 4.6.

4.4 Structure and Topics of Storytelling Circles

The initial data collection plan required participants to meet over four sessions. Each intended session had its objective: 1) To build connection and partnership and establishing their safety, with activities including signing consent forms, sharing the research vision, creating trust, and encouraging commitment and participation in the research project; 2) To brainstorm the research problems; 3) To identify strategies, and 4) To implement the identified strategies. Each session was estimated to take between 3 and 4 hours. However, due to participants’ personal circumstances, this plan had to be altered.

4.4.1 Building Partnership and Ownership of the Research Project

This session aimed to build connection amongst the participants and establish trust and their safety. Other activities included signing consent forms, sharing the research vision, and encouraging commitment, participation and ownership of the research project. As mentioned, the number of planned sessions was initially four and was reduced to one, to lower the amount of time required for participants to commit to the group sessions. This significant change from the original research plan had the potential to compromise the quality of data. I quickly learnt that I needed to invest more time in creating trust amongst the participants. The objective: *to build partnership and ownership of the research project* was therefore modified by building relationships and connections with each of the individual participants instead of building relations in a group setting. I met some over a cup of tea; with others I kept lines of communication open such as chats over the phone and informal emails. I found out my insider/outsider status did not pose a threat to the participants as I was a recent migrant with no inside information or links that would pose a threat to confidentiality. However, in retrospect, it worked against me in that they did not have a connection with me for them to have a sense of commitment or the need to engage in the whole research process, as discussed later in this chapter and in Chapter Eight. By the time we convened for the sharing circles, I assumed that the participants had an increased understanding of the research focus and were aware of what to expect and what was expected of them.

The method in action

The 15 participants were split into two groups: A and B.

Group A

I conducted three sessions with group A. The first session was attended by seven participants. The second session was attended by three participants. The third session was attended by three participants plus Muk. Participants in Group A were aged between 21 and 28 years.

Group B

Only one session was conducted with Group B. Eight participants attended. They were aged between 19 and 36 years. They were not open to the idea of meeting again. This meant that the three remaining objectives had to be covered within the same session.

Each session took between 210 and 240 minutes. It was impossible to cover all set objectives. Table 7 summarises the sessions conducted with each group and the participants who attended the respective sessions of the groups.

To secure and maintain an atmosphere conducive to participation in the sharing circles, I reminded all participants of the ethical issues noted in the consent form and the participant information sheet. For example, I raised awareness on their right to withdraw from the study. I spoke of the principles of research with Africans with a specific focus collective participation and collaboratively engaging in actions that empower us to make an informed decision regarding our health. Because it would be done in a group setting, confidentiality must and would be held with outermost importance. I communicated that in using their stories in writing up my thesis, pseudonyms will be used to protect their identity. I also used a few games as an icebreaker to get everyone comfortable to participate before commencing with the group discussions.

Table 7. Summaries of the storytelling circles sessions

Group and session/s	**Session**	**Date**	**Activities**	**Attended (pseudonyms)**
Group A	1	23 March 2019	Building partnership, ownership and research skills of the research project, Brainstorming the problems	7 participants Muk*, Tof+, Gaga*, Du, Nku*, Ku, Kud*
Group A	2	5 April 2019	Reflecting on the previous group discussion; identifying strategies for action	3 participants Gaga, Kud, Nku
Group A	3	26 Oct 2019	Action: Digital storytelling artefact	4 participants Gaga, Nku, Kud, Muk
Group B	1	12 April 2019	Building partnership, ownership and research skills of the research project Brainstorming the problems; identifying strategies for action	7 participants Ayo*, De+, Am+ Gra*, Deb*, Ga+, Fei+

+ Participants who withdrew after the first session.
*Participants that were phone interviewed.

The first icebreaker introduced six words to the group: mobile phone, family picture, emergency contraceptive pill, condoms, alcohol and/or drugs, youth health service contact list. They were asked to pick only four items to go with to a party and/or short vacation. I aimed to engage respondents in a conversation about critical aspects of their personal lives—having them begin to establish an environment where questions could be asked and answered in a non-judgemental way (Brennen, 2012). Following the icebreaker, we started with the brainstorming of the problems.

4.4.2 Brainstorming the Concerns

This phase sought to understand how young African migrantwomen understood and made meaning of their health and wellbeing. I would ask a question, and anyone was welcome to share their stories and experiences which opened more discussions with other participants deciding to share their stories. I also asked them to use visual materials like artefacts, symbols cut out from magazines, verbal interactions such as oral testimonies and storytelling, and drawings to construct knowledge. For example, one participant in group A drew a human head with a positive sign to illustrate that mental health was key to her overall health and wellbeing. More detail is in Chapter Five, section 5.2.6. I learned that lack of mental health was often exacerbated by unmet needs and barriers such as exclusion from health, social, and economic resources. They identified other health problems as they saw them amongst young African migrant women and illustrated the obstacles in achieving health and wellbeing. This phase included an exercise on ethnocentrism where the participants evaluated other cultures (also in respect to intersectionality) according to preconceptions originating in the standards and customs of one’s own culture. This aimed to provoke more discussion on how different cultures influenced their health and their health outcomes. This led to the development of strategies to address identified health concerns.

4.4.3 Developing the Strategies

The aim of this phase was for participants to translate the knowledge they produced into practical solutions and strategies. The importance of expressing their health aspiration for future policies and initiatives to improve their health and wellbeing in Aotearoa New Zealand was further agreed. The strategies and their aspirations were discussed in both storytelling circles. Due to time constraints, and the participants’ inability to regroup, one participant in group B suggested creating a WhatsApp platform where further deliberation would take place on the kind of strategy that would address their collective aspirations. This had the added benefit of merging the two groups into one. Group A consented to this process. The WhatsApp group was created on 16 April 2019. Although all agreed with the WhatsApp platform, only 11 of 15 participants made up the membership. One participant was initially keen to be part of the WhatsApp group but later expressed her hesitation in joining the group chat for personal reasons. The other three participants did not respond to the WhatsApp invite. By default, I became the 12th participant. After deliberation on the strategies, they wanted to implement, the participants agreed to have a web page where they would post their stories in a blog format to get the attention of the migrant youth health stakeholders and communities. The outcome for this phase was to promote actions.

4.4.4 Action: Bridging the Voices, Ideas, and Aspirations

Starting with a Facebook page seemed to offer the best shot at seeing how people would respond to the web page given the uncertainty about how the community would take the initiative and how feasible the web page development would be. In the first week, the Facebook page had 26 group members. Almost half of the women (12) were participants of the research. In the two months that followed, I observed meagre participation and engagement. I posted on the page about some health issues discussed in the sessions. The same two to three people would respond every time. Following the unforeseen non-engagement and lack of participation on this Facebook platform, I consulted with my supervisors. We came up with a strategy to identify engagement barriers through individual storytelling.

Addressing implementing challenges of identified action

I sent text messages to ask for times that participants would be available to converse over the phone or in person. In the text, I informed them of my call’s purpose. I had intended to meet face to face with them, but they all opted for a phone conversation. Some asked for the questions in advance to prep them for the interview. The questions included: 1) What are factors hindering participation and collaboration? 2) What elements are needed to enable young women to work together? 3) How to promote inclusion? 4) What are the other ways that can be used to communicate with stakeholders without having to tell one’s own stories? These questions served as topical guidelines and were asked in order of the participant’s lead.

I phone interviewed eight participants (see Table 7). De and Ame were not responsive to my phone texts and calls, or individual WhatsApp chat. Hearing each individual participant's stories lasted between 20 to 45 minutes taking over a month (5 June to 25 July 2019) to complete. The availability of the participants determined the completion. However, much of the delay was attributed to the build-up of mental and emotional fatigue in coordinating times and dates for the interviews. This was further propelled by the themes emerging during the interview process, as discussed in Chapter Eight, like expectations of financial rewards for their participation or fear of damaging gossip that might spread in their communities.

Working with these young women, I learned later, required lots of patience, flexibility, and often instant changes to meet their busy lifestyles. For example, it would take several text reminders to schedule an interview. I was therefore not surprised that all participants opted for telephone interviews.

Keeping up hope

Thoughts surrounding changing the research methodology, removing the 'action' component of the research, started becoming louder by the day. But those thoughts conflicted with the key principle of African epistemology – where knowledge can never be produced for the sake of it but always for the sake of problem-solving and social transformation (Anyanwu, 1989; Bassey, 2007), and what I personally stand for. The research project had to have a purpose; to bear fruit, liberate/emancipate, and empower the young Black African migrant women. This is important for social action for their health and wellbeing. Even though the project became a considerable burden, emotionally and mentally, as a Christian, I had my relationship with God to draw strength from. I had hope that some participants who shared my vision could turn our hope into a reality that could be achieved. It made me resilient to propel change in the African community; a pathway for willingness to take chances to progress with the research project. The participants had entrusted me with their aspirations.

The need to be flexible and open

Being at a crossroads, and as a novice researcher, meant I had much to learn and reflect on. One of the lessons was that any strategy chosen should not be one to continue to require the participants to commit their time. I was placed in a leadership role as, on reflection given the landscape outlined above, these young women were not likely to initiate a strategy and engage in implementing it. Consequently, I relayed the idea of making a video artefact suggested by the pilot group to the main study participants. Many saw the idea as “great” but I wondered if their perceptions translated into them participating in its development. They had before shown great excitement about the Facebook project, but it died before it began. One participant, Kud, withdrew their consent to participate further.

The first three young women I got in touch with were not available on the proposed date but were not forthcoming with the date they would be free. It appeared as if I was going to face the same challenges I encountered recruiting participants to kick start data collection. A few hours later, one proposed an online meeting, like Skype or Zoom. I shared that thought with three more participants and it appeared to suit everyone. To secure at least half of the participants for this phase to completion, I decided to communicate with the remaining eight participants. In any case, having all participants on board was ideal for the collective knowledge production for problem-solving—core to the research study design.

On 30 July 2019, I met with Tia. In section 4.2.2, I introduced Tia as the lady who had volunteered to assist with the filming of the documentary for the pilot study. The second meeting with Tia two weeks later was more fruitful than the first. It involved communicating what the participants’ availability and how that would work with her schedule. I felt more committed than the others to participating; that is, setting up a date, time, and venue to do the video brainstorming.

After failed attempts to get a date that worked for everyone, Nku advised me to come up with the options of how the video would be developed and then share it with everyone individually. Each participant would choose the preferred option. Details of the processes are discussed in Chapter Eight. This approach got the project moving. I got responses quickly as it did not require the participants to invest time in brainstorming how to go forward. As the project evolved over seven months, many initial participants went on to become “out of reach”. The ‘action’ component of the research saw four of the 16 participants engage. These four also shared their reflections on the participatory and collaborative processes, and how they saw their subjective principles of African research of participation, building collective knowledge, and social transformation into the research processes (see Chapter Seven).

4.5. Data Analysis

The research was envisioned to develop meaningful partnerships towards shared findings and intended outcomes. The following sub-sections outline the stages that were applied in the analysis of the two forms of data collected—the storytelling circles and individual storytelling.

4.5.1 First Stage of Analysis

This first stage of analysis was done in two parts:

Analysis in the sharing circles

Being mindful of the challenges of regrouping with participants to co-analyse the knowledge produced, at the end of the sessions I reported back to participants a list of issues that could potentially become themes, such as mental health, misdiagnosis by Aotearoa New Zealand medically trained doctors, racism, unprofessional conduct of African health providers, and the role of religion and culture in shaping the health of young African women. This was particularly useful for the design of the problem-solving course of action.

Analysis with the individual participants

With the eight participants who participated in the individual storytelling, I gave the participants an overview of data collected during the individual storytelling interviews which enabled them to provide feedback or ideas that required adjusting, changing, or addition for the strategy and the research process for successful participation and collaboration of the participants. Words like ‘that is important,’ ‘this is the problem when people do not see the vision,’ were used by some participants to add emphasis, or ‘people have trust issues and are generally sceptical with research about them’ were words used that served to revise the approach. A consensus on the core issues driving their concerns was reached through these continued dialogues. For example, the presence of feelings of mistrust amongst themselves and social divisiveness within the

African community were hindrances in the participation and collaboration of the participants in actionable problem-solving.

4.5.2 Second Stage of Analysis

Following the first stage, I embarked on transcribing the recorded stories collected from the storytelling circles and the individual stories. This stage of analysis was done in two cycles.

First cycle

The first cycle consisted of reading and listening to each interview in its entirety. With potential themes at hand from the first stage of analysis, data presented in condensed stories were aligned to the preliminary themes. A deductive approach to coding was applied following Neale (2016), who recommended this technique to coding to give feedback into the study aim or question. More inductive codes complemented these deductive codes to derive more creatively (using mind maps) from emergent themes. I applied Braun and Clarke’s (2012) thematic analysis method through the coding process. Here, a decolonising lens was used to address power relations, ensuring participants’ voices were heard by shifting focus from my aim to the participants’ (Chilisa, 2012; Kovacha, 2010), as previously outlined in Chapter Three.

Second cycle

The second cycle focused on the participants and the language used to identify their voices (Chilisa, 2012; Kovacha, 2010). The aim was to understand these young women’s reality and how they thought others might perceive them (Brown & Gilligan, 1992). I listened for sentences containing the words “I,” “me,” and “my” to gain insight into the pathways of participants’ thoughts and feelings, distinguishing what they said by the way they said it. It allowed individuals’ narratives to be explained in terms of their relationships and the broader social and cultural contexts within which they live (Brown & Gilligan, 1992). It helped to identify the voices of participants and created a space for them to speak of themselves in their own bodies, before I, the researcher, spoke of them.

4.6 Rigour

Reliability and validity are still, and will remain, appropriate concepts for attaining rigour in research (Rezapour, 2018; Rose & Johnson, 2020). Triangulation—using multiple sources or methodological approaches to data—allows for the contextualisation of knowledge from multiple points of view (Fusch, Fusch, & Ness, 2018). This creates a joint and collaborative reconstruction from multiple existing realities (Noble & Heale, 2019; Renz, Carrington, & Badger, 2018), a technique used to ensure rigour in this study. Section 4.3.3 highlighted the use of field notes which involved observation and in-depth reflection to evidence meaning and aid in understanding contextual information, encounters, and information gathered during individual storytelling, and the storytelling circles. My supervisors also checked and rechecked emergent themes for credibility.

Critical to participation and collaborative research methodologies within an indigenous research framework is the application of relational layers of reflexivity to include self-reflexivity, inter-personal reflexivity, and collective reflexivity (Nicholls, 2009; Palaganas, Sanchez, Molintas, & Caricativo, 2017). These I applied to minimise relying on my personal impressions and the potential for subjective bias and subjectivity, to situate knowledge or to counter my power as the researcher.

4.6.1 Self-reflexivity

I became aware that my interpretation of participants' behaviour and the data collected made me liable to some level of subjectivity based on my values, beliefs, experiences, and interests (Palaganas et al., 2017). Therefore, to promote rigour, I was concise in identifying categories and data, and in stating the assumptions underpinning the process, and explicit about the methodological procedures employed. Most importantly, I detached as much as possible from my own interpretation. I worked on selecting core and fundamental data and patterns of data that converged to give importance to the participants' information. As I listened to participants' stories and views, I understood more their lived worlds and appreciated how far they had come in this collaborative research journey. I examined my own experiences and became more appreciative of how the participants had found time to participate in the research. Although self-reflection did not necessarily add to the broad agenda of social change evaluation in the research process, it did enable an improved quality of interpretation and participants' understanding in the research processes.

4.6.2 Inter-personal Reflexivity

This layer of reflexivity, which calls for researchers to position themselves in terms of their inclusion within the research collaboration and the capacity to work in partnership (as opposed to lead, control, or delegate), was pivotal in this research context (Nicholls, 2009). In my research journey, the participants communicated collaboration as an equilibrium between building connections and their engagement in research. The individual storytelling became a learning curve to move in and out of collaboration. Indeed, as I sought to establish a strong alliance with the participants, I was rewarded with greater connection and achieved meaningful engagement which aided in improving the quality of data.

4.6.3 Collective Reflexivity

Reflexivity also has a collective component where the researcher's positionality interacts with others and influences research outcomes (Cayir, Felder, Nkwonta, Jackson, & Dawson, 2022). Therefore, collective reflexivity allows the researcher to process conflicting perspectives, enable the development of a shared vision of the research concepts, methods and innovative approaches for actions. I had to be transparent about my position as a young African migrant woman, a youth health worker in one of the DHBs, a novice researcher and one who is passionate about bringing health issues for young African migrant women to the fore. This positionality could have made me subject to priori assumptions, personal biases, and interpretations that are not rooted in the data. Collective reflexivity was therefore very enriching during the one-on-one interviews I conducted to understand the lack of participation and collaboration. Each one of us communicated relevant dimensions of our multiple and intersecting identities within the research context, and reflected on how these and our lived experiences, values, and beliefs shaped our approaches to participation, data analysis and interpretation. My understanding of the research phenomenon (in particular, the lack of participation) was transformed through the diverse perspectives offered by each research participant.

4.7 Dissemination

The dissemination of findings and mobilising people into action around those findings are fundamental parts of the research process. This is all the more so for a community that has aspired to see change for so long after participating in research and bearing the consequences of exploitation. In an ideal world, the dissemination research strategy for participatory research should be developed by the co-researchers; but due to the reasons outlined throughout in this study, I developed and shared it with the participants (see Appendix H). This was due to challenges met in having participants committed to ongoing participation in the research. The approach recognised several parties of interest, those within the African community, public health, academia, and beyond. A selection of dissemination/mobilisation strategies have been, and will be, implemented including working with African based/ethnic organisations and mainstream media (Abbas et al., 2022), presenting at conferences, and writing journal articles. My intent is also to contribute to the CALD training programme to raise awareness on the African concept of health and wellbeing and how that understanding can be used in delivering appropriate healthcare; and to advocate for a standalone categorisation of Africans in population and youth health service data. Literature reviewed in Chapter One showed the programme to focus on the Asian (mainly Chinese) and Muslim communities; and other widely different cultures are placed together in a perceived homogeneity (Kanengoni et al., 2020).

4.8 Summary

In this chapter, I presented my research journey which began with entering the community to assess relevance of research topic and to also have the community’s buy-in. I also gave a detailed description of the pilot study and how I modified the research instrument and described the recruitment processes. Sixteen young African women of African origin and identity between the ages of 19 and 36 were recruited. Challenges and obstacles experienced in the field were highlighted, which included organising the time and date for data collection and the participation and collaboration of the participants in the research. Thematic analysis, using a decolonising lens, and a deductive approach were employed to analyse data. This approach aimed to capture feedback on the study questions and shift focus from my aim to the participants’ agenda. Rigour in the form of triangulation and reflexivity were methods adopted in the study. A dissemination pathway was outlined.

CHAPTER FIVE: WE GOT OUR FOOT IN BOTH COURTS: MAKING MEANING OF OUR HEALTH AND WELLBEING

5.1 Introduction

This, the first findings chapter, provides insightful information on 16 young Black African women's understanding of how they make meaning of their health and wellbeing. Thus, the chapter presents in-depth discussions around participants' understanding of health and wellbeing informed within their social and personal existence as young African migrant women living in Aotearoa New Zealand. This related to their genetics, family, spirituality, and state of positive mind with a particular interest in mental health. Participants' discussion on mental suffering was associated with spirituality, family support, racism and a collective identity of resilient young African migrant women. Included in this chapter are the narratives and testimonies of women who participated in the pilot study. The pilot study is not fully representative of the targeted study population. It included both young and older African women.

I begin this chapter with Nku's story which displays a life of a young girl who migrated to Aotearoa New Zealand to live with her uncle and aunty. At some point in her life, Nku experienced a debilitating illness which was not well-diagnosed for a few years.

Nku is 28 years old. She came to Aotearoa New Zealand when she was 19 years; thus, had the opportunity to live both in Africa and in Aotearoa New Zealand. Nku entered into adolescence in Africa. As a teenager, newly coming to Aotearoa New Zealand, Nku remembered thinking how teen Kiwi girls dressed quite differently from her. From her African peers, she heard that Kiwi girls love parties, drinking, smoking, drugs and engaging in pre-marital sex. Being raised in a Christian home, Nku was taught to avoid those behaviours. She remembered how she had to behave differently when she was with her peers and when she was with family at home. Due to the curfew imposed by her uncle and aunty, she missed out on many party invitations. Her friends stopped inviting her. At school she would feel out of place when her friends chatted away about the events of the parties. She noticed that her guardians did not apply the same set of rules to her brother.

She recalled being occasionally sick during the first few years of university.

> I have been misdiagnosed for years. They didn't know what was wrong with me and I was on medication every day to try and fix everything… I don't know how much I spent every month on this problem. Every month I had to take five days off work. I couldn't walk, I couldn't move. They thought it was something else, they dealt with that. And after that, it was still the same thing and I kept going to my doctor telling them that I'm in pain there's something that is wrong with me. (Nku)

One day she woke up only to find herself on a hospital bed. "*It took me collapsing one day. My flatmate found me up passed out at the door. When I got to the hospital, they didn't know what was wrong with me*", Nku said. Once again, the doctors could not find the problem. Instead, they referred her for counselling, believing that her pain and non-stop bleeding was of psychological origin. Finally, it was a foreign doctor, who happened to be within the vicinity, who knew what could be wrong with her. Nku then was asked to have another medical test. Finally, she was given the right medication, she gained back her health and strength. She was fully recovered.

At the time of this study, Nku was working full time. In the next section, Nku's explanation of her health addresses social and financial aspects. Some financial aspects of health included the feeling of being burdened to pay off her student loan on top of sending money to Africa for her relatives' upkeep. The other 15 young women also expressed specific meanings of health relevant to their life context which echo Nku's explanation.

5.2 Making Meaning of Our Health and Wellbeing

The conceptualisation of health as a resource for everyday life is one of the many health definitions endorsed by lay people, scholars, policy makers, academic programmes, professional and community-based organisations, and government departments, and adopted by the *Ottawa Charter of Health Promotion* (WHO, 1986). Wellbeing is the state of being in a positive rather than a neutral condition (WHO, 1986). Participants in this study explained the crux of their health and wellbeing beyond these definitions—as cultural, spiritual, and a manifestation of their identities as a young woman, as a collective, as a Christian or Muslim, and as a Black African within other intersections of their social, physical, mental, sexual, and biological contexts. The participants' interpretation of health and wellbeing also included an articulation of migration status and stages of migration to Aotearoa New Zealand, and length of residency.

In responding to the research question, participants used drawing, mind mapping, and word arts to visualise and express their answers. Participants found the use of the visual methods fun, interesting, and exciting. In the pilot group, young women were elected by older women to create mind maps and drawings on behalf of the groups. The visual products and narratives that were produced yielded varying definitions of health to include the domains of physical or bodily health, pain-free explanation, spiritual and cultural, to name a few.

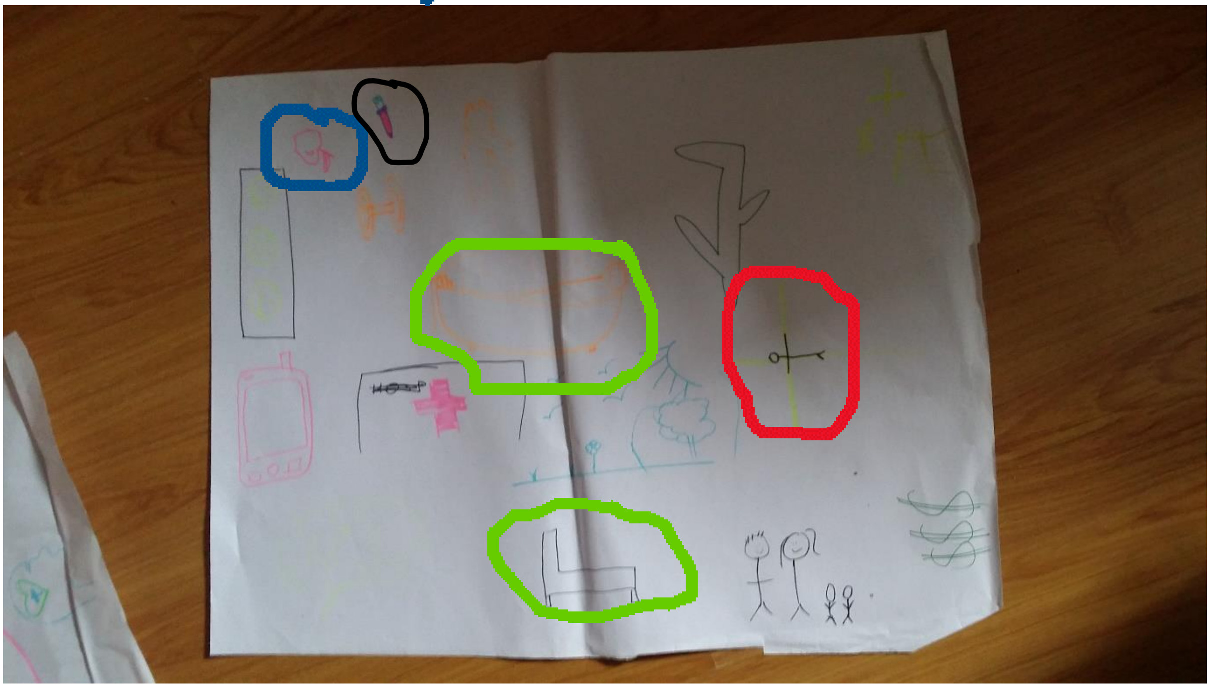
5.2.1 A Body Free from Pain and Disease

The meaning of health most frequently articulated by the participants was having day-to-day activities without any restrictions of pain and disease. For example, Gaga drew a dumb bell (Figure 5: circled in red) to depict the importance of having physical exercises to maintain health.

Gai, Deb, and Gra worked together to produce the following drawings (Figure 6). Gra, drew a picture of an apple and quoted a 1990s English cliché, '*an apple a day keeps the doctor away*'. While physical exercises and healthy nutrition, like having fresh fruit in a daily diet, was important for some participants, others also focused on 'self-care' and having 'time out/respite' or 'me time', depicted by Gra in a picture of a bathtub and Deb's drawing of a bed.

Figure 5. Participants' drawing to express meaning of health and wellbeing (i)

Figure 6. Participants' drawing to express meaning of health and wellbeing (ii)



Up to this point, the participants conceptualised their health elements as physical and self-care (i.e., 'me' time). Others brought forward aspects of sexual health.

5.2.2 Sexuality and the ‘Cons’ of Reproducing

During the icebreaking exercise, prior to the group discussion, I noticed that many of the participants were excited and motivated in discussing sex and reproductive health, such as unplanned pregnancy and STIs. I was relieved to find out that participants felt safe to talk about sexual health having only met each other as a group for the first time. I wonder whether my status as a young mother, but an ‘outsider’ (see Chapter Four) also made them feel comfortable to share stories about sexuality and sexual health.

Gra was the first to raise the sexual health issue, with others slowly joining in the discussion. I gathered that Gra, a Youth Coordinator at the time of the research for an organisation that stands to empower African communities in Aotearoa New Zealand, was a role model to the younger girls who felt confident and safe to discuss sexual health. Gra drew a space rocket (Figure 6) symbolising a penis having a condom on (circled in black). She said, “*...that’s just for protection purposes. So, like condoms and contraception and getting check-ups and pretty much all of those things that come together*” (Gra).

Warming up to the discussion on sexuality and health, participants and I established some central aspects to sexual health relevant to young Black African women: 1) sex: fun vs safe; 2) sex as taboo: no safe space to talk and know about sexual health; 3) parents’ denial of their daughters’ sexual activities; and 4) males’ responsibility: girls are not the one responsible for getting condoms.

Sex: Fun versus safe

According to the participants, engaging in sexual activities at parties was not uncommon. Participants explained that unsafe sex often occurred during parties, when young people were under the influence of alcohol and drugs. Du professed:

> We really don’t care about [safe sex] ...like to be honest with you a lot of young women don’t even take the morning after pill. They buy it [morning after pill] when they get there or when they need it. Because they’re too busy to be wanting to get lit from the alcohol or from the drugs that will be used.

According to Gaga, “*girls don’t really drink… not to that extent [that they end up in Accident and Emergency]*”. Gaga seemed to suggest that, in most cases, when young women had unprotected sex they would be of relatively sound mind. I was expecting to hear accounts of sexual abuse or women feeling pressured by their peers or coerced into having sex. No such accounts, however, were mentioned.

Of interest, I noticed that participants' stories were often a recount of the experiences of their peers and not their own experiences. Likewise, while they were articulate in explaining a myriad of methods to maintain and achieve good physical health, their understanding on how to achieve good sexual and reproductive health remained sparse.

Sex as taboo: No safe space to talk and know about sexual health

Taboos around "sex talk" and associated behaviours are well observed in many African cultures (Kanengoni, 2020; Rade et al., 2018). It was not surprising that participants would find it taboo and shameful to look for sexual health information, especially STIs or HIV. A few of them understood that the prevalence of HIV is highest among Africans: "*After the gay bisexual and lesbians in New Zealand, Africans have the second highest rate of HIV in New Zealand*", informed Du. Some participants did not understand how such a small community was ranked second highest for HIV rates. "*Like we are a small community, how do we get to be the second highest? I like know one African with HIV for 18 years. So how are we number two?*" asked De. Chapter Eight reveals gossip to be rampant in the African community, a reinforcing factor for people not to disclose their status for fear of stigmatisation. This may explain why participants believed the prevalence of the virus to be lower than that reported. Likewise, Gaga felt "*like there is no safe space to talk about it [HIV] for most people, so you wouldn't know but I think it's quite common*".

Participants also reported health professionals often missing one's ethnicity through unconscious bias learnt by skin colour and the bias of association of Africans with HIV. Chapter Seven further discusses how health professionals do not pay attention to detail when they work with Africans.

> We've already established that a lot of the professionals here don't listen. Someone may walk in like a dark Indian. There are some dark Indians. There are some dark Asians and so if you think about it, a lot of the Indigenous people are dark. And so someone walks in... 'oh there is a Black person' and they will test positive for HIV. So this person will say, 'oh yes, I come from India blah blah blah'. At the end of the day, they've [health professionals] forgotten that you've said you're from India and they just write 'African'. That's honestly the reality of that. (Gra)

Gra's testimony of health professionals unconsciously discriminating against dark-skinned people and automatically categorising them as Africans might explain the increased number of Africans with HIV when other ethnicities with dark skin also test positive.

Gaga also explained that "*Chlamydia is the most common STI… quite common as well*". Chlamydia is the most prevalent STI in Aotearoa New Zealand amongst the 15-29 years age group (The Institute of Environmental Science and Research Ltd, 2018).

The prevalence of sexually transmitted infections also came with participants' unintended pregnancies. The participants mentioned knowing women who had an unintended pregnancy; with some having backyard abortions. This would be of interest to sexual health education programmes and policies for young African migrant women to prevent pregnancy and STIs.

> A lot of African girls do not actually know about youth health services. From doing my own research, it [knowledge] is actually lacking and young African girls do not know where they can go and get an after-morning pill. They actually don't know that it's safe to go to hospital and talk about sex or even get an abortion because they feel like nurses are like the one in Africa that will go and tell your mum or their auntie. (Du)

Many participants expressed little knowledge about abortion services and whether young African women could access them:

> Abortions. I don't know how high it is, but I know that it's happening. Yeah. Yeah, so I don't know about it because it's taboo to talk about it. Even the girl I knew who went for one [abortion]… she was so scared to even tell me stuff like that. (Du)

The taboo nature of "sex talk" led to fears of stigma when accessing health services. Fears of being seen or heard about by other African community members when accessing a sexual and reproductive health service would bring shame, as explained by Gra:

> So even though the services [sexual reproductive health] are there, we are not accessing them. We know it's there but it's not for us. Everybody knows everybody. When they see you walk into that clinic you're going to be talked about. Even walking into the pharmacy. You need to have an alibi.

Gra once escorted one of her young African friends to an abortion clinic. That memory haunted her for years. On the day of the storytelling sessions, Gra was still feeling fearful of people finding out she had once visited an abortion clinic, what those people might have seen, or thought and gossiped about her.

> I remember a friend of mine went for an abortion. And she was so scared that I had to walk her into the place. Now, this was against everything I believe in, but I was like, you know what this is something she's going to do regardless of whether I'm there or not. I would rather be there for her right now as a friend so that she knows that she's not alone because again, going through that is hard enough. That night somebody called and said, 'so what were you doing in the city? So, we saw you'. So, in my head I'm thinking, 'Okay. So, they knew I was in the city. They saw me in the city. Where else did they see me go? Till today, I don't know because I didn't have the courage to ask that question and we don't even know what's been talked about me. (Gra)

I was not surprised that none of the young women in my pilot study had not brought up sexual health matters; it could be that they were aware of the presence of older women and feared being judged as 'bad girls'. The sensitive and 'taboo' nature of sex talk and sexual health services imposed a strong barrier to young African migrant women accessing sexual and reproductive health services (see also Chapter Eight). The 'taboo' nature of sexual matters in African society led African parents to deny or avoid addressing the sexual health needs of their daughters.

Our parents are in denial and not accepting that we are sexually active

Many participants explained that Africans, due to their religious and cultural values, are known to condemn pre-marital sex as immoral and sinful. They believed that most African parents were in denial of the possibility that their daughters might be sexually active.

> Yeah. I used to volunteer for the New Zealand AIDS Foundation and I was out there trying to help people and I remember because I was also in the worship team, I was asked how can I be supporting people using condoms? You should be telling them to restrain and blah blah blah. I was like, I'm trying to be practical right now. We're trying to tell people not to have sex but at the end of the day people make mistakes, people fall in love and they think okay… this is it and then you end up having sex with somebody. But after that, especially in our culture, we do not want to go and look for help [to prevent unintended pregnancy] that is why you end up seeing people getting pregnant and they don't tell anyone and they end up trying to abort then having complications in the future because they thought if my church knows that I'm pregnant I am going to be an outcast. The best we can do is make sure they have tools to protect themselves so that they don't end up with STIs and HIV and other worse situations like being pregnant and everything. But if you're not going to allow me to help people protect themselves, then we're

> not helping ourselves because we are lying and trying being hypocritical about it, like people are not having sex. That’s a lie. People are having sex. People are having sex in a church community. So, the more we talk about it and try to put things in place to help each other and educate each other, the better. (Nku)

The taboo surrounding sexuality issues may be intergenerational and based on long-standing religious mores of women’s morality and sexual conduct. Nku: “*If the African community finds out I am pregnant; it is going to be another whole conversation. I am better off going to abort the baby because this is me with the other side of me being a good girl*”. Ame got pregnant at 18 years of age outside wedlock. She explained that a young African woman who got pregnant outside of wedlock would likely to be condemned or ostracised by her parents.

> I think the fear in a lot of African teenagers when it comes to their parents, I think they would…. because hand on heart, when I found out I was pregnant, I was like ‘do I keep it or let it go’ because my mom is going to be like... I’m gone. I’m homeless with the baby. What am I going to do? (Ame)

Du related the experience of African girls with girls of Pacific descent, where premarital sex was condemned in society. African parents, like those in the Pacific cultures, would disown their daughters for being pregnant. Du was aware of the amendment made to the Abortion Law (Section 38 of the Care of Children Act 2004 No. 90), which she believed to give more authority to young women (of whatever age) to make decisions relating to abortion without parental consent:

> But it’s not just us that has the issue of not being able to talk to parents. It’s also our Islanders and that is how they bring these laws to change. No offense, but only White people can go to them [parents] and be like, ‘hey, I’m pregnant’ and it’s normal... but Islanders and Africans, we’re kind of on the same level sometimes in the sense like “Hey, get out of my house. You are not my daughter anymore’. When you have White people have an abortion, it’s a normal conversation over a glass of wine. With an African....ummh, never!

Being born and raised in Zimbabwe, I was raised to the value of a woman as the guardian/custodian of acceptable behaviours and bear the duty of morality. Similarly, in light of being viewed as the duty bearers of morality, participants argued for their male counterparts to bear the same moral standing relating to safe sex.

Males' responsibility: Girls are not the ones responsible for getting condoms

In African communities, there are widespread expectations that single (unmarried) should women not engage in sex; consequently, girls do not need sexual health services or contraceptives services. Most of the participants believed that it was a man's responsibility to always have condoms with him. Nku had never seen any young woman carrying condoms and wanted to know if anyone in the sharing circle did. "*Has anyone actually ever thought of taking condoms? I have never come across any girl who actually carries condoms*". Du was quick to answer and noted that the young women expect men to bring condoms.

> But isn't that the guy's responsibility to get a condom? Guys always have one condom in their wallet. I know that is the guy rule, well at least they carry one condom in their wallet. But basically, that's where the problem comes in because some females are shy to carry condoms. And I used to work in the community giving condoms and stuff, it's always the guys coming to me to get the condoms. A guy and a girl will walk into the event together and you'll see the guy comes and talks to me and the girl is standing at the corner.

Fears of being the object of social gossip, being seen as promiscuous or 'loose', continue to reinforce self-stigmatisation in young African migrant women, furthering their vulnerability to STIs and unintended pregnancies. It is, therefore, anticipated that women would feel safer to expect the men to always carry condoms:

> When I first came here and went to university, during orientation we were given a pack of condoms. Before I got home, I was actually thinking that I needed to find a bin to throw the condoms away because if I got home with them it was going to be a whole big story. So, I got home, and I totally forgot to throw away the condoms. My aunty found those condoms and she wasn't talking to me the whole day. She waited for her husband to come back from home. They both went to their bedrooms and later on came to the dining to have a chat with me. They lectured me about the consequences of having sex at a young age. But a few weeks later, she was doing laundry, and she came across condoms in the pocket of my cousin brother. She put away all his clothes and all she had to say was 'at least he is being safe'. So, I'm not being safe, but he is being safe? So, it's also a gender issue. As a woman if you are found with condoms, you are seen as a forward woman not 'wanting to be safe'. (Nku)

Kud confirmed: "*even now I am 25 years of age, it is a big issue [to be seen with condoms]*". The same norm is, however, not imposed in Aotearoa New Zealand Pākehā culture. Du noted: "*young White women would be able to freely discuss about abortion with their parents 'over a cup of tea', without fears of any repercussions*".

Closing off the discussion on sexual health, one participant referred to the inheritance of genetic disorders to be an important contributing factor in health.

5.2.3 Genetics: I Am Getting this Disease from My Parents

Earlier I illustrated a story of Nku, who frequently sought medical care for several years. Nku gave her meaning to the experience of health and wellbeing by placing it in the context of her individual life history. She presented her story in a specific language of distress by looking back on the events of her parent’s life and events that preceded her birth. She explained her health condition might have been inherited within her familial line. She commented: “*I look back as to why my health was suffering. It wasn’t anything that I was doing but it was because of the genetics, what has been passed down by my family*” (Nku).

Other participants explained their health and wellbeing as interconnected with the health and wellbeing of their living family members and ancestors.

5.2.4 My Family Has to be Okay

Like Nku, Kud and Oya also believed that their health and wellbeing are dependent upon the health and wellbeing of their families. During the icebreaker activity, I asked participants to pick four out of six items to bring to a trip: 1) mobile phone, 2) family picture, 3) emergency contraceptive pill, 4) condoms, 5) alcohol and/or drugs, and 6) a youth health service contact list. Oya’s first choice was a family picture. When asked to share reasons for choosing that item, she confirmed feelings of self-belongingness and having her loved ones well was central to her health and wellbeing: “*It is about having loved ones that actually love you for you. Its having loved ones around we can share things with and can feel what you feel. This contributes to my healthy self*” (Oya).

Kud drew a family tree with the family genealogy (Figure 5), and likened it to Māori health beliefs, where family (whānau) is central to an individual’s wellbeing. She argued for her health and wellbeing to be intertwined with the health of her family members and their support:

> If one branch suffers, everyone suffers. If one person is diagnosed with cancer, it’s not going to only affect you but the whole family. And you can

> choose to eat all the good stuff. If you're all about the Kentucky Fried Chicken, I mean it takes the whole family to support you in whatever journey you are on. Māori people also believe in this philosophy as well. Their health is centred on the whānau. (Kud)

Both Kud and Oya were living with their families. I wonder whether living with family plays a significant role in how family-collective norms are reinforced and manifested in the life of these young woman. In an African traditional life, a family member is always an integrated part of a family, and he or she is conditioned to always act from within the family—being constantly in their conscious mind (Kisembo, Magesa, & Shorter, 1998; Mbiti, 1975); that is, for one to be of good health, such good health should be extended to family members and community (Ajima & Ubana, 2018; Omonzejele, 2008). An individual's illness in African communities is regarded as an illness for the whole community. Therefore, the health and wellbeing of Africans is a collective matter. Others, like Du, however, saw that one's ability to 'manage oneself' was independent of the family's wellbeing as central to her health. These diverse opinions and understanding of health amongst young African migrant women need to be taken into account in health programme and policy planning.

While family connection and belongingness were important for some participants, others argued for spirituality and religiosity as central to their wellbeing.

5.2.5 Mental Health: Positive Minds, Witchcraft, Upbringing and Spirituality

Positive attitude, thoughts, and minds was believed, by some participants, as the ultimate manifestation of good health and wellbeing. Muk drew a head of a person (Figure 5) and explained: "*In this drawing, he has love inside his head and the positive sign is representing positive thoughts, positive health, and the person's head represents us. Positive mind in terms of mental health*". Here, I was reflecting on participants' explanation of having positive attitudes, thoughts, and minds as reflecting a state of positive mental health.

With Muk starting this conversation, Fei, Kud, Ga, and Gra turned their discussion to emotional and mental health. Fei was adamant that mental health was most important: "*I would say, from our discussion, I would say mental health is probably the biggest* *thing. I know we're trying to teach our parents but there are a lot of parents who don't know*".

I gathered that mental health was important to the participants, but rarely amongst Africans and/or parents. Of note, none of the older women in the pilot study mentioned mental health or healthy minds and thoughts as central to their health. I also gathered from the discussion that mental health is a socially constructed and clear concept, denoting that different cultures, societies, groups, institutions, and professions have varied ways of conceptualising its nature and causes, defining what is mentally healthy and unhealthy, and deciding what interventions, if any, are fitting (Amuyunzu-Nyamongo, 2013). Here, the participants' stories alluded to mental health issues as being caused by 1) witchcraft; 2) lack of spirituality; 3) cultural identity clashes; and 4) association with Kiwi peers.

Back home, we believe witchcraft causes mental illness

The belief that mental illness is caused by witchcraft in the African context is not new. Mental illness is often linked to supernatural power, seen as a curse and not a medical condition needing medical attention (Aina, 2004; Ventevogel, Jordans, Reis, & de Jong, 2013). People with mental illness are stigmatised and discriminated against, isolated from their communities and, consequently, hidden, which is equated to a 'silent epidemic' of the victims (Amuyunzu-Nyamongo, 2013). This contributes to the reluctance to recognise the need for seeking mental health services, as explained by Kud:

> I came across an African social worker and we were having this discussion and she was telling me that genuinely we Africans are really struggling but because it's a taboo to talk about mental health, so when you go back home you don't mention it because according to our culture, it's witchcraft. This is my opinion, but I think when it comes to mental health in Africa people are suffering. Africans here in New Zealand are suffering. Whether they are in Africa or here they are not taking advantage of mental health services.

Some participants expressed fears of going back home due to witchcraft. Gra's grandmother had passed away back in her home country and, despite the approved bereavement leave she received from her manager to attend the funeral, Gra was hesitant to travel back to Africa because of fears of getting bewitched.

> You know, the other thing is they could be stuff like, you know, witchcraft and stuff involved. People will now be going and collecting things and hurting people. So, I personally didn't know if I wanted to go [back home to bury grandmother] but I wanted to take the time off anyway. (Gra)

I question to what extent this cultural belief linking mental illness to witchcraft directly or indirectly influences the health-seeking behaviour of Africans living in Aotearoa New Zealand to access mental health support and services. Their behaviour of not engaging with mental health services may be hindered by health professionals not having an adequate cultural understanding of mental illness in African communities. Participants also attributed factors influencing their wellbeing as related to their identities and context of being African migrants in Aotearoa New Zealand.

Upbringing: We got our foot in both courts – Tension between African upbringing and youth reality in Kiwi culture

The participants reported experiencing tension between adhering to African norms versus dominant Kiwi social norms. Some participants had lived with their parents in Aotearoa New Zealand between 9 and 20 years. Participants were aware that their parents brought with them values, beliefs, and traditions which influenced their parenting styles. Some participants found challenges in negotiating the tension between parental rules and the rules and norms of their Kiwi peers. This tension affects young people's wellbeing as, Ga clarified:

> I think Gra said in the beginning that most of us are first generation. So, your parents bought you with them and you grew up here, but your parents are direct migrants. So, they are coming with another mentality. Like sleepovers, Africans parents do not do sleepovers. They will ask you why you are going to sleep at somebody's house? What's wrong with your bed? ... Take for instance, parties, they start at 6pm and your parents want you home by 6pm. If you stop going to these social events, after a while, you find they stop inviting you. You are not a cool kid anymore. You are not part of the crowd anymore so something would have happened at the party. Your friend will be talking about it during lunch, laughing. You are not part of the conversation. So, you try to find yourself along and it keeps building up. As that is building up, you're dealing with adolescence, you lash out. So, when you lash out, your parents don't know why you're lashing out because they don't see that other part of you that you're struggling with. But you can't explain it because you don't want to add to the burden so that becomes a problem for you like mentally. And then the parents start saying, 'she used to have such great grades, what happened?' But because you're fighting all of that, your mental is not right. When your mental is not right, your emotions suffer. So, your relations around you suffer. They start looking at it as if like you've picked

> up this Western culture. But sometimes actually no I'm not picking up. It's sometimes a cry for help. Like it's one of those things where you feel like you're in the middle of the street. There's a storm in you screaming, and no one can hear you. Many times, the parents don't pick up that cry for help and I think that to me personally like having gone through my last part of adolescence here in New Zealand, I felt like that was what I was struggling with... trying to like keep my morals intact and still being with my friends. Like having to pick it does work on your mental.

Ga used the terms 'a cry of help', struggling to 'keeping my morale intact', and 'no one can hear you' which may reflect feelings of hopelessness, being unheard and demoralised.

Ame had recently reconciled with her mother after having a bad fall out with her. Ame struggled to manage the tension between maintaining her African tradition and the social context of the life of young people in Aotearoa New Zealand. Conflict arose when her mother insisted Ame follow the values, norms, and behaviours from the African culture and to contest the values and behaviours of their host culture.

> We have all grown up in the African culture and when we came here, we had to adapt to a new culture. So, we, in some senses, we got our foot in both courts. Like we have lived here for so many years, we have citizenship and people say 'yes, you're definitely a Kiwi' but what about how I live at home, it's not how you live like at home. How you talk to your mother it's not how I talk to my mother. It's different. Like if you go to different households, it's different. One of my closest mates swore accidentally in front of her mom and she was like, 'oh my gosh! My mom is literally going to kill me'. And I'm like 'do you know what year we are in? Do you know how long you have been living here? You said a swear word, like really. Like it's a swear word. But what is your mom going to do? You're old enough. You gotta start living your life'. I think that's where the problem is with our parents. They don't realise that you're actually grew up different to the way they did. And it's them who have to adjust the way. Okay, they might think differently to the way I do because you go to school. You go to school and your teachers live different lives. Everyone and your peers around you or you might have some people who are from the same country and you can relate with them. But in school, that's what you know. And I hear a student yelling at a teacher. I ask myself if he talk to his parents like that. Probably. I'm not going to try it because that teacher is going to tell my mom and my mom's going to hit me. I'm not gonna get in trouble and that's all it is. (Ame)

Similarly, De, Gra, and Ga also experienced a struggle to exist in this 'two worlds' reality. They constantly had to straddle to work on two different world rules—the values of African upbringing and the social reality of young Aotearoa New Zealand:

> You feel like there is a disconnect. You're one way with people and when your home, you are another way. So, it's kind of like you can't be yourself. We're only exposing certain parts of yourself and to be two people it's hard. It's hard trying to maintain it because sometimes you find that you're slipping. You speak and say, 'I should not have said that'. (De)

> If you've gone through the school system here, that already on its own will change you. Your parents will start hearing stuff about you and they will say, 'that one is lying about my child because the child I see at home, isn't that'. So, what happens is you are not coping. You become two personalities. When you try to fit... like I have a lot of respect for people with one personality. Those with two [personalities], you have to make all of that work. Imagine that two people with their own personality in your body, but young people are going through both those personality fighting inside themselves. (Ga)

> they brought us up as Africans in a place that is not ...and so there's always going to be a bit of conflict there just because expectations set for us at home and expectations set up when we go out is very different. (Gra)

Many young Africans often do not know enough about their African culture and norms. According to Gra, confusion about one's cultural identity was unpleasant.

> My thing is I feel like we don't know enough about our culture to say that we are for it or not. There's this whole thing about if something's happening to you. You must suck it up because the next person is going through worse a bit. It's basically like whatever you're going through someone else is going through worse, and I'm like, yeah someone else coming to work, but I'm also going through something so, you know, so there are things that I'm kind of like, yeah for the culture. So, I am kind of 50/50. I feel like both cultures have good things in them and it's about picking and choosing what works and kind of almost creating our own little thing. (Gra)

De, however, was clear about her self-identity. De chose not to identify herself as a Kiwi which she believed would only reduce her visibility and representation of Africans in Aotearoa New Zealand.

> I don't look at myself as a Kiwi because it's kind of like I am represented here. How am I represented in TV shows? Even research, there is nothing about Black people so why would I sit here and say I am a Kiwi when I'm not even represented. So, it doesn't make sense. (De)

I wonder how many young African migrant women are as confident and assertive as De in embracing their identity. I sense a message of self-confidence in De making a choice as to which identity she lives in. It takes maturity and self-confidence to come to this stage of understanding one's own identity.

For some, mental health problems were a result of lack of connection to higher divine powers, gods and associated religious acts.

The spiritual aspect of mental suffering: ‘New Zealand doesn’t have Jesus!’

According to Fei, some would be at risk of having mental health problems when they are not being religious. Fei shared a testimony of one of her church mates who was on the verge of committing suicide, until he found God.

> I even noticed like someone in my church. I remember when the guy came to camp, he was telling us that he had been clinically depressed and like tried to commit suicide and all those different things. He even said it because he wasn’t coming to church. Him coming to the camp was kind of like rejuvenating that charge of like remembering like what it was and what it feels like to be in God’s presence. Now he’s no longer depressed and it’s kind of like that was his testimony. It was because of that. (Fei)

Fei was aware of the high suicide rate in Aotearoa New Zealand and used this knowledge to further argue her case. For Fei, a relationship with God would help people find peace and purpose in life and would prevent them from having suicidal thoughts.

> Like mental health in New Zealand …why does New Zealand have like a really high suicide right? It’s because New Zealand doesn’t have Jesus and as long as people…. yes, I know everyone can believe in like whatever they want to believe in but at the end of the day like the truth is the truth. It’s like everyone’s trying to do things on without with our own strength and we are human beings and we can’t. And it’s like if people know how to channel or like allow God to do what he needs to do. Like people would honestly live better lives, happier lives, even though you won’t be like the richest person in the world. They’re always the kindest people, more caring because they’re at the bottom. And they have gone through everything and they say it could have been worse. They have this kind of level of hope and you look at people who have everything and then they are the ones who want to commit suicide and they’re the ones who want to be like, ‘I need more’ and they have all these different things. So, it’s kind of like that mental health thing. (Fei)

Gra explained how she found it hard to believe that Kiwis do not believe in the power of the divine being:

> Like that’s really one of the things that I find really funny, especially in New Zealand and I was actually listening to like a preaching a few days ago that was talking about how New Zealand is a country that doesn’t do God, doesn’t know God. New Zealanders will tell you straight up to your face. Like you’re just believing a lie. You’re literally living a lie because you believe in God and I find it really funny because we talked about health and stuff, immediately I thought of Te Whare Tapa Whā, which is like a Māori health

> model and you know, it talks about not only like your physical (and mental and family) …but also how important your spiritual health is and how maintaining that balance across all the four aspects is really important. And so, we have a lot of people that are going to the gym, you know, they're going to counselling and all of that. So, they're really taking care of, you know, like the first three walls of their life, but then there's no spirituality, you know, like we forget about that.
>
> And like even bringing it back to the African community, we have so many people now that are really lost because they are living lives …away from their spirituality. They say, 'I am a Kiwi and I don't believe in God and God is just a scam and someone tried to sell this thing'. And I am not even judging or anything, but it reflects in people's lives. (Gra)

As a Christian, I resonated with Fei and Gra's testimonies. I remembered how I had to seek God in my moments of despair during my data collection. I was mentally incapacitated with the challenges I encountered and when I realised I could not do it by my own strength, I tapped into the divine power of God to see me through. During the same period, I also came across African migrants in Aotearoa New Zealand who were once devoted Christians but now questioned God's existence. I wonder if they had been conditioned by the social and cultural attitudes inculcated in Aotearoa New Zealand on Christianity. Similarly, the following narratives demonstrate how participants found associating with their Kiwi peers to disable their ability to cope in times of stress and other adversities.

We hang around the Whites; We have been assimilated to cope less with hardships

Some participants, Oya, Gaga, and Nku, felt associating with Kiwi peers had reduced their abilities to cope with adversities. Gaga explained: "*after a while you, you start seeing things the way they [Kiwi] see things. There is power of association. If these are the people that you associate with every day, you are bound to dress like them, think like them*".

> In my perspectives, it doesn't matter if you're African or non-African, if you've been in New Zealand for a long while …there is a thin line between being African and Kiwi, the line disappears. So just everyone becomes a Kiwi everyone does what everybody else does. (Oya)

Participants felt more relaxed in discussing mental health and mental illness. I wonder if the age of first arriving in Aotearoa New Zealand and the length of staying in

Aotearoa New Zealand determines participants' acceptance of conversing on mental health.

> I think our generation is more open to therapy [mental health] because we've kind of grown up here. So, for us it's a normal thing [mental health], but I think for those people who just come from back home, they won't talk about that. They won't even go there [counselling services] but because we've been here for a while, it's normal for us to be like 'I need to go for therapy', and no one will blink an eye and it's okay. (Nku)

Interestingly, some participants believed that being an African woman raised in African traditions and practises, made them resilient and strong.

Collective identity: Being African women, we are strong, we don't break, we keep on going

Some participants reported that Africans were generally resilient and able to handle anything life had to offer. Even when times were not okay, they still did well as they kept going. Their mantra 'we do not give up easily' has given them mental strength in times of adversity.

> I think in terms of mental health, there is a lot of resilience. ...There's a whole aspect of, you know, you don't want to share your story but then there's another aspect of when life gets hard, you're not just sitting down waiting for good luck to come to you. People are actually doing things to improve their lives and they just... I find we don't give up easily. (Tof)

Further, Nku believed that social support is important to prevent mental illness in Africans.

> Back home [Africa] we have got such a strong support system, that you do not get to that very point [mental suffering]. You don't hear suicidal situations back at home. It is not like they do not happen, but they are not often. Even if it does happen, it makes the headline. (Nku)

Du was once suicidal, but with support from families and friends she was able to find meaning of life.

> Personally, for me, I don't understand suicide because I did not get the edge to want to cut. Okay, maybe that's a lie. I have attempted suicide but going beyond to actually doing it... I have had to come to situations where I didn't want to live anymore and I have had friends who supported me but to actually end it, you know how actually people end it, that I can't say because I've never gotten to that point. (Du)

Participants' reflections of mental illness were determined by what is acceptable, what is personal strength and resilience, and tensions between Africans and the Aotearoa New Zealand way of life. I sense, however, fears of having a mental illness, and cultural and social support as a shield for one's mental wellbeing. Referring to section 5.3, I discuss factors that participants believed to influence their health and wellbeing which are often beyond their control.

5.2.6 Spirituality: My Relationship with God is Central to My Health

A deep sense of aliveness and interconnectedness with God which is intricately linked to association with a church or mosque, reading the word of God, and praying, tended to be a great source of coping, survival, and maintaining overall wellbeing for some of the participants. For Tof and Fei, spirituality and religion were central to their health and wellbeing. Tof explained how feeling spiritual emptiness negatively affects her wellbeing:

> Positive health to me, I guess…. everything is kind of related physical, mental, spiritual and at my soul level. I have tried the gym I have tried to eat healthy. But I find myself always going to this place searching for more. Mine goes back to the spiritual. I found my relationship with God was lacking, so I had to invest more in that. That is when the other aspects in my life started to rise. So, I found out that if I am lacking a relationship with God, all the other aspects will suffer. (Tof)

During a group drawing session, Fei drew Jesus on a cross (Figure 6). She practiced daily reading of the Bible and prayers to communicate with God, asking for strength and acceptance of what life brings her, especially when facing adversity.

> With me, managing university and all these other stuffs, sometimes you just feel really stuck. I always feel like when I'm not reading the Bible and I'm not praying; I was finding myself going into a dark place. If I keep that constant, everything for me feels like I'm able to do what I need to do. But I know that... especially when the university semester starts, you like forget to pray in the morning and just carry on with your day and not reading the Bible. And you try to like do things on your own and I you're like... 'Well, I kind of remember God. I need God' and you're like, 'okay'. It is like you start to see things with a human eye and that's when you see the obstacles. That's definitely me. (Fei)

Gra confirmed:

> You know when someone's spiritual life is actually not there in terms of knowing God and having a relationship with God, like I don't know how to put it, like just the hope for tomorrow is removed, you know. And it's not that hard to have a terrible life or they're doing horrible things, but it's just like

> having that hope for tomorrow, having that hope for a better future, all of that stuff is almost removed.

I wonder if Fei's understanding of spirituality was synonymous with religiosity. I understood that for some participants their spirituality was grown and maintained through their connection with their church and church congregation. Yet, for others, spirituality was defined beyond religious practices, in their identity, connection etc. For instance, the women in the pilot group expressed their Islamic religion to be part of their identity as witnessed, for example, by their dressing. That same identity made them vulnerable to terrorist attacks like the one witnessed on the 15 March 2019. The Muslim community refrained from activities that identified them as Muslims including the continuation of pilot study. I pondered how this lack of freedom to worship may affect their coping strategies when experiencing trauma or ill health wherein they may find comfort in their religion or spiritual practices. As I paid attention to the participants' testimonies, I observed nurturing spirituality not to be far off from cultivating the soundness of mind—positive attitudes and thoughts—as the definition of health and wellbeing for the participants.

5.3 Racism: Things We Don't Have Control of that Influence our Health

I sensed that most participants believed that they were socially and economically disadvantaged, and this affected their health and wellbeing. Two main factors are socio-environmental and socio-economic.

5.3.1 Socio-environmental Factors: We Cannot Live Our African Ways Here

The role of the socio-environmental factors includes African norms, beliefs, customs, practices, and behaviours, as well as the experiences of racism and discriminatory policies and practices in Aotearoa New Zealand. Most of the participants explained their struggle to cope with the individualistic culture of Aotearoa New Zealand, which is very different to their collectivistic nature.

We are judged by our African accent, how we dress and wear our hair

Participants viewed racism as prevalent in all walks of life in Aotearoa New Zealand. Participants perceived that racist attitudes, beliefs, or ideologies Kiwis had about Africans had been deeply ingrained. Participants frequently faced discriminatory treatment which was either overt or subtle. "*Oh, racism is here. It's very sly, like under* *the carpet. They will smile at our face and invite you at their tea parties, but it's there*", said Gra, recalling the time of growing up with White people around her:

> And for me growing up, I grew up with White friends. I didn't start hanging out with African friends till, I think I was 18 or something. For me it was like, 'wow, I can be myself'. At high school, I was the loudest person. And they would say, 'You're always so loud when you speak' and I would be even whispering. And they would be a time when you want to just wear jeans the way your friends wear jeans but this thing (bum) doesn't allow it. The little things that we go through as Africans growing up… honestly, we just need a space where we can come together and say, 'well I'm African and it's okay to be African'. Someone really said to me, 'where's your hair?' I said, 'it's on my head'. And she's goes, 'I mean like your other hair'. I was like, 'yeah, it's at home resting. Its needs a break'. But I do not have to explain myself to anyone. If you see me with my long weave today and tomorrow you see me without it, you know, you know what is going on. (Gra)

Ame added:

> I've got a White South African friend and she's way more African than I… like to the core. She's been here longer than me. She just recently started wearing her natural curls and they are like out and huge, but not so long ago, she would not be caught alive in her natural hair.

Participants also felt they were being judged by western and White standards for use of phrases and accents. Those who failed to meet the standards were often seen as being 'improper'. Gra explained:

> Like to them [White people], you're not proper. At the end, we're all judged based on that [African accent]. If you speak like them, they be like 'Wow, you're so articulate... pronunciation... everything is on point'. And I am like, 'because I came here when I was a child'. 'Your accent... ', they [Whites] say.

Nku also observed how Africans were treated differently to other migrant groups (i.e., Chinese or Asian) due to the thick African accent. Sadly, this circumstance may create another tension between different ethnic migrant groups in Aotearoa New Zealand. Of concern here is a preference for one ethnic group over other groups, which is subtle yet imposes a complex picture of inequities across ethnic migrants in Aotearoa New Zealand.

> Yeah, there's another thing that gets me emotional. I had an argument with this guy because there's this tendency to think that because Africans have a very thick accent and is not polished like theirs [Whites], they tend to judge our intelligence based on our accent. You can have someone [African] who's very intelligent but their accent is very thick and immediately when they start speaking, they're just ignored, you know. I've seen this happen at my workplace and they say, 'I don't understand'. 'What do you mean you don't understand them they speak clearer than a Chinese you were talking to before

> them? But because they have a thick accent, you're not just going to take a moment to listen to them?' And I've also heard a lot of people say that they also do that at the hospital. They're trying to explain …but they are being taken as someone who's dumb and so they don't take you seriously …it's such a huge struggle. (Nku)

Interestingly, even though Gaga acknowledged her mother had been discriminated against because of how she dressed and wore her hair, she did not recognise racial discrimination to be her reality but accepted it be a reality for others.

> To some people, racism is a reality, but not much for us because we grew up here. So, they see us as part of them. But I know my mum experienced racism when she was at school because her English was not good. Her hair was a little bit funny and the way she dressed. Even when she put her African attire, even though she looked amazing in it but going to school like was probably not the best thing to do. Of which, I wouldn't. I don't even own an African attire. (Gaga)

Participants' experiences of adopting the hair or dress style of the Whites suggests a manifestation of subtle racism about what are 'acceptable' or 'unacceptable' styles or conduct according to the White norms. I wonder if this is society being a control mechanism of 'normalcy' where diversity could be seen as a threat. Subtle oppression is maintained to endorse the 'stability' of 'conformity' and neglect the discourse of injustices. Du found the only way to deal with such discrimination was to have an 'I do not care attitude.'

> I always encourage young girls to carry themselves in a certain way [carrying oneself in ways that would deflect racist attitudes and behaviours towards them]. That's why I'm like, 'I don't care', because sometimes you have to put yourself out there to fight for what you really believe. (Du)

Although they come from a collective society, individualism had been rooted in the lives of the participants and they observed it to also determine their health and wellbeing.

We support each other back home, but not here

The dictum: "I am because we are, and since we are, therefore I am" (Mbiti, 1969) is known to explain one's identity within collective family, clan, tribe, and society in African knowledge and belief systems of life. However, most participants considered that they have adopted an individualistic culture independent of collectives and put individual needs above those of the collective (Hofstede Insights, 2017; Triandis, 1995). Gaga and Nku viewed this loosely knit society of individualism to have negative health impacts in ways they may not realise, in expecting self-reliance even during times when they are sick and need to be looked after. Nku:

> When you are sick, they actually ask you why you haven't taken yourself to the hospital and it's also because of the environment we are in. It's very individualistic. But don't you think it's adding to our health issues? Because even if it's doable, the structure is like you don't have any other help. You have to learn to do everything yourself. You get to that place where everything is all on you. You get used to it and you know you can do it, but it doesn't mean it's a healthy way of living.

Nku recalled she had once read a UNICEF report quoting Aotearoa New Zealand as having the highest suicide rate amongst 41 OECD countries. Aotearoa New Zealand was reported as having a suicide rate of 15.6 per 100,000, nine times higher than the lowest, Portugal, at 1.7 per 100,000 (UNICEF, 2017). Nku believed it was because of the society's individualistic approach to life. Nku and Gra reminisced about the collective values of African societies back home which stood to provide a support structure for life to have significance and meaning:

> There is a study where New Zealand is said to have one of the highest suicide rates in the world. I think it is because you are all alone. Even though it may appear as if you have a lot of friends, actually …you are alone. When it comes to things that really matter, no one is really there. Whereas back home [Africa], we are not as outgoing but when it comes to a point where people need to step up, people will step up. If it's a wedding people will say 'I'm going to contribute something, I am going to buy chicken, and I'm going to buy that'. (Nku).
>
> Like in all honesty, I am for the African culture of coming together and no one stands alone, like a collective, that I am a hundred percent for it. I'm very much like yeah, we're a community. Let's do this! Let's do this! (Gra)

Gaga concurred with Nku and Gra. She had observed at her workplace that no support was given to grieving people who had lost their loved ones apart from flowers and offering condolences: "*That reminds me, a work colleague of mine lost his father. All we did was to buy him flowers to say we are sorry but if you were back home [Africa], we would meet for a week to support and assist the grieved family*".

Interestingly, Kud and Du saw an individualistic society to have positive influences on individuals. Kud, for instance, favoured the individualistic systems which enabled her to act autonomously and choose freely, a manner one could not exercise in an African collective society. Kud said,

> If you are to go home [Africa] today you will have an extended family, you'll be dishing about 10 plates a day. It's not going to be you and your kids. So, you do not have the freedom to do what you like.

For Du, it took her to visit her home country to compare her individualistic approach to life with the collectivism custom of Africans to be convinced that an individualistic system had negative effects on one's health:

> Personally, for me I don't think I would need any help because the way that I live [in New Zealand] it is normal. Maybe if I go back home, I will see the difference and then look at myself and say, 'I'm not living a healthy way'. Because I'm here and everyone around me has to be ... I mean everyone is moving.

Indeed, Du was justified in her standpoint that everyone was on the move, referring to a competitive culture which potentially had negative effects on the health and wellbeing of individuals raised in a collectivistic culture.

Other participants, Tof, Nku, Muk, and Ku, claimed even though they had an individualistic approach to life, they were still in favour of building and having social relationships. Thus, individualism, as explained by participants, was about relating to the values of being independent yet still operating within wider social relations.

5.3.2 Socio-economic: Trying to Live Well and Affording Too

Socio-economic factors were explained via three domains: educational attainment, income, and gender-based discrimination at work. These domains socially position a woman within her groups and communities, which indirectly influences her health and wellbeing.

Schooling: Penalised rather than rewarded for schooling

Getting employed, having fair opportunities in the labour market, and earning good salaries were central to the health and wellbeing of the participants. Most of the young women in this study aspired to attain a tertiary qualification or good education. Many, however, found it hard to secure a job within their qualification level. They argued Whites were '*favoured*' and '*being Black and coming from a non-White culture influenced equal opportunities to employment*', regardless of their skills and qualifications. I therefore question if the concept of the 'incompatibility of cultures' may be interpreted as cultural diversity being viewed solely as a threat.

The participants’ narratives also reflected the lived realities for Black African women in Aotearoa New Zealand as mostly working in hourly paid or non-secured employment, such as a kitchen hand, cleaner, and carer, or, at best, as nurses, regardless of their academic qualifications. The 2018 Census reported similar findings to participants’ narratives where 87.9% of the African ethnic group aged 15 years and over had obtained some formal qualifications, compared to 81.8% of Pākehā, 74.7% Māori, and 75.5% Pacific people (Statistics New Zealand, 2018). About 92.7% of Africans aged 15 and over were participating in the Aotearoa New Zealand labour force, either full- or part-time, compared to 96.8% of Pākehā, 91.9% Māori, and 92.9% Pacific people. The census also found the median income of Africans was NZ$23,100 compared to NZ$34,600 for Pākehā; NZ$24,300 for Māori, and NZ$24,300 for Pacific people (Statistics New Zealand, 2018). Despite Africans having the highest percentage of people with some sort of educational qualification, they disproportionately experience inequalities in employment opportunities and have a lower mean annual income, suggestive of a higher proportion of Africans on welfare benefit (see Chapter Eight).

Gaga had attained a qualification in events management and was employed as an Event Coordinator. She worked twice as a hard as everyone else at her workplace who had no university degree. She often found herself working after hours whilst others had the privilege of enjoying ‘after hour’s drinks’; yet her income did not correlate to her scholarly credentials, extra hours, and the hard work she put into her job. She had this to say:

> I can just say the salaries here are just terrible especially for the amount of work you actually have to do, I should be getting double the money that I do. Like today, we have Friday drinks at work. So, I’m the one who’s organised. So, I got on the train went to New World to buy all the stuff that they were going to eat and alcohol. Went back to work, set up their drinks and their food and everything. While I was doing that all the other work that I didn’t do those two hours are still waiting sitting there and it still needed to be done. We have a wedding tomorrow and I needed to make sure everything for that client was sorted, whilst everyone else is upstairs drinking. Sometimes I don’t even go out of my way too much because I’ll be like ‘they can replace me anytime’. You know, I love my job, not even gonna hide but I think with my education, I’m worth more than what they give me and I think a lot of people in their professions feel that way. (Gaga)

Many participants also highlighted the issue of having to have a minimum of two years Aotearoa New Zealand work experience to be able to get employed, even after attaining a Aotearoa New Zealand qualification. After 30 interviews or so, Nku ended up with a job outside her academic qualifications, attributable to an emotional breakdown during an interview:

> I ended up getting my current job after having gone for almost 30 interviews and all just saying, 'No. No. No, you need two years' experience'. You know when you're so emotional about something because you've been dealing with them, I said in the interview, 'you know what? Every time someone asks me for two years New Zealand experience, I'm about to explode because I just got to New Zealand. Where am I going to get the two years New Zealand experience if no one wants to employ me? Like, where are you expecting it to come from if everyone else has the same condition?' Like how does that even make sense? And I was like, 'can you get your manager or someone in charge I can talk to. I want to know if all the employers out there are saying two years' minimum experience, then who's going to hire the person without the experience?' And they said, 'you're hired'. Yeah, that's how I got the job. (Nku)

Du understood jobs to be available but acknowledged how difficult it was to get a job in line with one's academic field. She explained education or experience not to be relevant in getting a job, but it was who one knew.

> In general people can get jobs but to get jobs in line with your field, it's really difficult. There is competition. Competition is high right now you need to know somebody to get a job. It's not about experience anymore. Yes, that comes into play but you have to know somebody to get a good job. I always tell people to go for network meetings, meet with people. (Du)

I gather participants believed that good education did not automatically guarantee a well-paid job, especially when they were Black Africans. Their experience of high unemployment rates and lower earnings than they would otherwise experience if rewarded by merit may reflect the subtle institutional racism that operates in Aotearoa New Zealand industries and trades, or perhaps the subtle oppressive, controlling logic of slavery and the presupposed inferiority of Black Africa women.

Trying to live well and affording too

Economic factors play a significant role in women accessing health services. Participants believed that financial security influenced their happiness and wellbeing. They often found it hard to afford the lifestyle they wanted. Nku's job was not providing a good income, and at the same time, she had to pay back her student loan.

She also carried a cultural sense of obligation, brought on by expectations and demands from extended family back home:

> My student loan is more than NZ$50,000 that I need to pay off. I have been working for six years but I'm still looking at this loan. You also ask yourself if I should continue paying rent or should I look at buying a house? And then they [banks] are telling you that you need a minimum balance to buy a house. You need 20% deposit and they're also looking at your student loan. And when you look ladies back home [Africa], there are already living in their houses with their husbands. So, if you really look at it, we are really stressed; like we are very stressed. And you get people back home sometimes requesting for money from you. (Nku)

Gaga ran a personal business and always came home feeling very exhausted: "*by the time I get home, I just don't want to talk to anyone. I'm just so exhausted like today*". Gaga's experience is not new to many participants. I recalled my difficulties in scheduling interviews with many participants as many had more than one job or long working hours. I also recalled Ame telling me her frustrations and accumulated stress from balancing life and work stress.

Financial constraints also influenced participants' decisions to access health services. Gaga, for example, chose not to seek treatment as she preferred to keep her hard-earned cash than pay for a doctor's consultation when she knew she would not be able to afford to buy the prescribed medicine:

> I don't go to the GP when I'm really sick because I'm calculating my budget like, 'am I going to afford this', because last time I went to the GP I had only enough to be seen for them to tell me what was wrong. I walked out of there with a prescription. I couldn't even buy the pills. (Gaga)

Gaga would use home remedies or Google to self-diagnose and go to local supermarket or pharmacy to get remedies like many of the other participants. Many participants said that they would go to doctors only when they felt like they were 'dying' and could afford to attend. Nku explained:

> If I'm sick and I've got different symptoms, I try to manage them at home until it's now a combination of different things and I'm like at that point, it's more than one thing. I probably should now go and tell them that for the last few months, this is what has been happening and now I can afford to see you.

Apart from economic barriers to seeking medical care, I wonder how important it is for participants to find explanations of illness and health to fit with their belief and views, and how doctors explain and diagnose their health complaints.

5.4 Summary

The participants’ meaning and understanding of health and wellbeing was founded not only on their own perceptions, but on others’ perceptions as well as a collective understanding. They showed the understanding to be a multidimensional and holistic concept which includes physical, mental, social, sexual, and spiritual health. Unique to the conventional meaning of health and wellbeing were factors they had no control over like their genetic makeup, socio-economic status, and the health and wellbeing of their family members. Of particular interest was the emphasis on sexual and reproductive health, mental health and racism that hinders a full achievement of health and wellbeing.

CHAPTER SIX: YOUNG AFRICAN WOMEN'S VIEWS OF AOTEAROA NEW ZEALAND HEALTH SERVICES

6.1 Introduction

This chapter is presented as a multi-voiced account of what my participants and I thought and experienced with our co-constructed exploration of youth healthcare services to answer the question: what are the views and experiences of young African migrant women on Aotearoa New Zealand's youth healthcare services? Dividing this chapter into three sections, I first bring the readers' attention to the introduction chapter (Chapter One) where I offered a review of the structure of youth healthcare services, where they are found, why they are so important, and how they fit in the Aotearoa New Zealand health system. This layers the foundation for the first section that enables an understanding of the participants' experiences with the Aotearoa New Zealand health system as a whole, as opposed to youth healthcare. The study participants were, in general, not aware of existing and specific youth related health services. Therefore, their views were on the range of healthcare systems and providers they have encountered, such as their local primary health organisations (PHOs) which provide essential primary healthcare services; general practitioners (GPs); public hospitals operating under the DHBs for secondary and tertiary medical care; and non-governmental organisations (NGOs) like Family Planning which provides sexual and reproductive health services. Waitemata DHB (2010) found the majority of young people go to GPs or family doctors as their primary point of contact to access healthcare. Therefore, I understood the participants' perception and knowledge of youth health services to be dominated by clinical services relating to GPs, doctors, nurses. However, I was mindful of the mistrust and fear of judgement participants may have had, which may have influenced what they shared, especially related to the use of services, like mental or sexual health services, which have stigma connotations (see Chapter Five). The participants also viewed the healthcare system beyond medical facilities with medical professionals to include family and the community (discussed further in Chapter Seven).

Of note was the way participants differentiated or gave status or characters to their health providers. They would use the term 'doctors' mainly to describe those health providers of European descent and/or New-Zealand-trained. Otherwise, they would state the ethnicity of an ethnic health provider. Further, in many of the accounts, participants tended not to distinguish or specify other allied health professionals, beside ‘doctor’, suggesting doctors are the ‘face’ of the Aotearoa New Zealand health system. The second section of this chapter presents the participants’ critique of the Aotearoa New Zealand health system; and the third section concludes the chapter with a summary.

6.2 Participants’ Experiences with Aotearoa New Zealand Health System

A dominant concern, expressed by all participants regarding their experiences with the healthcare system, was doctors diminishing their realities of their illnesses which resulted in adverse health outcomes and the greater severity of the conditions. Most participants reportedly felt that their doctors had failed to either refer them to the correct treatment or specialist or did not inform them of the underlying medical reasons or cause of their illness in a satisfactory manner. Other experiences were around accessibility, affordability, and the delivery of healthcare in a timely manner to increase the prospects of getting the best health outcomes.

6.2.1 It is Hard Work Behaving as a Credible Patient

This section displays an outcome of an interactive storytelling session on how the participants made meaning and understanding of their health and wellbeing. It includes participants’ ideas of interconnecting factors that influenced their interactions with their healthcare providers.

The term ‘gas lighting’ was the main term used by the women to describe their experience with the healthcare system. This term was new to my vocabulary, and I asked more questions to ascertain the meaning. Participants referred to ‘gas lighting’ to explain experiences of having doctors talk down their symptoms or forcing them to question if their illness was real. Nku shared her story in which doctors believed her to be overplaying her illness (psycho-somatisation) and that her feeling of pain was not medically supported. She illustrated how her untreated condition, and lack of a diagnosis, had interfered with her general wellbeing and her physical and social functioning and placed her circumstances as being viewed in the realm of mental ill health.

> I have been misdiagnosed for years. They didn’t know what was wrong with me and I was on medication every day to try and fix everything only to realise that it was not what I’ve been taking medication for and the problem is those medications had side effects as well that I had to endure for all those years until they figured out what was wrong… …I had bad period pain. I don’t know how much I spent every month on this problem. Every month I had to take five days off work. I couldn’t walk, I couldn’t move. They thought it was something else, they dealt with that. And after that it was still the same thing and I kept going to my doctor telling them that I’m in pain, there’s something that is wrong with me. It took me collapsing one day. My flatmate found me up passed out at the door. When I got to the hospital, they didn’t know what was wrong with me. I overheard them say, ‘ah, women! She’s probably being emotional. It’s probably all in a head and maybe she needs to sit down and talk to somebody’. So, the nurse came back and asked me how I was feeling. I told her that I was in so much pain. She responded by asking me if it was all in my head. She suggested that I change my mind set. How can I change my mind when I am in pain? They gave me a referral to go and see a counsellor. (Nku)

The root cause of Nku’s painful menstruation was later diagnosed to be uterine fibroids—noncancerous tumours in the walls of the uterus. Yet, Nku was being offered counselling for her ‘emotional problems.’ The doctor perceived Nku was ‘stressing out’ or ‘overthinking’ as ‘all was in her head.’ Studies on culture and health note culturally specific coping strategies through somatisation: presenting stress and worries through bodily symptoms from a particular organ such as stomach pains or shortness of breath (Helman, 2007; Kleinman, 1977). The doctors’ diagnosis may have been influenced by cultural stereotypes of African youth and their own westernised, medicalised, and privileged cultural filters. I wonder how healthcare professionals can learn to understand and identify local or cultural concepts of physical and mental health disorders in order to provide culturally appropriate services.

In support of Nku’s accounts, Du felt that such occurrences were “*very common”.*[11] Nku implied the health providers who treated her believed that she was exaggerating and being irrational about her explanation of her pain. Nku believed that her illness was associated with not being well understood; that it was reflective of how systems of medical knowledge are a result of both symptomatic cultural and linguistic barriers that influence stereotyping, complicated by individual expectations regarding

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[11] Such occurrences are very common with connotations of the cultural stereotyping of beliefs, discrimination, and attitudes regarding race, gender, age (Rai et al., 2020; Remedios & Snyder, 2018; Turan et al., 2019) which influence how pain, symptoms, and illness are explained, honoured and acted upon by both parties (Helman, 2007; A. Kleinman, Eisenberg, & Good, 1978).

interpersonal interactions and skills (Napier et al., 2014). Lower quality and lower efficacy of care, and consequential mistrust of the healthcare system, is a significant problem in healthcare utilisation when it is most critical that a patient's account of her own symptoms be believed (Bradby, Lindenmeyer, Phillimore, Padilla, & Brand, 2020; Werner & Malterud, 2003). The narratives may therefore have major implications for the education and training of healthcare professionals in new skills to encourage doctors' responsiveness to the patients' unique experience and cultural context.

6.2.2 We Are Not Referred to the Right Service or Given the Right Treatment

Most of the participants regarded "Kiwi" doctors to be passive in their treatment approaches compared to African doctors. De remembered going to see her GP with an itchy discharge from her vagina. She reported how her GP did not take a swab; instead, gave her antibiotics, perhaps under the assumption of her discharge being a STI. She later found out that it was candida (a yeast infection in the vagina) when she sought a second opinion from the Family Planning service. The antibiotic given was a wrong treatment for candida.

> The only time I've been satisfied with our service [healthcare system] is when I got to Family Planning. And the reason I went to Family Planning was because I had candida. Before that, I had gone to see my GP and they been pretty much giving me amoxicillin for candida. They did not swab for anything. (De)

De's medical encounter suggests that doctors are professionally socialised to mould the explanation of a patient's condition to fit with their biomedical view of disease, which assumes disease states—abnormalities in the structure and function of body organs and systems—to be of clinical significance.[12] Du: "*So, they'll give you one thing and say use for a couple of days, and we start reacting to it that, you go back and they tell you to try different medication.*" However, the element of perceived misdiagnosis is controversial in view of two main points: (1) Clinicians' responses are bound by ethical principles to direct health which are not determined by the status of a social group, yet on the other hand the epistemic goals often force health professionals to make clinical decisions based on the social group status (Macdonald

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[12] Therefore, curing, not healing, is the chief objective, manifesting as a technical "fix", dealing with the patient as a machine, referring to the disease discourse (Kleinman, 1978). Kleinman (1987) stated this biomedical viewpoint is common among western doctors.

& Worthington, 2012; Rosen, 2021); and (2) I am also aware of how participants' social and economic circumstances shaped their understanding and communication of their illness (see Chapter Five) which, in turn, influenced their explanation of the origin of the condition to the doctor and, subsequently, the treatment they received.

Most of the study participants see the doctors as not communicative or unable to explain the underlying causes of health issues to the satisfaction of their patients. Not surprisingly, being unhappy with the communications received from health providers, participants would rely on researching health information from the internet. Gra: "*You know, Google tells you more information than your doctor will tell you. Google will tell you, 'you are about to die in two days' to 'oh, it's just a mild cough like'. It will give you everything in between. Whereas your doctor would say...*". Deb added, "*yeah, your doctor will be like just rest and drink whatever. So, why did I pay the $20 to waste my time?*"

The poor quality of doctor–patient communication is a major determinant of patients' intention to engage, and feel satisfied, with services (King & Hoppe, 2013; Vermeir et al., 2015). Communication can be influenced by doctors' biased expectations, patients' perceptions of discrimination, linguistic asymmetry, and racism, which is not new in the field of medical practice and patient–doctor relationships (Chin et al., 2018; Kleinman, 1977; Paradies et al., 2015). Earlier in my PhD journey, during the research proposal phase, I collected data on the utilisation of services by Africans in three DHBs within the Auckland region and found utilisation to be very low. Such narratives may, therefore, have major implications for the education and training of healthcare professionals regarding communication skills and practicing new skills to encourage doctors' responsiveness to the patient's unique experience and cultural context.

6.2.3 They Give Us Paracetamol and Antibiotics for Everything

The participants reported that the Aotearoa New Zealand doctors intentionally prescribe pain relief medication for any medical condition. These experiences convinced them that the doctors were capable of leaving them to die. They believed that some illnesses required interventions beyond prescribed antibiotics and painkillers. Yet, the doctors offered no active and progressive treatments. Gra:

> When I tell you every solution in New Zealand is antibiotic and Panadol. You're either on antibiotics or paracetamol. It's like what you said about being in immune now to Amoxicillin. Some people have been on those antibiotics for as long as time has existed, and so for that child who has an ear infection and it hasn't been dealt with… what is it called? Grommets? And all of those things that can be done but you're just on antibiotics and you've been on antibiotics for maybe three or five months. So, at 18 when you develop a serious problem and you need to go to the doctor, and they need to do something and they need to help you out, guess what, antibiotics no longer work for you.

I could not ascertain from the participants' stories if overprescribing of antibiotics and pain relief drugs was viewed as particular to the African ethnic group. I was aware of the possibility of overprescribing of antibiotics to participants to reflect bias and assumption of African refugees and migrants to be poorly nourished and living under poor and overcrowded conditions, as noted in the local literature (Mortensen, 2011a; Perumal, 2011), making them more prone to bacterial infections.

Deb contested Gra's view. Using her sister's experience, Deb reckoned doctors did not know when to prescribe antibiotics or paracetamol: "*my sister always gets sick [infections] and my mom will be like 'when you go to the doctor, ask for antibiotics because if you don't ask, they'll just give you like… paracetamol*". This action taken by the doctor may suggest that some doctors' decision to prescribe antibiotics may be taken in the absence of a diagnosis and the need to prevent the infection worsening. This circumstance is of interest to policy makers and practitioners for preventing irregular use of antibiotics and pain-relieving medication.

6.2.4 'You Will Walk into the Hospital, With Your Bone Literally Shooting Out, But They Will Not Attend to You'

Participants' experiences showed healthcare services to be inaccessible, in many ways, in light of their individual characteristics and life circumstances. Some participants saw the cost of health services to be too high; others had communication problems due to not having relevant interpreters; while others saw the long waiting times at the clinic to be incomparable to the loss of their working hours.

Conflict between going to the clinic vs long waiting hours and losing paid hours at work

Some participants reported waiting times at clinics to be very long, costing them time off work and putting their employment in jeopardy. The participants reporting being charged NZ$5 for lateness to an appointment. Some had to wait between 30 and 60 minutes until they were seen. Deb and a few others also expressed dissatisfaction with the allocated time with the doctor and viewed it as not worthy in comparison with their travel and wait time. "*And you are sitting there for like three hours waiting for a two min consultation*", complained Deb.

A 'lateness' charge is not unique to already impoverished areas dominated with Africans like Mount Roskill or the Avondale-Roskill ward as reported elsewhere (Chile, 2002; Mortensen, 2011a; Perumal, 2011). As noted in Chapter One, these areas are the most medically deprived wards in the Auckland region with disproportionately high rate of hospital admissions (Auckland District Health Board, 2010). The 'time pressures' put on health providers may make it hard for doctors to meet participants' expectations. I also learnt that most general practices are private business owners, part-funded by the taxpayer (Goodyear-Smith & Ashton, 2019). Hence, for such a doctor, his/her income is directly generated from the number of patients they see, therefore the short time allocated for consultation. Healthcare is, therefore, commercialised, as confirmed by Gra: "*I find that here a lot of things are done with a very business sort of mind set… Let's get you out of the way. Let's get the next person in.*"

Long waiting hours at accident and emergency (A&E) departments were also not uncommon. Once, Gaga had to wait for nine hours at the A&E:

> It is a long story. Anyway, I ended up at the hospital [accident and emergency department]. I was there from midnight till 9:00 a.m. the next day. I didn't go to work. Yeah, and I was the last person to be seen… You have to be visibly dying for them to attend to you or if you're experiencing shortness of breath. (Gaga)

Gra believed that they were often treated as second-class citizens and that White patients would be prioritised, especially among White physicians, regardless of who came first for medical attention.

> Honestly, you must go there and pass out in front of them and they will say this is a serious case. But they will get you a bed and see you after 12 hours. They will say, 'but at least they have a bed they're not sitting on the chair'. You will walk into Middlemore and your bone is literally shooting out from here [pointing body parts] but they will not attend to you. (Gra)

Middlemore Hospital, under Counties Manukau DHB, to where many of the participants would be referred, is generally overwhelmed with the large population it serves (Counties Manukau Health, 2019). I recalled the period of my attachment to Counties Manukau DHB in February 2018 to June 2019 where I observed a high staff turnover and nurses complaining of being burnt out and working long shifts. The participants also acknowledged the provision of timely and effective, adequate medical care to be measured by their ability to pay for services without financial hardship.

Being able to afford medical treatment

The participants' accessibility to healthcare was largely determined by the cost associated with using the GP services. In most cases, in Aotearoa New Zealand, one has to first visit a GP before accessing specialists if needed (Planning and Health Intelligence and Health Gain teams, 2019). As noted in Chapter Five, many found primary care services to be expensive. Moreover, most believed that where the doctors received medical training determined their overall health outcome.

6.3 Participants' Perception of the Aotearoa New Zealand Health System

The participants' perceptions of the Aotearoa New Zealand healthcare system were centred on the commitments and motivations of the health system to provide services which were culturally appropriate. Participants believed that positive health outcomes were largely dependent on where the healthcare professionals acquired their training, and their attitudes, work ethic, and behaviours towards them.

6.3.1 'I Feel Like Different Cultures, Different Body Needs'

Participants mentioned concerns over doctors' general lack of knowledge about how African communities present and understand their ill health, their bodies and health expectations. Participants often felt dissatisfied when being seen by White healthcare professionals. They felt frustrated trying to explain their health which was viewed through a western lens. For instance, Pa and Nku's accounts show how doctors failed to acknowledge uterine fibroids as peculiar to African women who are three times more likely than women of other races to get uterine fibroids, as reported elsewhere (Medikare, Kandukuri, Ananthapur, Deenadayal, & Nallari, 2011; Stewart, Nicholson, Bradley, & Borah, 2013).

> My mother suffered from severe anaemia due to heavy periods. She consulted several doctors of her condition, but no one could figure it out until someone referred her to a Pacific GP. The Pacific GP was able to detect the cause of her condition. She was told that her condition was very common with women of colour. (Pa)

Nku too was correctly diagnosed with uterine fibroids and treated by a doctor from a minority ethnic group:

> After the doctors were trying to convince me that my pain was in my head and were organising a referral to go see a counsellor, there was a Chinese doctor, a junior doctor who was passing by who looked at me. He asked me if I wouldn’t mind having a chat with him. He told me that he was listening to the doctors and he realised what was going on with me. ’They don’t know what is wrong with you because you are an African. Such problems are common with Africans, Asians and Pacific women. You don’t usually get it with White women or with Arabs. It’s common with women of colour’. He told me that he might know what is wrong with me but needed to send me for testing to confirm. If it had not been for him sending me off for the tests, I will probably still be having the same problem and not knowing what was wrong with me. (Nku)

There is not yet a known cause of uterine fibroids but, due to self-reported race as a significant factor, assumptions hang on genetic heterogeneity (Medikare et al., 2011; Stewart et al., 2013). Thus, the ability to diagnose such conditions is related to the presentation of the disease between races, and awareness, or the lack thereof, of the population health factors in question.

Gai believed doctors were more likely to provide better care if they took the time to understand and connect with African cultural values, beliefs, and practices. According to Gai, when an African female patient went to see a doctor, she would bring with her not only her symptoms, but her cultural, social, and historical background.

> They don’t exactly connect with the African culture. They [doctors] don’t understand that we Black women are strong, and when we come to you [seeking medical attention], it will be our last resort. So, if you don’t get me in my first few sessions, why am I still coming here? (Gai)

I contemplate if the narrative given by Gai is a call for approaches which centralise a diasporic identity of an African woman which encompasses a culture, such as a shared history linked to colonisation, slavery, and poverty that shapes African perceived and collective resilience against multiple adversities. Thus, when these women finally seek medical attention, it is often at a late stage of their disease progression. This knowledge and practice has significant implications for healthcare policy for African communities.

Similarly, Du's remark appears to be suggestive of race as a cultural category which interlinks with people's biological and or genetic makeup, bodily presentation and functioning. She believed that what works for non-Africans would probably not work for Africans.

> I think personally for me, I feel like different cultures, different body needs, and it does make sense because sometimes I feel like something that happens to a non-African person is not similar to how it would happen to my body. I don't know how to explain it, but I just feel like sometimes they have like these diagnoses that would probably work for them, but it wouldn't work for me, I don't know. (Du)

I recalled reading a study which confirmed Du's narrative. The study showed that, on average, Black people in the United States have higher blood levels of a molecule called creatinine than White people, despite having similar kidney function. It documented the unfair and biased decision-making by a race-corrected algorithm on Black people in evaluating kidney function, potentially making their kidneys seem healthier than they are (Diao et al., 2021).

Being of ethnic minority culture, Du and Kud believed they were at a disadvantage to receiving healthcare. They described Aotearoa New Zealand's healthcare structure and processes as dominated by the specific cultural context of the Māori Indigenous people, with little recognition of other ethnic minorities' beliefs about disease, treatment, and practices; implying health equalities in health services exist between the mainstream population and those of ethnic minorities.

> God forbid getting sick and sharing the same hospital room with a Māori. When somebody's sick in the hospital and it's a family member, in the Māori culture, they have what they call the Kaumātua, which is the man that comes and pray and be loud and do that prayer in Māori and then you can have your family stay there as a Māori person but as a non-Māori person, if it is 8 o'clock, its 8 o'clock. Even if your wife just had a baby or whatever, you have to leave at 8 o'clock unless if you hide in the room. But if I'm a Māori person, I can have my whole tribe in the room and it's okay. (Du)

> In New Zealand, there is like everyone and there is the Māori. Like the way they take the Māori seriously in health, it's like wow. If only they could do that to us... if only they could look at us. (Kud)

Kud's cry for help and recognition of her African culture, health beliefs, practices, and expectations, which she and Du both viewed to differ from Māori views of health, was cut short by Tof's sharing of a similar experience at her workplace.

> interesting that you say that because at work, at the District Health Board, they are making us have all these meetings now because Māori people are underprivileged in the health system and we have to go to training because they are supposedly overlooked and other things like that. They are putting a lot of effort into it. (Tof)

Aotearoa New Zealand health policies and services are informed by a Crown entity which is obligated to protect and ensure equitable health outcomes for its Indigenous Māori (Kanengoni et al., 2020). Māori are often amongst population groups with poor health outcomes and experiencing health inequity and inequalities. Ample literature has recorded the experiences of stigma and discrimination resulting in poor access and hesitation of Maori communities to seek medical care (Came, 2014; Came, Doole, & McKenna, 2018; Came, McCreanor, Manson, & Nuku, 2019; Harris et al., 2018). Similar experiences of discrimination, stigmatisation, inequities, and inequalities within Aotearoa New Zealand healthcare services have been experienced by African communities. One may wonder to what extent current Aotearoa New Zealand health policies, health providers, organisations, systems, and culture worsen stigmatisation and discrimination. Unfortunately, discussion on stigma and discrimination cause uncomfortable feelings. The victims are afraid to call out racism and fear negative consequences more than those who are racist. Such feelings of discomfort are not equal. For instance, White people's discomfort when called out for racism takes precedence over people of colour's distress from experiencing it, but they still have the privilege of being able to avoid such discomfort. This, with other many reasons, leaves little room to welcome a robust dialogue regarding existing policies, health services, and programmes.

6.3.2 Cultural Clash – Incongruent Belief Systems of Professional and Lay Persons

Participants compared their satisfaction in receiving a medical examination by African doctors in their home countries and by Aotearoa New Zealand European doctors.

New Zealand doctors are ‘book trained’, not like our doctors in Africa

Participants regarded New Zealand (Kiwi) trained doctors to be “book trained”. Nku:

> Like with their exams here, they are an ‘open book’. Like if it’s a certain topic then you put bookmarks. So, when you get to a question, you quickly read for the answer. So, they are more like textbook doctors than doctors that we have back home who memorise what it is going on with someone’s body.

New-Zealand-trained doctors were perceived to rigidly follow books and guidelines and, subsequently, were not able to have dialogic conversation with patients, listen well, or answer questions effectively without referring to their ‘guide’. De was often left with unresolved questions and feelings of hopelessness during her medical consultations. As time passed, she eventually stopped asking questions.

> I guess it comes back to how we learn so we are conversant. We try to kind of make sense of things through conversation without a book. Now with them [health professionals] everything is by the book; guidelines and I find sometimes when you practice the way you communicate things, it could be controversial to the way they expect you to do things. So, they expect you to kind of have a piece of paper, read everything off the piece of paper, end of story. Whereas we have questions that aren’t on this piece of paper that needs answers. So, in a situation like that, do I just leave those questions unanswered or do I actually answer those questions from how I kind of learned things or how I was raised... it’s hard to explain. But yeah, it’s just, you see a lot of women with questions that they have and aren’t answered properly. And so, there’s no closure because of those unanswered questions. (De)

Most participants believed that African-trained doctors were more thorough and took a holistic, cultural, and comprehensive approach in their examination. Nku:

> So back home, when you talk to the doctor, they’re not thinking about just one specific thing. They’re looking at you from an overall wellbeing point of view. Now with our appointments here… like my GP down the road charges $52 for a 15-minute session times. It is too much for just a 15-minute session and they do not even examine you like our African doctors back home.

Ame was born in South Africa and migrated to Aotearoa New Zealand when she was six years of age. She had, however, gone to South Africa a couple of times and used the healthcare system in her visits. “*I feel like even when I was back in SA, I had a bit of health issues, the professionals went deeper than just the surface. I think one of you was saying that before*”. Ame continued to applaud African doctors but lamented about the Kiwi doctors.

> They [African doctors] go further than what they see. They will tell you what it is and what needs to be done to prevent that happening next time. But here [in New Zealand], you get, ‘here it is. Take it and deal with it. If it happens again, come back’. But I should not come back. Why should I come back? You need to tell me how to beat this. (Ame)

Both of Gai’s parents were doctors trained in Africa. Gai recalled her brother having a serious throat infection which her parents were able to diagnose before taking him to see a Kiwi doctor. Both of Gai’s parents, at the time of this research, had not been successful in gaining registration and practice permits to work as GPs in Aotearoa New Zealand.

> Most of the people in New Zealand are very book trained. Whereas I’ve noticed in Africa, they are people trained. I can give an example of this GP. Like my little brother almost died because the GP didn’t do what she was supposed to do. He was complaining of a sore throat. My mom kept telling the doctor to do a throat swab, but she was like ‘no’, not knowing that my mother has a medical degree. My mother said ‘okay, I’ll take the antibiotics, but you have to take a throat swab, I’m not leaving without one’. So, she had that done when the results came back, he had streptococcus and the doctor had said it’s just a cough, it’s just a bad cold. But if the streptococcus was left a long time, he could have developed a fever, a heart problem and suffered. My dad was so angry that he wrote a letter to the medical board. So, when he went to talk to the doctor, the doctor started crying. My brother was like, ‘Oh Daddy made the doctor cry’. Africans are people trained. Like, I remember when I was going to the doctor like back home, they will ask you, do you have this and this and this. They ask you questions that you feel like… they relate to what you’re trying to get them to understand. (Gai)

Gai’s narrative supports the assumption by most participants that their doctors ‘back home’ were superior in knowledge and experience in providing satisfactory services for them.

The participants understood Aotearoa New Zealand doctors and nurses to be bound by a shared set of professional behaviours, values, and attitudes such as caring for patients, being respectful and ethical, listening and responding to concerns and preferences. They, however, had seen otherwise.

Kiwi doctors don’t pay attention to detail

Some participants observed Kiwi doctors did not take the time to fully examine patients’ medical records or consult to gain health history, risk, and social profiling. Ame spoke of her journey as a cancer survivor during her treatment course. She recalled being resistant to amoxicillin (an antibiotic), yet she was prescribed amoxicillin as the doctor failed to check her medical history.

> I have become resistant to amoxicillin. Yeah. So, when I was younger, I had cancer, so I was on amoxicillin since 6 years. When I came to NZ, I was on it all the way until I don’t remember what age. And in all my records, they’ve something to say it stopped working. I was there for an infection in my tummy and they gave me amoxicillin. So, I was left for another week with upset tummy because amoxicillin wasn’t working. I had to go back and they’re like, ‘yeah, we did see in your records that you had a long history with amoxicillin’. They started then to prescribe me a stronger medication which led to constipation and everything. It made my life actually worse and my skin. Like why don’t you just give me something strong enough in the beginning? I don’t have to go through all this again. It’s like you are paying double to get a different result of what they could have done the first time. It like just open your eyes and just look. Don’t be hurry, hurry. (Ame)

Ame also lost her unborn baby. Without disclosing too much information of her medical history, she was adamant that it was the norm of Kiwi doctors not to pay attention to patients’ medical records. Gathering sufficient medical data from a patient’s history is a skill acquired during medical school training which gets perfected with daily practice, as noted in the literature (Ohm, Vogel, Sehner, Wijnen-Meijer, & Harendza, 2013). The absence of such practice alludes to the participants often being attended to by medical students in training and or recent graduates with limited experience (Akoorie, 2017; Kee, Khoo, Lim, & Koh, 2018). It may also be a paradoxical system that promotes a superficial view that doctors know best without resorting to patient history. It also remains to be understood if this neglect in practice is a general phenomenon or directed to specific ethnicities due to personal attitudes or stereotyping against a certain ethnic group, gender, or both.

Ame further spoke of the lack of empathy or compassionate attitudes of the doctors towards the loss of her unborn baby. What disturbed her most was the lack of explanation of what caused her loss. Ame spoke of her ordeal:

> When I lost my baby, there’s this whole thing about what happened with losing my baby. So, there is this one person who I dealing with me before it happened. So, we were just talking about it and she said it just doesn’t make sense. So obviously she knows what she’s talking about because she’s a midwife. The whole thing to be honest, it feels like everyone was just covering their back. I left with no closure and everyone had made peace; like this is what happened, and this is what you get and that is the way it ends. For me, I’m very… like calculated. Like if something happens you go back and go and dig deep into what happened. And what I found is it that some of the

> people here, they don’t look close enough into things and it’s like they brush it off. And in some senses, I do actually feel like they think we are just being dramatic, like we don’t understand how they work here. I don’t know if it happens with people from other race, but I found that in my situation a lot of the time I don’t get a lot of answers from people.

I understood that Ame was very upset about her loss. Yet, a feeling of not receiving empathetic care was another issue. These tensions and perhaps ‘victim-blaming’ situation which occurred in this scenario further led to Ame’s distrust of the medical professionals and the perpetuation of health inequalities. Here, one can see the role of biomedicalisation in taking away focus from human experiences, feelings, and emotions, where physical failures, sufferings, and illness are seen separately from people’s emotions.

These conflicting views between the participants/patients and the doctors show the limitation of current training for clinicians in working in a transcultural space, making visible the limited number of doctors with an African cultural background employed in Aotearoa New Zealand.

6.3.3 Limited Number of Doctors with an African Cultural Background

The participants reported the Aotearoa New Zealand healthcare system should recruit a limited number of doctors with an African cultural background. They perceived that current migrant health professionals from Africa had failed to practice in areas they had acquired training, skill, and expertise such as medical doctors. The participants identified two main barriers. First, they reported overseas qualifications not being recognised, hence practitioners required re-training:

> Like qualifications obtained in Africa have its own problems. They say they can’t trace it.... so they can’t rate it. You know Gai’s parents, her dad is a doctor. Her mom is a doctor. When they came here, they were told their qualification do not matter here. (Deb)

Secondly, having English as a second language added to the struggles and complexities of getting a certificate to practice. Gra found such an obstacle to be unnecessary when most African countries use English as the primary language in educating its nationals from pre-school through out to tertiary level. Posing rhetorical, sarcastic questions, she asked:

> And English is a barrier. So in Africa, like we don’t speak English at all? We don’t know English? Like English is a very foreign concept for us? So the

> studies that you did or the qualification you claim you have would not have been done in English for starters? And because it was done in Africa, I mean what we working on? Rhinos and lions? So clearly there were no human beings involved? (Gra)

For those African born and trained doctors who had been able to obtain a practising certificate, Gra witnessed "*one doctor here in Auckland, she went through so much just to become a doctor and even then she had to move all the way to Whanganui to practice*". Some participants reported that doctors from Africa were overlooked for opportunities for high positions even after adjusting by years of training and re-training, productivity and specialisation: "*Even if they study and re-train here, they still won't give them ... like a high position*", remarked Deb. For Nku, such incidents took away her expectations of receiving adequate care from professionals who are most likely to be familiar with their health problems.

> The doctors who understand what is going on with you from a cultural point of view, they can't even diagnose you because they are not allowed to practice. They have to go back to school. So, most of them are working in hospitals like orderlies, or whatever but I can't help you even though they know what is wrong with you. The doctors dealing with you are not familiar with who you are. (Nku)

Like the participants' narratives in Chapter Five on employment opportunities, race appears to shape the everyday practices of recruitment and hiring and the treatment of licenced African doctors in Aotearoa New Zealand. It suggests the Aotearoa New Zealand medical culture to have produced processes that evolve into institutional racism or aversive racism in clinical practice, which violates the rights of the health professional to practice their skills in accordance with their preferences, and the equity rights of minority ethnic groups who stand to gain.

Interesting to note, and conflicting as it may be, despite emerging knowledge amongst the participants that African health professionals listened to them and provided more cost-effective and patient-centred care associated with lower rate of negative health outcomes, African health professionals were not respected and trusted by some participants.

6.3.4 Lack of Respect for and Trust in African Health Professionals

Although African doctors were applauded for their ability to address African health issues, the participants, ironically, disregarded their medical opinion. They also raised alarms regarding the ability of African doctors to protect their confidentiality and privacy.

Disregard of African health professionals' medical opinion

The participants disregarded Black African health professionals' competence when it came to making clinical decisions. While they highly regarded African-trained doctors as culturally sensitive, accommodating, and understanding of the cultural context of diseases and illness, they questioned their competencies in making clinical decisions, as described by Du:

> We tend to respect White doctors than we respect our own. If a White doctor tells you, 'oh you've got terminal cancer', they will go like, 'haaa, I am going to die'. But if it is an African person was to say it, they will take it differently like ... you know, like we don't trust our own people.

I was acutely aware of discrepancies or inconsistencies in participants' attitudes and perceptions towards African-trained medical doctors. I found Du's narrative of how they stereotype White doctors' medical opinion to be superior to African doctors to not be any different from internalised racism.[13] The participants' attitudes towards, and their disregard of, health professionals of their racial background actively depresses and undercuts their power and their community, and mires them in their own oppression, crippling them in the process, in their attempt to create a health system that works for all of them.

African doctors and confidentiality

Participants had witnessed personal information being disclosed inappropriately with friends and relatives in the African community. Kud saw herself in a dilemma between consulting an African nurse versus non-African nurses:

> When it comes to sex, I really took my time. In late 2017 a week later after engaging in sex, my body reacted. My body felt really different. Mind you I was at work during the day so I had to go at the A & E because I couldn't get hold of my doctors. So, I get there and the first person I saw was an African nurse, an African male nurse for that matter. I thought this is my health, I

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[13] Bivens (2005, p. 46) described internalised racism as "a situation that occurs in a racist system when a racial group oppressed by racism supports the supremacy and dominance of the dominant group by maintaining or participating in the set of attitudes, behaviours, social structures and ideologies that undergird the dominating group's power and privilege and limits the oppressed group's own advantages."

> hope whatever I discuss with him stays in the room. I walked in and he asked me about my last name. So, it turns out that him and my dad are building next to each other back home in Zimbabwe. To be honest I didn't tell him the full story. I didn't tell him that I just had sex for the first time. When I spoke to the doctor that's when I opened up because it was a different ethnicity. I worried about my results. I told the doctor I didn't want my results to be sent to my GP and that I would come and pick up my results. I remember when I went back to get my results, I asked if that African nurse was there. Of all things to worry about I was worried about that African nurse. I asked if the African nurse was working that day and I was told that he was going to come in later. I was given my results, and everything was okay with me but that whole experience was quite traumatic for me. Those two days whilst I was waiting for the results, I really suffered. I could have asked for a different nurse but then I went in my work uniform, so I was trying to be very professional. The other thing is that I didn't want to raise any suspicions by asking for another nurse. Our fathers and mothers are nurses everywhere you go, be it any hospital you will just find an African nurse. The whole stigma is real. (Kud)

The participants also described how African health professionals tend to be judgemental towards certain issues like sexual and reproductive health, making it difficult for them to use facilities that offer abortion services, leading them to use backyard services. As noted in Chapters Five and Eight, African community's ethics and Christian values do not condone pre-marital sex, more so when it results in the bearing of children. To maintain their reputation and avoid being stigmatised and judged, young African women choose to terminate pregnancies. It is against such a background in which Du found herself where she had to accompany a young African woman to have an abortion but had to check the facility first to ensure no African doctor or nurse was on duty at that time.

> I have actually taken someone to go for an abortion and she is an African. It is really hard to help someone to go and get an abortion. That room is not pretty, and I had to hold her hand and I'm like 'ahhhhh'. You can see that the young girl it's not even ready for that process to have that abortion. And she even wanted to run away because she said the same thing about having an African in the hospital. I had to go to Greenlane hospital myself first. I actually looked at the doctors and luckily, Africans do not work in abortion clinics so that is good. I asked the lady why [requesting to check if there are Africans who are working at the abortion clinic]. She said most African women or whatever say they are Christians and I said "ah, nonsense". After going through the whole hospital to see if they are African nurses or doctors that was the time, she was comfortable to come through the hospital. But it shouldn't be like that. (Du)

African doctors were also described as behaving in an overly familiar way which can cause discomfort. They were described as nosy, intrusive, patronising, and disrespectful to young African women. Nku, who had been in and out of hospital for years, shared her experiences dealing with two different African doctors.

> It is really bad though [over familiarly behaviour]. I once had an issue where I had cancer cells and I had to get operated on. So, they [cancerous cells] was supposed to be taken out and everything before they spread and stuff. And then, there was another doctor who was a church member with us who found out about my surgery. Instead of coming to talk to me, you know what he did? He went and looked up my surgery at hospital at work then comes to me because he had heard from somebody else saying, 'oh Nku had surgery at this hospital blah blah blah and everything'. He went to look up my medical records to know what the surgery was for and then comes to me and goes, 'So, I saw in our records that you were in our hospital, blah blah blah'. I'm sitting there looking at him. Like that's none of your business. And he started talking about, 'Oh, you know, so after your surgery, you know, you're not supposed to have sex. So if you're sleeping around with any of these boys, you know...' and he just went on and I'm sitting there like, 'are you serious?'
>
> Another time, I remember going into hospital and had them [Kiwi doctors] asking about my sexual life. I told them that I was not sexually active. I had an African nurse come in and she kind of looked at me like 'are you sure?' Instead of having a professional space it was almost having like 'would you tell me if you were?' I was sitting there thinking, 'are you serious?' Even if I was sexually active at that time, I don't think I was going to be comfortable to be continuing with the conversation with her to the point of being free to open up. But if I can't open up about exactly what is going on how are you supposed to be knowing the thing that you are supposed to be dealing with. (Nku)

'*It takes a village to raise a child*' is an African proverb which illustrates a child's upbringing to be a communal effort in African cultures (Achebe, 1958). I wondered if this proverb influences the conduct of African doctors and nurses in their interaction with the young African women; that is, assuming roles of safeguarding young women to enable them to experience and grow in a safe and healthy environment. The health professionals may have had good intent without realising their breach of professional conduct. However, I was cognisant of emerging studies on stigma and health in other forms of ostracism due to ethnicity, socio-economic status, race, sexual orientation, gender, age, and so forth, and their joint effects on health and wellbeing (Rai et al., 2020; Remedios & Snyder, 2018; Turan et al., 2019). Here, I viewed a potential case of convergence of the participants' race, young age, and gender where every illness they presented with was increasingly associated with sexualised behaviours. Resultantly, participants potentially harboured feelings of being stigmatised and stereotyped by African health providers, coupled with the interplay of perceived power imbalance making them reluctant to disclose information.

6.4 Summary

Although the youth healthcare system comfortably sits within the Aotearoa New Zealand healthcare system, the participants professed ignorance of youth healthcare services and, therefore, referred mainly to GP services and doctors, in particular, as the face of the Aotearoa New Zealand healthcare delivery system. The young women participants shared their experiences of these services as being ‘gas lighted’ and not being referred to the right service or treatment. They further perceived their access to adequate healthcare to be influenced by the unavailability of culturally, as well as linguistically, competent services. Of interest was the recognition of race as a cultural category which interlinks with people’s biological and or genetic makeup, bodily presentation and functioning. Thus, they believed the treatment that works for non-Africans would probably not work for Africans. In accessing services, reference was also made to their financial abilities; long waiting periods for consultation; where health professionals attained their training; and health professional behaviours, values, and attitudes towards the participants; and the participants’ attitudes towards African health professionals. Of significance was the participants’ cry for the recruitment of African health professionals, while still disregarding their medical opinions, in addition to not trusting them. This forfeits in their effort to create a health system that works for all of them.

CHAPTER SEVEN: ‘HONEST CONVERSATIONS’: PRACTICAL SOLUTIONS AND STRATEGIES FOR FUTURE IMPROVEMENTS IN THE DELIVERY OF YOUNG AFRICAN WOMEN’S HEALTHCARE SERVICES

7.1 Introduction

As outlined in the preceding chapters, this research sought to offer a platform, through a collective critical dialogue, wherein young African women felt confident as the experts in translating the knowledge they produce to practical solutions and strategies. This chapter discusses the participants’ ideas and recommendations for future improvements and development in healthcare services. This chapter offers answers to research questions three and four: What are the best strategies for enabling young African migrant women to contribute to existing health, social, or youth services? And what are the best ways to implement those strategies? Participants came from different social circumstances and walks of life, with different degrees of agency and social capital; thus, they provided unique accounts yet, collectively, they held similar aspirations which facilitated critical conversations turning individual experiences into collective knowledge. In collectively assessing and negotiating solutions, the learning produced recognised multi-level solutions to improve participants’ health and wellbeing.

As described in Chapter Four, one of the solutions offered was developing a video, titled ‘*Honest Conversations*’. This video demonstrated critical consciousness and knowledge formation in interpreting the participants’ reality as experienced by discussing social oppressions, struggles, and power structures that lead to health inequities and inequalities. It enabled collective critical thinking by participants to uncover their place in society; and stimulated thinking beyond perceptions and powerlessness, propelling them towards actions of gaining control over their health. How the ideas were developed, the negotiations and tensions, are discussed in the last section of this chapter. Closing the chapter is the evaluation of the research processes. Succeeding this introductory section are two sections detailing the participants’ problem-solving ideas for the community in which they live and the recommendations they put forward for the healthcare delivery system.

7.2 Participants' Shared Prosperity and Aspirations for Positive Health Outcomes

Earlier, Chapters Five and Six established that the participants' community played an active and vital role in their health and wellbeing. The participants, therefore, perceived the community to be central to their health. This led them to offer solutions on how their communities could be an important platform to address their unmet health needs. The participants imagined a world where their health concerns, current and anticipated needs, were documented, and promptly and responsively acted upon. They desired shared prosperity and wellbeing, where their full potential was realised. For that reason, their ideas and aspirations needed to be valued and put forward to relevant leadership or authorities deemed to be in key roles at the national or community level, such as: (1) African parents; (2) the Ministry of Health, and the Prime Minister of Aotearoa New Zealand; and (3) social media.

7.2.1 Engaging Our Parents.

In Chapter Five, the participant's mental health and sexual and reproductive health stood out to be significant health issues affecting them. In the same chapter, it was also established that the parents and the African community had influential roles in the causation and addressing of these health issues. Gra, Ga, Ame, De, Fei, and Deb, therefore, favoured engaging parents. Gra, relating to her observation as an early childhood teacher, thought little could be done without the involvement of the parents:

> As an early childhood teacher, our parents are important, and I totally believe you can't take the child out of the space they're being raised. You know, you take the child, clean them and then put them back into the dirt, that sort of thing. It doesn't work. (Gra)

Using a metaphor of *watering a plant on concrete*, Gai mentioned how impossible it would be to implement youth health interventions without involving the parents.

> You can't address it [mental health] with young people without addressing it with the parents because that young person can have all the help and access to all the tools, but if the parents are not in a calm place... in a safe space to offer additional support it's kind of like watering a plant on concrete. (Gai)

While parents' engagement was necessary, most participants believed that their parents would detest anyone telling them how to raise their children. They confessed potential hurdles likely to be faced when engaging African parents in interventions that focused on their parenting style and how that influenced their children's health and wellbeing. Deb remarked: “*that would be hard…. The programme for the parents will be hard. Parents are not open. Like I know my mom … she is not going to leave her house to go and hang out with people*”. Gai commented, “*They will say, ‘now I have to go to somebody else to tell me how to raise my children’*”.

As a migrant born and raised in Africa, I could relate to some of the participants’ positioning as first-generation migrants whose parents had been born and raised in African countries. I had observed African family values to differ from those of Kiwi families. I was used to the traditional African parenting practices in my home country which contradicted values learned when in Aotearoa New Zealand at a very young age. For instance, the interaction between African parents and their children is generally traditional, gendered, and hierarchical. The father is seen as the head of the family, making major and final decisions. Children do not participate in household discussions and decision-making. Consequently, it was not surprising that these participants might find it hard to tell their parents what they want to achieve. I also recalled my encounter with parents at a particular African community event, which echoed the participants’ concern. I had been met with resistance and, for the most part, had been at the receiving end of non-constructive advice. I shared my experience with participants:

> The parents were aware of my research via their respective African presidents whom I had approached a few weeks prior to help me reach out to potential participants. During that encounter with the parents, I found out my research project had not been entirely welcomed. Many of them believed there were no health issues with young African women. They told me to focus my research on young Pacific pregnant women and their support from the government. Others confessed it was a sensitive topic that would not get much-needed support from the African community. One parent I had met three times prior and approached to be a member of my Research Advisory Committee flipped on me and joined the other parents to talk down my proposed study. I was surprised, knowing that previously she spoke highly of my research. My jaw dropped. Another parent told me I was wasting my time. ‘We are doing well in New Zealand, especially Zimbabweans’, she said. ‘The problem with you is you just what to get a piece of paper for your qualification and be called a “Doctor” ’. (Researcher)

I likened these African parents’ behaviours to African pride. They used words such as ‘we are doing well in New Zealand’ and assumed their children were not in a position to contribute anything substantial to my research by saying, ‘you are wasting your time’. I later learned such behaviours to be a case of competing interest and social divisiveness within African communities in Aotearoa New Zealand (see also Chapter Eight).

Gra described African parents as ‘proud’:

> As much as we want to educate them, it‘s hard to go to a proud African parent. And when I say proud, I mean ‘I migrated to New Zealand. I created a better life for my children. The fact that I’ve given my children a better life alone means I am parent of the year, of my world’. (Gra)

Ga offered a suggestion on how to engage with the parents:

> I think we start with women [mothers]. Women are cool and they always come [to events], unlike men. You ask them to go and have a dialogue, not a Q&A or anything else. I think people [young people] actually talk more in a group because they know mom is not going to flip. Your mom is less likely to flip. Then you say, ‘mom, I feel like I can express myself... then you put it down. I feel like when I say this, you take it as, and then you put it down. I feel, because of our culture, I can’t be myself because... then you put it down. Your parent reads what you have written and thinks about it. Give mum 20 minutes to reflect on what their children have written. The parent should now have a response. ‘The reason why I respond in this way when you do this is that...’. So, they should respond to every point the child puts down, and through that, you will see it’s a lot of cultural things. You will get answers like ‘well, I do that because that’s how I was raised’. Now that is the conversation we should have. Tell them that the way you were raised is great, but you also need to give the children a chance to be able to navigate. (Ga)

Some participants paid respect and deference to the rank, status of a person, or hierarchy; and thus, preferred strategies that involved relevant leaders and authorities.

7.2.2. ‘We Can’t Start Anything Here Without Involving the Prime Minister or Ministry of Health’

Ku and Nku advocated for strategies driven by authorities, whose input they believed had a direct impact on changing current health service deliveries and their health outcomes. Such plans were thought to be effective, faster, and “*more official*” (Tof). Prominent role models included Jacinda Ardern (the New Zealand Prime Minister at the time of this study). She was viewed as an exemplar who was inclusive and cared for the wellbeing of all ethnic communities, with actual actions and solution under her belt: “*Jacinda because she gets it. She got that gun thing changed in a week*” (Ku). Prime Minister Ardern had immediately introduced change to gun ownership as a reaction to the mass shooting of Muslims on 15 March 2019. Nku commented, “*and* *she is a woman too*", expressing her understanding that being a woman, Jacinda would relate much more to issues concerning women.

Principles of leadership, like making sound and timely decisions, looking out for people's wellbeing; and attributes, like being trustworthy, intelligent, and empathetic, have shown to be what people desire in their leaders (Nichols & Cottrell, 2014; Sharma & Jain, 2013). This was true for some participants. They viewed Prime Minister Ardern as making the changes they aspired to see. She had challenged New Zealanders to exceed expectations to pursue future goals; for example, by encouraging them to work as an integrated team of five million during the COVID-19 epidemic response. She had shown herself to be an outstanding leader, positive, and compassionate towards people's plight. They trusted her to be able to address their challenges.

I wonder if this approach would yield the intended results, as African perception of leadership differed from Aotearoa New Zealand's leadership culture. For instance, Africans are raised to respect authority, to view hierarchy and power inequality as appropriate and beneficial—dating back to the era of African religion, the colonisation under the banner of Christianity, and globalisation (Michael, 2013; Nkomazana & Setume, 2016). Therefore, the participants may have a general acceptance of power and the valuing of authoritative figures to spearhead their proposed initiatives. At the same time, Aotearoa New Zealand's leadership culture values the collective involvement in the task and engendering ownership amongst those involved so that all feel jointly responsible for the direction taken and its achievement (Hofstede Insights, 2017). In Chapter Six, we see in Nku's testimony that being 'proactive', and 'vocal' finally got her a job after 30 failed interviews, affirming that people are required to take initiatives in matters close to their hearts

Participants' experiences, education, and professional backgrounds also influenced actionable solutions. Du, for example, a health student with established networks within the Ministry of Health, preferred to:

> Propose to the Ministry of Health says this is the problem. This is our research, and this is the solution we have. This is how much money we think we're going to need to solve this problem. This is the support we need from the government this year. (Du)

Gra was more practical in how she saw the feasibility of any proposed idea without the involvement of the Ministry of Health. She recommended:

> At the end of the day, we have to be very honest with ourselves. We can't start anything here without involving the Ministries as they are a part of it. You know, there's no point in saying, 'okay, we're going to be a separate group. We're going to do our own thing as Africans' because the truth is, we live in New Zealand. Even if we were to have many African midwives, African doctors all of those, they would be working under the Ministry of Health standards, so we can't have our world separate from the world. (Gra)

Du further proposed "*doing a petition via social media even though it will take much longer*".

Participants in the main study concurred with Du. They viewed social media as a potential platform for their voices to be heard. In contrast, the young women in the pilot group had an unfavourable view of social media in promoting positive changes, seeing social media as 'a weapon' used to discriminate against refugees and Muslims.

7.2.3. Social Media – The 'Go-To' Platform

Most of the main study participants deemed social media to provide an effective, easy, and cheap platform to share knowledge and information among groups of people at any place, at any given time (Baruah, 2012; Mahajan, 2015). They saw social media as a platform to connect with other young African women who had not been part of the study but would have been eager to contribute and share their experiences. Subsequently, the collective could draw publicity to relevant stakeholders and the issues that concerned them. Gra explained:

> I think we can use it [social media] to our advantage. I like the idea of social media. I find it can generate enough hype, and anything that produces hype gets enough backing. If they are enough people making noise about it, it's going to get done. So, in a way, we have got social media; we've got, I guess, the news. ...did you read or hear that story on the child's information that choked on an apple? My place of work immediately [daycare centre] no longer serves apples and we if it is going to serve them, they should be grated. So that's the kind of power that we have in this computer generation age. If you can get it on the news, you will get some sort of outcome out of it.

Nku suggested the development of "*a webpage where we can post our stories in a blog format to get the attention of the Ministry of Health*". Gra, an experienced blogger, preferred to start with a Facebook page as a closed group only for young African Black women living in Aotearoa New Zealand, given that "*the research topic is the first of* *its kind and at the same time very sensitive*” (Gra). I was reminded of African leaders in the community I had approached to form part of my research advisory group in my early stages of ‘entering the community’. They had raised concerns around the possibility of the young people finding the topic too sensitive and being likely to be unwilling to openly share with their peers.

Having all the participants on board with starting with the Facebook page strategy, De, Oya, Du, and Gra volunteered to be the Facebook page administrators. I also became an administrator by default. A date was set to meet as the administrator team to deliberate further. Oya, Gra, and I were present for the meeting. De sent her apologies due to being unwell, while Du did not communicate. Minutes and a recording were shared with the rest of the participants, including the advantages of starting with a Facebook page, like not incurring unnecessary expenses.

> It would be the best shot at seeing how people would respond to it given the uncertainty about how the community would take the whole initiative. A website at this stage may prove costly. Any editing comes with a cost, whereas editing the Facebook page is free. (Gra)

A name with a fitting logo (Figure 7) and the page description was agreed on for the WhatsApp group. The Facebook name was AFYA SAWA, a Swahili term meaning ‘equal health’.

In the two months that followed (June-July 2019), I observed very low participation and engagement of the participants on the Facebook page. The same two to three participants would comment on my posts, but no one would take any initiative to post a topic for discussion. I wondered if this unforeseen setback in young African women’s participation suggested an unspoken ‘collective view’ of expecting the researcher to drive the Facebook page. I found myself deep in thought on the ways in which my assumptions, aspirations, character, social identity, values, experiences, and political commitment were or could be shaping the research. The research aimed to amplify the voices of the participants whose lives are heavily rooted in its culture and traditions and appeared to have its limitations in terms of social change; that is, in silencing voices. My participants were silenced.

Figure 7. Logo and name of the Facebook page

To answer my 'own' question, I provided a one-on-one platform (individual storytelling) to understand the difficulties or barriers that deterred the participants from participating on the Facebook platform. Eight participants were available. The findings are presented in Chapter Eight. During the individual storytelling, as a way forward, I relayed the suggestion from the pilot group on developing a video portraying the life world of young African women and the challenges influencing their health and wellbeing. In their scoping review on the use of storytelling approaches, Rieger et al. (2020) noted creating a video using multimedia materials like narratives and photographs to tell individual stories (also known as digital storytelling) to be increasingly used in indigenous health research. All eight participants agreed to this suggestion, with Deb saying, "*I see that working. You see, young people want to be part of something that brings them fame*". Further, I was somehow curious how the suggested video by the pilot group would be accepted by my participants. I wondered if digital storytelling would be one of the most effective ways to be heard by African parents and health policy and decision makers who were instrumental to improve the health and wellbeing outcomes for young African migrant women; as well as making the research findings easier to understand (Bergold & Thomas, 2012). Details of the processes leading to the creation of the video entitled '*Honest Conversations*' will be presented; but first I display the recommendations put forward on how to deliver healthcare to young African women.

7.3 Participants’ Recommendation on Delivering Culturally Appropriate Healthcare

The young women were aware that their health and wellbeing had been influenced by how the health system is set up, as illustrated in Chapter Six. Improving healthcare delivery for this group appeared to be a complicated and multi-layered task, but solutions existed. For instance, they proposed lobbying for an African health referral to African health professionals, an African youth health model, and the training of health professionals on African health and belief systems, all of which had a role in providing safe, reliable, and culturally sensitive services. Their recommendations also focused on changing the racial categorisation of Africans in Aotearoa New Zealand.

7.3.1 Let Us Have an African Referral System Established For Us

The participants noted how they perceived the recruiting system to discriminate against African health professionals based on English literacy and overseas qualification (Chapter Six). They suggested a referral system to African health professionals, whose skills were not utilised. For instance, De saw this as an opportunity for such professionals to practice their professions. She also viewed it as a solution to address the existing financial barrier in accessing healthcare for them.

> I say, have these people we can be referred to, so when we have problems, we can go to them, rather than go to the GP who we are paying like $20 to see them. We have doctors here that we may know but do not practice as doctors to speak to them. (De)

A referral system includes any process in which healthcare providers at lower levels of the health system work together or seek assistance from providers with better facilities and equipment to upskill and better-manage their practice and patients’ needs in a given situation (Hensher, Price, & Adomakoh, 2006). I wonder whether the study participants were implicitly proposing African-trained health professionals to participate; like outreach workers or youth health support workers to provide cultural support for youth health issues. This warrants further study. I also learned from Gra that some of these African health professionals’ skills were being utilised in similar health delivery services such as care of the elderly, commonly at a lesser level of qualification needed: “*I know of someone who trained as a midwife in Nigeria. Here, she’s a healthcare assistant because it’s so complex*”. At the time of the research, De and Oya worked at rest homes as healthcare assistants. They, too, confessed to working with other African-trained midwives who failed to get a practice licence in Aotearoa New Zealand. De:

> You meet doctors by trade but are working here as nurses or healthcare assistants... I work at a rest home as a healthcare assistant. There are five midwives there who practiced in Tonga, Philippines, India, and Africa, and they can't… they can't [get a licence to practice in New Zealand]. (De).

Unfortunately, African health professionals working as healthcare assistants, mostly in aged home care facilities, would not have relevance to the participants' healthcare needs.

Culture shaped Deb's knowledge about her health. She understood her healthcare to be best provided by professionals who had the same cultural understanding. This influenced her expectations of treatment and care.

> We need people, especially those people, professionals who can stand by us; support us. We need people to talk to who understand what we're going through. If you try to speak to a White person about these things, they just... it's like they throw in the air, the next up. There's no understanding. (Deb)

Likewise, cultural differences affected Ku's attitudes towards medical consultation with White doctors and the medical treatment that followed. For example, she viewed mental health as an area best delivered from an African worldview. She proposed having African elders work with western mental health practitioners as they did not provide adequate counselling services. A similar discussion on health workers' cultural competency and sensitivity was also presented in Chapter Six and will be presented in Chapter Eight.

> We've got quite a few older people, you know, in our community, and I think I would find a way to get those more senior people to work with professionals so that when Africans are seeking couples counselling, it's coming from someone who understands African perspective. I've heard a few counselling sessions and like the common theme that sometimes they just don't get it. They will tell me that I am an independent woman, but I'm also an African child. (Ku)

Relating to Ku's account, I reflected on my experience of distress I experienced during the last year of my PhD in which we also had the first COVID-19 lockdown in Aotearoa New Zealand (March 2020). At that time, I believe I had a mental health breakdown. I had found it hard to cope with the pressures of completing my PhD. With the limited time remaining on scholarship and juggling three children under the age of five, and an equally overwhelmed husband, mental and wellbeing support through my university was offered. I stopped accepting such support after realising that none I had seen had understood my situation, nor related to or had insight into my case. Studies have confirmed that the cultural health and practices of the ethnic minority of migrant status commonly differ profoundly from those of the host healthcare culture (Degrie, Gastmans, Mahieu, Dierckx de Casterlé, & Denier, 2017; Harrison et al., 2019; Helman, 2007). Yet, the expectation of many healthcare professionals in these host countries has been that patients will conform to mainstream values, as reaffirmed by Ku. Such expectations are seen to have created barriers to accessing care, further compounded by differences in language and education between patients and providers from different backgrounds. The experiences of engagement among African ethnic minority healthcare users warrant further recognition and consideration.

Tof and Nku were not amused with the idea of an African referral system. In Chapter Six, they labelled African health professionals as unprofessional. Tof asserted, "*preferably not Africans because of Africans and this over-familiarity rubbish*". This inappropriate informality, which included being intrusive—a volition to act as one pleases—is believed to be shared amongst African community members; more so amongst those of the same nationality. Gra, therefore, suggested patients get allocated to African health professionals who have a different ethnicity to theirs:

> Yeah, I think one way to tackle that is to work against communities and not like in a wrong way. So say, I'm a Ghanaian when I walk into this... I am just going to call it the hub. So when I walk into a hub, I would prefer to see a South African nurse. Yeah, because I know we're not in the same community. Yes. We're both Africans. Yeah, we‘re not in the same community and that's a way to tackle it. So at the reception, they ask your nationality… Okay, you‘re Congolese. Great. We're going to pair you up with a Nigerian doctor or something like that. That's a way to break out that fear of.... 'Oh my gosh! My people are going to know my businesses'. Because we're not saying that it‘s not going to spread but if it was to spread, it‘s going to spread in the Nigerian community. You don't know me, you know my name but you know do not know who I am, you don‘t know my story. So that might be one way to tackle that. (Gra)

Gra further proposed toll-free lines, like Youthline New Zealand, to not only offer African services but welcome all ethnic groups. The service would be delivered anonymously to address issues of breaching of confidentiality by African health professionals highlighted in Chapter Six:

> It could also be a solution if we have like a toll-free line or something like that which you can... African services. As I said, we've got all these people that have trained as midwives, and all of that and people can call as anonymous and either get help or talk about what's going on, you know. Like this is what's going on in my body or... So maybe like Youthline and all of that. Or something we can call African line, but you know, like something that says—THIS IS FOR AFRICANS, but everyone's welcome. But the target is Africans, and this is a toll-free line. So you won't get charged, and all of that but also the conversation you have is anonymous. You don't have to give your name. So it takes away that shame of 'my gosh, what if this person knows me and that stuff'.

Additionally, the participants recommended health professionals to be culturally competent in delivering healthcare services.

7.3.2 'Our Health Matters Too'

Participants perceived the delivery of healthcare services focused predominantly on Māori. The cry for recognition of their cultural healthcare needs had Nku suggesting "*training support for professionals in the health sector on African health*". Du held the same aspiration:

> I would like us to have healthcare services that acknowledge our ways of doing things, I guess. Okay, as we've talked about how to like, you know, they cater for Māori in a different way to how they cater to the non-Māori. They should have classes [training health professionals on African culture, health and illness] for us as well. Like the same way they put so much funding towards the Māori. (Du)

Competency education in Culturally and Linguistically Diverse (CALD) populations for medical allied health service professionals has emerged as a strategy in immigrant-receiving societies in response to evidence of health disparities, structural inequalities, and poorer quality healthcare and outcomes among people from CALD communities (Bartholomew, 2013; Mortensen, 2010; Mortensen, Lim, & Puddle, 2018). In Aotearoa New Zealand, the CALD community are people who do not speak English or Te Reo (Māori language) as their primary language, or who have been (or are being) raised in a different culture from the predominant one where they live. Yet, Kanengoni et al. (2020) observed the CALD training programme in Aotearoa New Zealand to focus on the Asian (mainly Chinese) and Muslim communities, while grouping other widely different cultures together in a perceived homogeneity. Similarly, the participants' interest in having culturally competent health professionals indicates a failure of the cultural competency training in achieving equitable health outcomes for ethnic minority population.

A model to guide the planning and delivery of youth health services for Africans was identified as key in providing culturally sensitive and appropriate healthcare.

7.3.3 Let Us Have an African Health Model

All participants believed an African health model was needed to guide the planning and delivery of youth health service. However, they had diverging views on what African philosophy towards health would be based on. For example, Du struggled to visualise an operational African youth health model. She argued that Africa was a big continent with 54 countries with different cultures, making it impossible to come up with a model that would be inclusive of all cultures. She explained:

> In Africa alone, the cultures are different. So how are we going to incorporate an African health model into our hospitals the way they have done it for the Māori? Māori only have one culture and one way of doing things yet Africa, Africa is a continent. Let's not forget that in Nigeria alone, an Ibo person is different from a Uroba. The way that you would treat an Ibo person is different from the would you talk to a Uroba person. So, in doing and saying that, it's going to be really difficult because everybody wants, you know, you to cater to their needs. I think if you were to look at it, you have to bring more of the cultural element. Now, how are you going to do that to cater to everyone in Africa? That's something that you're going to really have to think about alone. But then in saying that, it's not impossible just amazing. You can't cater to all maybe you had to look at the majority group of people in New Zealand. And then focus on those groups. If there are more Zimbabweans, more Nigerians, more Congolese, then you focus on those three to come up with a model that will deliver health to all Africans. So with African health, that's a difficult one because it's a continent. (Du)

I deduced some participants to perceive Māori to have one culture; yet, I came to understand the Māori culture to have over 20 tribes (iwi) (Statistics New Zealand, 2016). Most Māori affiliate with one or more tribes which are divided into smaller sub-tribes of approximately 500 people called hapū, based on genealogical descent (whakapapa). These sub-tribes are said to be independent from each other; thus, they may not necessarily hold the same cultural health views. A similar logic applies with the Pasifika ethnic group in Aotearoa New Zealand, which includes distinct ethnic groups like Samoan, Cook Islander, Tongan, Niuean, Fijian, Kiribati, Tokelauan, and Tuvaluan (Ministry of Social Development, 2016); yet, they have a health model that ascribes to their Pasifika culture, as is the case for Asians (Ministry of Health, 2006; Waitemata and Auckland District Health Boards, 2017). This suggests the health models to have been centred on commonalities of the different cultures. It therefore made sense when most participants agreed with Nku's proposal to identify

> Things that affect all of us [Africans], if that makes sense, like a map diagram or something like that, then identify what affects many people from different regions and it be the basis to come up with an African health model.

Du was also doubtful of getting funds from the government to support the planning and implementation of an African youth health model. She believed that funding for African health would only happen if there was a threat to the Aotearoa New Zealand community. She had observed African health financing to control the spread of communicable diseases like HIV/AIDS. Africans are ranked second highest after the gay and lesbian community in groups most affected by HIV/AIDS in Aotearoa New Zealand. Such an observation was echoed by Kanengoni et al. (2018) in their integrative review study on the current knowledge of Aotearoa New Zealand immigrants' health. Even so, Du knew of only one organisation to have an HIV-funded project in Aotearoa New Zealand. This organisation had just one employee to address this health aspect of the African community:

> They say, for example, like HIV/AIDS… we are the second highest but then where extra training is? What is being done about it? All we know is this organisation New Zealand AIDS Foundation under Pamoja. It is the only organisation that kind of only raising awareness on HIV/AIDS. But what can we do because Pamoja is literally …just one person in the whole organisation to advocate for the second-highest group of people with HIV/AIDS in New Zealand. Is that practical? Like, don't you think that we need more, the same way that we have for Māori people and we have for the gays and lesbians… like have more people advocating for Africans out there and in the community. (Du)

According to Section C: 14(4) of the Health (Protection) Amendment Act 2016 (2016 No 35), HIV became a notifiable disease on 4 January 2017, enabling everyone to have access to care and treatment regardless of residency. This may explain why there are no specific HIV/AIDS programmes for Africans. It may also have resulted from past failed efforts in implementing HIV programmes for the African community where Du explained HIV testing services were free, but "*they [Africans] still do not come. So for you to get free services and get them available, we have to break that barrier of this whole cultural thing*". However, underestimating the African population in Aotearoa New Zealand (see next section) may significantly influence funding. For instance, in the financial year 2017/18, Aotearoa New Zealand’s primary source of health funding—Vote Health—allocated one-off funding of NZ$48,000 to migrant health. No similar budget was set for 2018/19 to 2021/22, except for workforce allocation and the strategies for Asians (Kanengoni et al., 2020; Waitemata and Auckland District Health Boards, 2017). This affirms Du’s testimony about the lack of funding towards African health and its implication towards realising equity in health outcomes for Africans.

The participants recommended having a ‘standalone’ categorisation of Africans to enhance African visibility, thereby promoting recognition of their cultural health and justifying financing to target their health issues.

7.3.4 ‘We Want Africans to Have a Standalone Categorisation’

Currently, population health data on Africans in Aotearoa New Zealand are categorised with Latin Americans and the Middle East under the grouping Middle East, Latin America, and Africans (MELAA), which has its problems for informing, planning, and monitoring services as there are many differences between the three ethnicities (Kanengoni et al., 2020). Equally, the participants had observed this racial, social stratification to conceal Africans within the Aotearoa New Zealand population. Gra described her experience at a cultural festival she attended:

> I feel like many stats [statistics] in New Zealand are constantly misrepresented, especially for us Africans. We went to this cultural diversity something, and they had Pākehā, and then they had Māori, and they had their Pacific Islanders, and then they had like Indians, and they had like Chinese, and they had this group... I have forgotten the name... MELAA. And I am like, ‘you want us to come and give you information, but you’ve put us with people that are not like us into one group’. (Gra)

Historical analysis of grouping ethnicities in the same category shows a significant shift away from emphasising relatively minor differences to similarities that are overwhelming (Bhopal, 2006). Bhopal (2006) explained it to be efforts put into controlling people’s propensity to be interested in ‘differences and the scientific approach of using the ‘differences’ as the starting point for research. In Aotearoa New Zealand, the implications of having more than 90 nationals from Africa, Middle East and Latin America in MELAA are unknown, meriting study. This argument is also true for other ethnicities like Indian and Chinese, who are all grouped as Asians.

The participants further reported the Aotearoa New Zealand current racial categories as classifying Africans under the ‘other’ category in the absence of MELAA category. “*They chuck us all in one group in situations where the MELAA categorisation is not available*”, remarked Gra. This made them feel less of a citizen. Yet they felt the increasing proportion of Africans in Aotearoa New Zealand justified a standalone categorisation. Deb said, “*there are so many Africans here. Why have we not made it to the list? Why ‘other’? I don’t understand. And it makes you feel something like you are not a citizen whose health is essential*”.

Indeed, healthcare administrative data usually record main ethnic groups only. The 2018 New Zealand census recorded the African population to be 16,890 (Statistics New Zealand, 2018), less than 1% of the whole population. The PHO enrolment forms therefore provide the option of “Other” category for minorities which groups all other ethnicities. This means that the health challenges of young African women are obscured in PHO data, as they are captured as part of the “Other” category. However, some studies argue the number of Africans in Aotearoa New Zealand to be around 100,000 (Kanengoni et al., 2020; Tuwe, 2018). The argument lies in the definition of Africans that excludes countries in the northern parts of the African continent and African nationalities from Zimbabwe and South African who are documented as ‘European’ regardless of the colour of skin, making Somalians and Ethiopians the largest identifiable African groups in Aotearoa New Zealand. Kutatai (2004) and Callister (2011), therefore, concurred with the participants’ interpretations in noting the process and politics of ethnic enumeration as informing Aotearoa New Zealand policy formulation and resource allocation.

Furthermore, in Chapter Six, participants reported the general assumption of dark-skinned nationals like some Indians being classified as Africans. The Aotearoa New Zealand definition of Africans, mentioned above, ironically appears to align with the participants’ narratives in which African nationals from the northern parts of the African continent are light-skinned and therefore not labelled as Africans.

The following section presents an account of the video script, *Honest conversations*. It includes the processes involved from how the ideas were developed, tensions and agreements in its production.

7.4 Honest Conversations

Earlier, in Section 7.2.3, I mentioned engaging eight participants individually to understand the challenges of participation and collaboration. These eight agreed to develop a video as the ‘action’ component of the research project. However, arranging for a date and time that could work for them to meet to collectively discuss the video content and script, as per their aspirations, was a challenge. Initially, only two of the eight participants would respond to the WhatsApp group. Nku then individually approached me and suggested that I develop different options of how the video may be produced and share it with each of the eight participants individually.

> I think you should initiate what you feel is ideal for the video. People are busy and will not be concerned with this. To save time and keep the research going, come up with some options and share them individually. People will be forced to reply if you approach them individually. So, the option that has more votes that is the one we will use. (Nku)

I understood Nku’s suggestion to come from a place where most participants had not taken ownership of the research project from the onset, based on the premise of many factors like priorities and busy schedules (Bergold & Thomas, 2012; Pain & Francis, 2003; Wilkinson & Wilkinson, 2017).

In Chapter Four, I mentioned Tia, who I had been introduced to by Fa, the NzEWT director. She agreed to help with developing the video. Tia gave me two options of how it could be done:

> Either they take turns asking and discussing various questions and themes as a group, sitting in a circle with someone acting as a moderator; or they pair up and film two at a time, staggering the interviews throughout the day, using one location. (Tia)

Following Nku’s advice got the project moving. Most participants chose to have everyone in one sitting. As the project evolved, most participants were out of reach. Oya and Tof communicated that they had busy schedules and could not participate in the research as we advanced. Gra, Du, and Deb were not available on the proposed dates but could not offer alternative dates that would work for them. Only four participants, Nku, Gaga, Ku, and Muk, kept communication lines open and participated in the video development and production. I observed their motivation to bring change. For instance, during the recruitment phase, Gaga had once shared that she would never participate in projects she did not believe in. Similarly, Muk and Nku had shared the positive impact the research had on them. Nku's continued participation also came from a place where she had wanted to break the cycle of Africans not supporting or participating in their fellow Africans' projects.

7.4.1 The Processes

Moving forward, I created another WhatsApp group with the four participants. In total, the group had six people, including myself and Tia. Nku, Ku, Gaga, and Muk agreed that the video would be undertaken through a collaborative storytelling. They would be interviewing each other; be both storytellers and lead conversations. The style was to be conversational, with occasional prompts and questions provided by me if needed. They had an idea to produce a unique and interesting video detailing the unspoken but honest conversations lived by young African women as it pertained to their overall wellbeing and the Aotearoa New Zealand healthcare delivery system. It would be both empowering and different from current mainstream health promotion which focussed solely on Māori, Pacific, and Asian youth. Nku summarised the discussion points as:

> I think we can talk about being an African young woman and how that affects our day to day lives like taboo topic of family planning, issues with privacy when dealing with African medical professionals, the lack of education or knowledge on the part of Kiwi medical professionals like the role of religion, culture, and mental health. Everyone can share examples or experiences on behalf of their sisters, friends, and community. And what we think should be done to bring the change we want to see. Did I leave out anything?

The participants agreed to Nku's summation with Muk responding, "*I think you pretty much touched on the main points, and we can just go with the flow and one can decide how far they can share*". This remark was suggestive of not doing any role plays or rehearsals of their narratives. Indeed, role plays and rehearsals would take away their narratives' authenticity and realness.

The participants agreed to record the video on 31 August 2019. Nku and Gaga arrived two hours late as they took the wrong road. This left Ku and Muk to do the video. At this point I found out that the participants expected me to be part of the conversation, as Ku said, "*we might as well start just the three of us, and when they arrive, they will* *just join in*". I was unsure why they felt I should be part of the conversation. I had relocated to Aotearoa New Zealand two years' prior as a novice researcher who wanted to understand their lived experiences about their health and wellbeing and how the Aotearoa New Zealand youth health system informed their experiences. I felt 'uneasy' to turn down the invitation. My initial decline of the invitation had been followed by an expression of shock and/or surprise, with a question, "*why not?*" from Ku. I understood I had promoted their independence to lead and own the production of the video. The dilemma revealed here was either they saw me as an 'insider' of equal interest or they saw me as being 'superior', therefore suggesting an expert-driven activity.

I recalled one of the four, Gaga, had earlier openly communicated how she viewed her participation to be '*working for me*'. I was not sure if the other three held a similar opinion. I wonder how being a part of the digital storytelling would promote ownership of the participants. I wondered if my lead role in the research processes had meant the participants assumed I would lead in the video making. The literature on participatory research projects show effecting change with participants is laden with challenges, which are, in some instances, lessened, but, in others, aggravated by the positions held by researchers (Baum, MacDougall, & Smith, 2006; Pain & Francis, 2003).

I finally agreed to be part of the video making. My agreement was received with smiles from the two participants. I told myself I would be in a better position to centre the discussions around the agreed themes than I would have been able to do had I been 'outside'. The script content is described below. I focus only on issues that were not brought up for discussion during the storytelling circles and individual storytelling, focusing on the recommendations.

The script

The recording started by Ku, Muk, and I meeting each other, making cups of tea, and taking our seats at the table. The conversation started with Ku on confidentiality and African health professionals:

> Ku: So, Blessing, say you need counselling, who would you go to? An African counsellor or a Kiwi counsellor?
> Me: To be honest, when I came here, I did not see anything wrong going to an African counsellor but knowing what I know now [from research data], I

> would not. I do not think I would. I would not mind what my business out there. And Africans … we are such a small community… I mean… If that safety is guaranteed, I would not have a problem.
> Muk: I would [see an African counsellor] but I am picky. It would have to be someone my age.
> Me: Why your age?
> Muk: I relate to them more. They cannot be older. I would feel like I am talking to my aunty, and I know there are some things I would not be able to say.
> Ku: Some of these African healthcare professionals are trained here. So they regard confidentiality at heart. Are we not stereotyping?
> Muk: I know I am [stereotyping]. But now that I have said it out loud, I do have a friend in that profession, and she has never discussed anything from work.

When Nku and Gaga, who arrived later, joined in the discussion, the same question was posed to them. Part of what came out of the discussion was similar to what was raised in Chapter Seven, such as breaching confidentiality and over-familiarity; yet, what stood out as different was the age of African health professionals being the deciding factor in using health services. Muk implied that she was likely not to receive adequate care if attended by an aged African health professional as she would view them as an 'uncle' or 'aunty'. She was bound to be less transparent with her health problems during the doctor–patient consultation. To ensure health equity for African youth, this finding is important for health policy and decision-makers in recruiting age-appropriate health professionals for specific youth health services. Figure 8 is Part 2 of the three video clips developed by the participants and me.

Figure 8. Honest conversations: Part 2

The discussion continued and dwelt on sexual health matters. Ku felt sexual health matters would not be an issue if a cultural appropriate conversation was held with the parents and their children.

> I am pro-African (giggles). Everyone who knows me knows I love my African culture. One thing that my parents did well was… there was a point in my upbringing, especially when I was a teenager, when I was going through the most, there is no point where I was not aware of my culture or what was expected of me. However, it would have been awesome to have the balance as well. I learned about condoms at school. I mean, it would have been better if it came from somebody who understands you culturally. Like, 'hey, this is what we expect of you, but if this happens to you, how you look after yourself or here are the services you can go to'. (Ku)

It has been well documented that family communication about sexuality can protect young people from unsafe sexual behaviour (Grossman, Lynch, Richer, DeSouza, & Ceder, 2019; Grossman, Richer, Charmaraman, Ceder, & Erkut, 2018), which aligns with Ku's sharing. Further, Grossman et al. (2018) showed extended family to play a confidant and trusted adviser role for sexuality communication, particularly when young people feel uncomfortable talking with parents. Similarly, Ku remarked, "*migration has separated us from our aunts and uncles that guide in sexual health matters, leaving our parents to shoulder that responsibility, but they don't*".

Unique to previous discussions in the storytelling circles was how Africans did themselves a disservice by the way they treated each other. Nku explained it by comparing her behaviour towards a different ethnicity.

> If I have bad service from an Asian store, I will not stop going to other Asian shops. But I will stop going to an African store. I think we are harsh on each other. We are harsh when it comes to us. We are like 'gosh! I knew it. African are like that. I am never going to any African shop'. I am one of those people, sad to say. (Nku)
>
> [Everyone agrees, acknowledging they do the same.]
>
> It gets me really emotional. I feel like I have set a standard for my people that I do not set for other people. I have made it seem like Africans are not good enough. It all starts with us because we are not fair to ourselves. (Nku)

I took away from this particular narrative: (1) the need to have a conscious shift in how participants think about themselves and their fellow Africans – the change they wanted to see had to start with them; and (2) "*Doing more collaboration together, like what we are doing now can help change our mind sets*" (Gra). These collaborations would further correct assumptions and misconceptions that have deterred young African women from accessing critical services for their health and wellbeing, like sexual health offered by African health professionals. Some of these assumptions were that "*all Africans come from a very strict and Christian, yet we never stop to think that the health professionals could be experiencing the same awkward struggles*" (Ku).

7.5. Summary

This chapter narrated the formulation of creative problem-solving, which the participants understood to be relevant and best viewed to improve their health and healthcare experiences. Although the participants shared similar stories and experiences, they differed in proposing strategies and actions. Their views reflected differences in perspective, experience, or preferences. These differing views led to an expanded perspective and a more comprehensive range of options, from engaging with the leadership and African parents to the participants deciding on developing a video (digital storytelling) to share their stories as the most effective pathway to be heard. In the digital storytelling, the participants openly shared and spoke about their culture, ways of thinking and behaving, and interpretations of collective knowledge to assess and negotiate solutions that contribute to their positive health and wellbeing. Other recommendations included designing an African referral system that would utilise

African health professionals' unrecognised skills, and the training of health professionals on African health. The participants' stories show the Aotearoa New Zealand Government's current ethnic classification of Africans limits in-depth understanding of African diversity and allocation of funding for relevant African health programmes, including the recruitment of African health professionals to deliver culturally appropriate services for this community.

CHAPTER EIGHT: HARD TO REACH, BUT NOT OUT OF REACH: UNDERSTANDING THE PARTICIPATION AND COLLABORATION OPPORTUNITIES

8.1 Introduction

Chapter Eight present findings from eight individual narratives on the complexities that discouraged participants from collectively working together. As discussed in Chapter Four, this occurred due to the unforeseen non-engagement and lack of participation on the Facebook platform leading to the identification of engagement barriers through individual storytelling. It answers the following questions: 1) What are the perceived factors hindering participation and collaboration? 2) What are the elements needed to enable young African migrant women to work together? And 3) How can we promote inclusion? This introduction precedes the second part of the chapter, which presents the answers to the questions listed above. Themes and reflections that arose included knowledge diversity and its impact on collaboration and information sharing; identity diversity as a stumbling block to 'action' and group ownership; finding common ground amid competing interests and social divisiveness; and the need for safe space.

The third section provides insight into the relevance of applying an African philosophy in health research; that is, whether the participatory tenets of African philosophy in research hold up to the reality of a research project addressing young Black African women migrants' health needs in Aotearoa New Zealand. Issues raised were the power of relationships and connections which build into collective participation and collaboration; the desired outcome of social change in the community; the ideal methodological approaches in health-related research and participants' reflection on the research processes. In reflecting on the processes, the section subsequently answers the fifth research question: How do young African migrant women participate and build collective knowledge and social transformation into the research process, and what are the inherent limitations? The question explored how the research processes fostered participation and which were instrumental in inviting participants to co-design the research artefacts. I was also interested in examining whether collaboration, problem-solving activities, and the sharing of experiences reflected their worldviews as Africans and as migrants. Subsequently, this enabled identification of the research processes that had been productive and warranted further research. Unfortunately, I did not use indicators to understand each individual motivation, or lack thereof, for participation. My research focus was not on individualised psychosocial factors. I drew on my field work notes which included my observations, events in the community like the presentation of my research proposal, informal conversations, and my reflections, as relevant, to increase the understanding of the participants' circumstances.

8.2 Barriers to Democratic Participation and Collective Action

Initially, the participants appeared to be very eager, full of energy and passion to see a change in their community and to be heard. Over time, various barriers, complexities, and group negotiation compromised the collaborative processes of collectively working together. While the diversity in knowledge amongst participants and co-locating individuals in the sharing circles resulted, in some instances, in shared knowledge production, this did not translate to the inclusion of all participants. Participants also brought to the collective forum their diverse individual identities which served as standard references or primary motivators of their engagement and ownership of the research project. Also instrumental in giving participants voice or silencing them were competing interests and social divisiveness within the African community.

8.2.1 Diversity in Knowledge and Perception – Not Being Able to Reach Group Agreement

I observed a few participants engaging in the discussions on the Facebook page. I further learnt the existence of knowledge differences and the different perspectives amongst the participants which then mutated into infrequent dialogue on the Facebook platform. For instance, four people—Deb, Ao, Ku and Gaga—had not fully accepted or understood the concept behind the Facebook page but chose to go with what appeared to be the suggestions of other participants who had exhibited leadership and knowledge on the modus operandi of a Facebook page. Gaga explained, "*I was never initially keen on the Facebook page. But because it was what the majority went for, I just went with it*". Deb added, "*besides, I am not a writer. I don't do posting*". I then learnt that to set or place together individuals in groups with the intent of engaging in discussions may not always result in shared knowledge production.

Gaga claimed to know the proposed ‘action’ would not yield the intended results, suggesting it to be why she did not participate on the page: “*I also knew that people would not participate even though they agreed to it. As is it, the Facebook page looks like a girl-chat group*”. Ku held the same opinion as Gaga but was not drawn into sharing her thoughts with other participants. Instead, during individual storytelling, she opened up and said, “‘*I do not understand how a closed Facebook page can make a difference. If people want to be heard, why do they not go to the New Zealand paper – stuff.co.nz?*” It appeared that the idea of the Facebook group as open only to a particular group of people had not been the best of the decisions yet, no one expressed her opinion in the group. From my observation, I was made aware that social interaction in the group has considerable bearing on the group process, like the co-constructions of meaning in research, or barriers threatening the collective learning. It is not uncommon to have different knowledge and perspectives in any group of people which hinders democratic participation and collective action in participatory research (Dedding, Goedhart, Broerse, & Abma, 2020; Femdal & Solbjør, 2018).

Again, I noticed the expressions of words like ‘people’ and ‘they’ used by Ku. This was suggestive of them disagreeing with the Facebook page and being detached from the whole project; seeing themselves as ‘outsiders’ or ‘others’ and their support to the Facebook group was an ‘act of solidarity’ and ‘go with the majority vote’.

There are studies which report knowledge acquisition for Africans to be based on African-oriented principles of interdependency and reciprocal interaction (Mbiti, 1969; McDougal, 2014; Senghor, 1964). Yet, I was not aware of how the collective interdependency and reciprocity was reflected in and by the group members. I wonder if I had observed what was called an individualist version of ethno-philosophy where such persons usually have individualistic and personal answers to issues (Oruka, 1990). Participants’ diverse beliefs and values, on individualisation versus collectivism were manifested in the sharing circles where everyone was expected to share equally their lived experiences. In Chapter Five, I discussed the participants adopting an individualistic approach to living in Aotearoa New Zealand where the value of being independent was highly encouraged within wider social relations.

I also wondered how social status could have influenced the course that the research project had taken. For example, Gra initiated ideas of starting with the Facebook page. Gra held specific portfolios in the African community, one of them being a youth leader for African Communities Forum Incorporated (ACOFI). Her social power would have had the buy-in of all participants; yet, it could to be repressive, both in the sharing circles and on the WhatsApp platform. However, I was also mindful that the WhatsApp platform did not allow for real time conversations, resulting in the participants missing out on some of the discussions. Gaga explained: "*I belong to so many groups on the WhatsApp platform and I cannot honestly follow through all the discussions I would have missed during the day*".

8.2.2 Multiple Identities as a Stumbling Block to 'Action' and Group Ownership

The expectations of participants' African culture, Christian religion and marital status may determine how participants chose to participate. The type of education and work background, time constrains, and priorities also informed the participants' interpretation of participation in research.

Cultural and religion diversities

Culture and/or religion were the 'lenses' through which many of the participants perceived, interpreted, and made sense of their reality. Culture and religion were therefore, instrumental in determining the type of topics on which one would feel safe to converse in a group situation. Most participants, like Muk, were unlikely to participate on the social media platform on issues they perceived as culturally and religiously 'unsafe' such as the topic of abortion which had been posted on the Facebook page. She felt unsafe to participate, and fearful of being judged, given the cultural and religious beliefs and morals attached to abortion:

> Yeah, I think for me, like for instance, that topic to do with abortion, my default… the African in me feels I have to say I am against it and yet I do not see it that way. It is an issue of being afraid of being judged and not feeling safe to share my thoughts. Maybe that is why people do not participate. There is that whole thing that if someone says something, people think people actually do 'that'. (Muk)

Nku was also aware of the influence culture and religion had on her day-to-day life, and more so her participation in the research. For instance, before sharing on the Facebook platform, Nku confessed to writing and rewriting her posts, making sure she explained her opinion in a well-accepted manner. "*If you have noticed my comments on Facebook, I write lengthy and in-depth written responses to the topics of discussions to explain where I am coming from so that I do not leave any room for judgement or misinterpretation from a culturally or religious angle*".

Ironically, I remembered doing the exact same thing—writing and editing, writing and editing—until I felt the content was appropriate enough not to elicit judgement or others' misinterpretation.

Gra confirmed these fears of being judged and misinterpreted as dating back to the time she tried to recruit people on my behalf to participate in the study.

> That's the thing, we just... it's almost like we just live in constant fear of the unknown and it hurts us and in a way; that's kind of what ruins so many opportunities for us because we don't really take it, you know, like this whole thing [research], this is so nice what you're doing and if this is something that, like ends up starting things and being the thing that you initiate changes for us, then it's beautiful. But then imagine if we open up. This is a missed opportunity, a chance for us to come together and talk about our own people and our own problems and what we face and how can we actually start something that will benefit. But it's like, 'no, I don't get it. I choose not to participate'. Nothing gets done. (Gra)

Reflecting on the context of the conversation, I recalled many participants spoke of the reoccurrence of 'suppressing of feelings' and 'moving on' when they were growing up. Some had seen no use for participating in the research and had become 'numb' to their experiences and may have been indoctrinated to not speak out. Therefore, some questioned: "*but why should I be talking about it?*" (Aed).[14] It may have been that young African women are confronted with day-to-day negotiations and contentions that arise with their 'Blackness' in a society that is racially oppressive and further situates them in the context of patriarchy and religion, creating a learned hopelessness, even for opportunities that may create positive change in their lives, like participating in this study.

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[14] Aed is a young African woman who had been approached to participate in the study, but she refused. She is added in the thesis as part of my reflection to show culture and religion suppressed the young African women's participation in perceived sensitive research topics.

Marital status

Marital status brought about another set of complexities in the collaboration processes. African culture and religion condemn engaging in sexual acts before marriage; yet many of the health issues the participants faced were sexually related. Only one participant was married, seemingly meaning that the others remained silent about their sexual lives, linking between marriage and socially legitimised sexual activity. For instance, Ku was not married and chose not to be involved in discussions related to her sexual health on Facebook:

> When there is a post that I see I can participate in, I will. But there was this one on pap smear, I did not participate because pap smear is normally done with people who are sexually active. So for me to take part in such discussions is like selling myself out that I am sexually active. (Ku)

In Chapter Four, I mentioned Kud, who had withdrawn her consent to participate further after the first sharing circle session. She had openly shared about her sexual health life and, upon reflecting on the information she had shared, she felt vulnerable and unsafe. She had become aware at the end of the session that she was the only one who had gone to the extremes of divulging personal information. Her consciousness was ignited to the possibility of her shared experience being made public knowledge and how damaging that would be on her identity in the community. The participants' narratives suggest the influence of their social context on their participation in this research.

The role of education and work expertise in collective, collaborative and participatory research

The academic background of the participants had a bearing on their understanding and interpretation of the concept collaboration, and participation in research, and ownership of the project. I was aware that many of the participants may not have been knowledgeable of the core values of African research like participation for social change which depends on collective responsibility and collaborative action (Anyanwu, 1983). For example, Du had some knowledge and experience in research when she mentioned being, "*a health student*" and her experience from doing her "*own research*". In her proposed strategies for this research (Chapter Seven), she used words like 'we' and 'our', which were suggesting or assuming collective learning to have occurred across the participants, and that participation for action needs to be a collective responsibility.

Others had not been “*involved in a research of this kind*” (Muk); and others were in professions which were not familiar with the values and conditions for participatory research. For instance, De and Ame worked in hair salons, fast food outlets, and aged care facilities, and showed their understanding of participation as “*being involved and being part of something great*” (Ame). However, their meaning making of participation for change was framed within the parameters of the storytelling circles, suggesting that they believed their participation would end in the group discussions and the proposed solution and action would be the responsibility of the researcher to implement on their behalf.

There is a rich body of literature that speaks on the benefits of research participants being conversant with the core values of African research such as the collective identification of problems that threaten the advancement of Africans’ functioning, while recognising multi-level solutions to address those problems that build on and improve African cultural strengths (Mash, 2014; McDougal, 2014; Ngara, 2007). Equally, I offered a session to build their knowledge and capacity in partnering with participatory research. The session would have offered clarity on the participants’ level of understanding, built on the initial state of knowledge, and developed it further in a process of empowering the young women. However, my offer was declined.

Time constraints or a case of priority?

Reflecting on their participatory research study, Pain and Francis (2003) noted the obstacles in engaging the same people again for continuous data collection due to participants having more immediate concerns than the research. The research participants problematised time constraints to significantly limit their participation in the WhatsApp group and, subsequently, ownership of the research project. They were at stages in their lives where they were studying and/or had work-related schedules, amongst many other responsibilities. “‘*The thing with me… I do not have time. I work, study and have other commitments. Whenever I am available, I am happy to be part of the project*” (Deb). Ku described her typical week but deflected the attention from herself to ‘people’ and how difficult it was for others to commit to anything with added responsibilities.

> I, for example, work from Tuesday to Saturday and study after work. Sunday and Monday are my study days as well. People are happy to take part in anything but are not committed when there is added responsibilities. People tend to drop when that happens.

Gaga was more pragmatic. She believed that anyone could create time and narrowed it down to prioritisation: “*I think people prioritise what they want to engage in. As it is, I am not in any position to take up any more projects. I am likely to read those that are important to me*”. These narratives depict the existence of competing interests in deciding how much attention to direct to the WhatsApp group. I recalled events during the recruitment phase where varying individual commitments or priorities of young African women presented difficulties in coordinating times and dates for the storytelling circles. For example, Gaga did not prioritise this research, yet she participated in the research to its completion, suggesting that participation was not dependent on the absence of constraints; rather, on negotiating through constraints.

The relationship between monetary incentives and engagement in research

The socio-economic status of the participants was also seen to determine the level of their participation and engagement. Most participants focused on monetary incentives, perhaps due to the low-wage occupations which often did not meet their basic needs, as reported in Chapter Five. A huge part of their salaries often paid their student loans and rentals, pushing them to work for more than one employer or for longer hours. The expectation of life was that it is hard and unpredictable with many interruptions for them as migrants of African descent where better employment opportunities were scarce. Gaga, therefore, believed her time and ‘service’ was worthy of payment, more so when perceived to be taking ownership of the project was working for me to attain a qualification.

> If you want people to give you a 100 percent of themselves, pay them. I do not expect anyone to work for me either. I recognise the effort, time, mental space it takes for people to help. I also never saw it as my project as I see it as your university work you have to submit for your qualification. I do not understand how it can be my project when it is your research… I never actually did not understand when you said I want it to be our project. (Gaga)

I recall how I had lost potential participants during the recruiting period after a misunderstanding on the issue of incentives stated on the recruiting flyer. They had understood that, in taking part in the research, in addition to a free meal, they would be awarded a fuel voucher of $20 after each session for four sessions, making them recipients of $80 fuel voucher at the end of the research. Giving a token of appreciation for and to acknowledge the relationship and respect for the participation and support I received in this research is in line with ways of doing in most African cultures. Yet, I felt the risks of payment for participation promoted sample bias, the recruitment of participants being driven by financial gain, and, more importantly, sent mixed signals to the participants who were supposed to take control and ownership of the research project. There are studies that have shown financial incentives as a motivating factor should not be disregarded when dealing with the challenges of recruitment and retention (Groth, 2010; Kanengoni, 2020; Russell et al., 2000), especially with ethnic minorities. Yancey, Ortega, and Kumanyika (2006) identified multiple studies to report on increased response rate when a financial reward was offered.

8.2.3 Competing Interest and Social Divisiveness

Some participants saw competing interests and social divisiveness between Africans underpinning the lack of support of each other. This indirectly had a negative effect on the participants fully engaging in the research. Understandably, most saw it as my project which would edify my life one way or the other; yet, if I were White, the same thought would not hold as explained by Nku:

> If you were a White-coloured researcher, you would not be struggling to get people [participants]. Africans are known not to support their fellow Black brother or sister but are quick to support the White men’s project and they are happy to even do it for free.

She further narrated the struggles of one Black African Ghanaian doctoral student in getting Africans to participant in her research study. Nku ended up being the only case study for her research. Kud concurred with Nku. She predicted that most of the participants would stop participating. She advised “*‘to just use the information you have to finish your studies and get your qualification*”.

I recalled a few weeks after I conducted the individual interviews, it came to my knowledge that some of the participants had platforms that they could have shared with the members of the storytelling circles to use as potential avenues to get their voices heard but chose not to do so. Similarly, I had approached an African community-based organisation whose focus is on young African people. I hoped to use its existing structure to carry out my research and complement the work the organisation does, but I was met with resistance. Most participants acknowledged Africans living in Aotearoa New Zealand as not supporting or helping each other as not unusual. “*‘That is part of the problem. We don’t help each other’*” (Fei). “*I feel like … yeah people do not help each other*”, echoed Deb. Gai deduced this behaviour to be the work of economic forces which create social divisiveness amongst Africans in the form of competition, jealousy, being envious, and not wanting one to do better than them.

> Have you guys ever noticed that it’s one of those things of feeling jealous. I watched this clip-on YouTube of an Africa lady who was showing her boutique and how she has made it this far, giving tips and all. Now in the comment section, a lot of people were like, ‘oh my goodness, it is good to see someone who’s so confident in their own boutique and not to be worried about showing people how to get started’. We think there isn’t enough to go around. Just like with braiding, back then, not so many people got braided so you would be afraid to lose your clients. But now, everyone wants braids. Every culture wants braids so you can never run out of clients. It’s just that thing of thinking like ‘we all came up the same way but look at me I’m doing better than you’. Instead of doing that, why not lift each other and say look, we are immigrants, but look at us doing so well as a community. It gives you power and it’s something we do not understand when you want to take something broader. Look at the Chinese, they support each other in starting a business to lift the community. So when they go to the Government and put down a business proposal, they will be listened to. Now amongst ourselves, this person, this person, this person, you want to do the same work, but why don’t you do together? (Gai)

While I cannot generalise to all Africans in Aotearoa New Zealand, this study asserts that at the broadest level, subjective experiences of deprivation, poverty, or resource allocation create enmity and competition for scarce economic and social opportunities amongst Black people in Aotearoa New Zealand, instead of friendship and collaboration. Ani (2013) also concurs that the underdevelopment, poverty, political instability, and conflict due to colonialism has created difficulties for Africans to promulgate their humanity towards each other. However, the participants were aware of and acknowledged the existing intra-race conflicts confronting the possibilities of what should be, and/or what could be, in supporting equalities related to emancipation and social transformation, as evidenced in other literature (Mashau, Kone, & Mutshaeni, 2015; Meiring, Kannemeyer, & Potgieter, 2018).

8.2.4 A Need for a Safe Space

Lack of trust and fear of potential information leaks amongst the participants were paramount in hindering the participation and collaboration processes. Many of the participants stated the need to be cautious and selective of the experiences and personal stories shared, especially with people they do not know. Gaga reported, "*a lot of us are strangers and are still strangers. There is no way I am going to open about my sex life in front of strangers*". There are studies that have shown the presence of others affecting personal accounts when sensitive issues are under discussion, leading research participants to require a safe space (Bergold & Thomas, 2012; Kanengoni, 2020; Pain & Francis, 2003). I, too, had observed most of the sharing of life experiences in the storytelling sharing circles to occur with participants coming from the same social circles. For instance, the sharing circle (group A) to which Ku belonged to comprised of her close networks who felt safe with each other. But the Facebook platform had people she hardly knew: "*As you noticed, the workshops [storytelling circles] we had, people were talking a lot because we felt safe with each other*" (Ku).

In the sharing circles, I observed the constant reminders not to speak the names of participants while the recording device was on. I also observed a subtle silence with some participants on topics related to sex and pregnancy, which I later discovered to be fear of social judgement. The Facebook platform, therefore, offered no privacy or security for some participants like Ku and Oya. "*I cannot say anything on Facebook. People can screenshot and use it as evidence whereas chatting in a group like what we previously did, I can easily deny,*" said Oya. Crucial to ethical practice in collaborative research is guaranteeing participants' anonymity (Wilkinson & Wilkinson, 2017). I came to learn from Gra that "*the African community is a very small community where everyone knows everyone's business and gossiped a lot,*" leaving many of the participants reluctant to participate in the research processes. Kanengoni (2020) also noted confidentiality to be highly regarded in African minority communities in Aotearoa New Zealand, which have a propensity for idle talk about issues that normally violates the moral codes of the community.[15]

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[15] Only 7,938 Africans (47% of the total African population in New Zealand (16,890) live in Auckland (Statistics New Zealand, 2013a, 2018). They predominantly live in suburbs in Waitākere City to include Henderson, Kelston, Rosebank, Avondale, New Lyn, Greenbay (11.8 percent); and 11.7 percent in the Auckland city suburbs of Hillsborough, Lynfield, Mount Roskill, Three Kings, Waikowhai, Blockhouse bay, New Windsor and Wesley (Chile, 2002; Statistics New Zealand, 2013a).

A few participants believed that people had to have a mind shift to be able to share stories for the good of the community: "*People are closed minded, so it is difficult when people are not seeing the vision,*" sighed Deb. However, no one was able to offer solutions to how to address the trust issues or to change people's mind sets, with Du saying, "*I do get that there are issues of trust and fear of gossip and I honestly do not know how you can work around that.*"

Although lack of participation and fears of disclosing sensitive and personal experience had a bearing on my research processes, I found their reflection on barriers important for the process of knowledge production. Not only did they offer a new and different take on the topic under study but offered knowledge on issues to consider in the designing of African research on health and related studies.

8.3 Values and Ethical Standards to Promote Collaboration and Inclusion

The value participants placed on safety and trust, and their relationship with the researcher, appeared to be critical in creating an enabling environment in which they could exercise control, work collectively with each other, and promote participation. Other standards the participants felt should be in place were having participants from the same social circle and a small sample size from the same social circle. For example, the four participants who remained through the research were friends. It warrants further research.

8.3.1 The Power of Relationships and Connections

Gaga, Oya, Ku, and Deb suggested facilitating group discussions to build relationships amongst them prior to data collection to promote inclusive participation. A study on African youth health in Aotearoa New Zealand stressed the importance of successfully building rapport—a feeling of mutual understanding, trust, and agreeableness between those involved in the research processes (Kanengoni, 2020). Yet, in hindsight, none of the participants had welcomed the proposal to meet more than once during the recruitment phase.

Gaga extended the value of connection and building of relationships towards the researcher and participants to address commitments and facilitate engagement: "*I like to meet people, know who they are and connect with them before I participate in their* *projects. This helps me to engage in the project*". Gaga appeared to suggest that they lacked connection or a relationship with the researcher, which hindered the young women from actively engaging in the project. I had met several participants over a coffee, showing the distinguishing characteristics of participatory research to be not so much about the procedures and practices used but the degree of engagement of participants within and beyond the research encounter (Kanengoni, 2020; Pain & Francis, 2003).

During my recruitment phase, I had observed some African scholars in Aotearoa New Zealand who appeared to be more easily able to recruit participants within their close network circles where trust had already been established. However, I still questioned if these researchers would have received the same support if their research topics were as sensitive and health-related as mine. I pondered if having more time to develop relations and being part of the community would have yielded the expected commitment or participation. I further wondered if their acceptance of me as being part of the community did not translate into being put under the same umbrella with African health professionals whom they perceived to breach their privacy and confidentiality.

8.3.2 Giving Back to the Community

The participants' desire to see change and have expectations of the research had been brewing over many years when they perceived African minority groups to be researched more often than they saw the research impact or outcome. They had become distrustful of every researcher and were reluctant to participate until they saw positive outcomes for the community. I recalled the gatekeeper (director) of NzEWT had expressed disgruntlement on behalf of the refugee community. Participants like Du believed the participants would engage when they saw progress: "*It is just many projects have come and gone and nothing has materialised from them, so people are a bit sceptical in participating in projects until they see something coming out of it*". I wonder if the participants were wondering how different my research was.

Understandably, the participants had put 'effort, time, mental space' into the research and were within their right to withdraw from participation until they saw results or the impact of their involvement. Prior research had not benefitted them and this had become a common perception in the community. Although participants aspired to see immediate changes in programme or policy-related issues, many failed to see the difference it made to them; that is, how they had been empowered by gaining new knowledge and learning the research processes. They confessed to this being their "*first time participating in this type of research*" (Muk) and needing more platforms like this to break the silence. Some African scholars reported empowerment as one of the distinct features of African research (Ani, 2013; Kanengoni, 2020; McDougal, 2014; Udefi, 2014). Similarly, Muk, referring to how the participants had significantly reduced from 16 to 4, noted her concern about the impact it had on people instead of worrying about the numbers: "*It depends what you are looking at; numbers or impact on people. You do not know what impact you [researcher] have made*". As part of the decolonising process, for some, I had successfully invoked racial pride, self-love and empowered them to re-politicise and re-historicises health through a paradigm shift, a leadership shift and a knowledge shift. The impact of the research on these four participants is discussed in section 8.3.4.

Reflecting on the challenges I encountered in recruiting and maintaining the participation of young African women, it was likely I would encounter the same challenges in getting the participants to share their findings with the stakeholders. Other studies have noted it not being uncommon to experience challenges in recruiting and maintaining the commitment of research participants (Kanengoni, 2020; Pain & Francis, 2003). I was also aware that not disseminating the findings would have the participants putting me under the same umbrella with other researchers who may have not put to use the information they gathered for the benefit of the 'researched'. I decided that I would share the findings. I joined interdisciplinary community networks like the Auckland University of Technology Centre for Migrant and Refugee Health Research Centre. This centre comprises academics and researchers who undertake, promote, and distribute research that advances understanding of issues that can improve the health and wellbeing of migrants and refugees. The network would provide the platform to disseminate the study's findings to relevant stakeholders. I also attended one international and one local conference to share my preliminary findings. My article (Kanengoni, 2020) also informs other academics of points to consider when conducting collaboration and participatory research processes with African minority groups on health-related topics. This includes ideal sampling methodologies discussed in section 8.3.4.

The dissemination of findings and mobilising people to action around those findings are a fundamental part of the research process, and more so for a community that has aspired to see change for so long after participating in research. In an ideal world, the dissemination research strategy for participatory research should be developed by the co-researchers; but, in this study, I developed and shared it with the participants (see Appendix H). This was due to the challenges met in having participants committed to ongoing participation in the research. The approach recognised several parties of interest, those within the Africa community, the public health and academic spaces, and beyond. A selection of dissemination/mobilisation strategies have been and will be implemented, including working with African-based/ethnic organisations like African Communities Forum Incorporated, mainstream media, presenting at academic conferences, and writing journal articles with an emphasis on policy, economic and social impacts. My intent is also to contribute to the CALD cultural safety curriculum being better understood in Aotearoa New Zealand, and also more linked to Te Triti curriculum to raise awareness on African concept of health and wellbeing and how that understanding can be used in delivering appropriate healthcare; and to advocate for a standalone categorisation of Africans in population data. Engagement with interested parties will be tailored to achieve a range of specific objectives which will be recommended in the Discussion and Conclusion chapter.

8.3.3 Ideal Methodological Approaches for Health-Related Studies with African Youth Migrants

Academic literature has set a benchmark for the number of research participants required to ensure a good representation of the study population (Femdal & Solbjør, 2018; Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007). Indeed, the recruitment and subsequent engagement of the participants are a complex issue beyond sampling representation. Only four of the 16 participants saw the research project to completion. Gaga recommended working with a smaller number of people as key to thriving research that required an action output: "*I think if you could have a committee of 3 or 4 girls who will run the project, it would work. It has also been difficult to work with a big number*". Deb shared the same sentiments: *"I think it is possible to work* *with a few people who can make things work. It is just getting the right people to back you up. It's sad that people are closed minded*".

One health researcher with African youth in Aotearoa New Zealand identified inter-related issues in African minority communities like mistrust and fear, and working long hours or multiple jobs due to low wages, as hindering recruitment of participants and further engagement (Kanengoni, 2020). In tandem with the narrative above, the four participants who completed the research project were from the same social circles of friends, suggesting that a project of this nature is likely to move forward when working with a small number of participants from the same social circles. However, this warrants further study.

Preceding sections have touched on some aspects of the participatory action process and how African cultural values and beliefs determine the participants' collaboration. The following section presents findings not yet discussed.

8.3.4 Reflection on the Research Processes

Having a scholarly and professional interest in African migrant youth health in Aotearoa New Zealand, I aspired to establish African research credentials as an academic pursuit. This led me to ask the participants to share their reflections on the participatory and collaborative processes, their subjective view on building collective knowledge, and actioning social transformation in the research process. Although "*this way of researching needs dedication to see people warm up*", confessed Muk, the participants reported the whole process of participation to have given them a platform to share their lived experiences which brought comfort in knowing they were not alone. Nku described the process as "*almost felt like therapy having to discuss the issues I have faced and knowing I'm not alone. It allowed me to speak honestly about my experiences unfiltered about my health in New Zealand as an African young adult*". Ku added, *"I got to learn that we need many platforms like this to talk about our concerns, fears and the change we would like to see in our community".*

> I got to talk about stuff that I really would not do with other Africans, even though I got the sense that people were too scared to talk". It gave us a platform to share what we have experienced good and bad. (Muk).

All participants in Group B called for more discussions of this nature as a platform to collectively discuss matters that concerned them, although they had to address the fears of speaking out. Gra:

> I also feel like the conversations are a lot richer, you know. Like when you talk to someone one-on-one, there's only so much you can go into you know, like I feel like with all these questions, it would have just been like 'what health problems have you identified?' 'Oh, ummh, sexual health, mental health, addiction, you know, stuff like that'. 'Okay, cool'. You want more on to the next questions. Whereas as a group, we actually go into detail, like stories to make it deeper.
>
> And that's the thing. We just... it's almost like we just live in constant fear of the unknown and it hurts us and in a way that's kind of what ruins so many opportunities for us because we don't really take it, you know, like this whole thing. This is so nice what you're doing and if this is something that like in the ends up starting things and being the thing that you initiates changed for us, then it's beautiful. But then imagine if we'd open up this is a missed opportunity – a chance for us to come together and talk about our own people and our own problems and what we face and how can we actually start something that will benefit as you know, but it's like no I don't I don't get it. I don't know I won't go anymore. Nothing gets done.

The quality of the research processes in African research is judged by the practical usefulness of new knowledge derived from the research (Botha, 2012). Nku felt the knowledge produced liberated her from issues that had heavily pressed upon her for a long time.

> We have come a long way. We are a new generation that is open to discussing and coming to the table to figure things. We are now open about our issues in order for them to be dealt with whereas normally we would complain in private and not have any solutions and it becomes a culture of acceptance of things that don't work for us instead of changing things so that they work for us. (Nku)

I began to view this as the beginning of an empowering process for them to be custodians of their health and wellbeing. One of the basic assumptions of African knowledge and belief systems is to empower and liberate people of African descent (Anyanwu, 1989). Therefore, the purpose of the knowledge produced is for the participatory and collective identification of problems that threaten the advancement of Africans' functioning and how that knowledge is shaped by migration and the context of host culture while recognising multi-level solutions to address those problems that build on and improve African cultural strengths. Nku felt empowered to take ownership of her health by openly sharing her experiences with other peers, building trust in a collective group of shared identity and needs, and being open to having her voice heard by policy and programme makers.

> It gave us confidence to put forward solutions to the New Zealand government to ensure that as part of the kiwi community we are also catered for us African women. Some of the issues we face are not the same as Pasifika or Caucasians or Asians. We have different things that affect our mental wellness based on how we have grown up and diseases that we are more susceptible to. Knowing these things allows for health practitioners' education in New Zealand to be on the lookout for those things when dealing with us so that they don't take a one size fits all mentality in our consultations. (Nku)

Muk reported the act of storytelling to be relevant in working with young African female migrants. She explained. "*I do not to know any other way to mark it [storytelling] against*", but further described storytelling to "*open conversations that Africans should have*" (Muk). Gra acknowledged the storytelling made the conversation much richer: "*whereas as a group, we go into detail. Like the stories make it deeper*". Storytelling and the art of storytelling are profoundly important in many Indigenous and African communities (Chinyowa, 2001; Drawson et al., 2017; Geia et al., 2013; Kovacha, 2010; Lavallée, 2009; K. Tuwe, 2016). For the participants, the stories were archives of collective experience and social suffering and to speak them was a form of emancipation, uniting them to determine the existing social issues and which one(s) to eliminate or change (Sium & Ritskes, 2013).

For Gaga, it provided her opportunity to "*put our heads together to try and come up with solutions instead of just complaining about things*". Studies with African communities have shown the primary purpose of African research to be concerned with attitudes, sentiments, and beliefs of Black Africans, which reflect the collective experiences of shared understanding of social oppression and marginalisation, and resolve those problems as a group of minority in specific life-struggles of persons of African descent (or Black people) (Airoboman & Asekhauno, 2012; Chilisa, Major, & Khudu-Petersen, 2017; Nyashanu & Serrant, 2016).

Similarly, the participants had been provoked by their reality. They aspired to change the course of their past lived experiences, which had denied them equity and social change in facets that influenced their health and wellbeing. For example, in Chapter Five on employment opportunities, race appears to shape the everyday practices of recruitment and hiring and the treatment of licenced African doctors in Aotearoa New Zealand. They wanted to see change in the Aotearoa New Zealand medical culture where processes promoted institutional racism or aversive racism in clinical practice, which violated the rights of the health professional to practice their skills in accordance with their preferences, and the equity rights of minority ethnic groups who stand to gain.

I noted the constant use of words, ‘we’ and ‘us’ distinguishing what the participants said by the way they said it. I deduced the participants’ thoughts and feelings to be explained in terms of their relationships and their broader social and cultural settings, making them confident to also speak on behalf of the other participants regarding the positive impact the research processes had on them. They had situated their stories, which held holistic knowledge, in their context; therefore, they had a culturally nuanced way of knowing and a socially sanctioned and legitimate way to understand complex phenomena related to health.

8.4 Summary

This chapter revealed the complexities and barriers in conducting health research with young African migrant women in Aotearoa New Zealand. Multiple factors arose, including diversity in knowledge and perception; multiple identities like backgrounds, individual circumstances, and personal attitudes, and core and renewed African values; social divisiveness in the African community; and feelings of profound mistrust amongst themselves. The data further offered potent insights into values and ethical standards that promote inclusion, long-term participation, and collaboration, such as building trust amongst the participants and connection with the researcher, and working in small groups, possibly from the same social circle. The chapter concluded by reflecting on African knowledge and belief systems which show elements that fit within the worldview like collectively working together; yet, some aspects, like supporting each other, were critiqued in light of the results. For instance, the participants appeared to be confronted with day-to-day negotiations and contentions that arise with their ‘Blackness’ in a society which further situated them in the context of patriarchy and religion, creating a learned hopelessness, even for opportunities that may create positive change in their lives, like participating in a study. This includes time constraints which significantly limit their participation in research and, subsequently, ownership of the research project.

CHAPTER NINE: DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

9.1 Introduction

This chapter discusses my key findings in light of my decolonising theoretical framework, research questions, and the broader literature to produce evidence-based recommendations for youth health policies that will contribute to the health and wellbeing of young African women migrants in Aotearoa New Zealand. This chapter includes the multi-voiced accounts of what the participants and I shared and experienced when co-constructing and exploring the participants' experiences with healthcare services. These accounts recognise that, as humans, the participants are not only biological organisms but social beings. I therefore borrow the notion of 'embodiment' and 'embodied belonging' from Manderson (2002) and Mattes and Lang (2021). The concept of embodiment advances two claims within the scope of this study research: (1) young African migrant women's bodies tell stories about the conditions of their existence—stories which cannot be divorced from religion and spirituality, and their social positioning as young African Black migrant women; and (2) the body does not just tell stories but histories (Manderson, 2002; Mattes & Lang, 2021). Here, an epistemological tension is visible – contesting and contrasting the participants' cultured bodily expression or embodiment against the mainstream biomedical perpetuated narratives. This tension applies both ways, for the participants as well as the western biomedically trained doctors.[16] Mattes and Lang's (2021) concept of 'embodied belonging' provides a more nuanced understanding of how migration, exclusion, and marginalisation contribute to shaping health-related inequities for young African women's lives and bodies, and how their struggle for integration may regain health and sustain their wellbeing. I wish to mention at this juncture that non-belonging and its health-related effects are equally applicable to underprivileged groups such lower socio-economic and racialised populations. They also reveal how belonging can be drawn on as a means and resource of social resilience. I discuss this tension in detail in section 9.5. Finally, I discuss limitations and provide general recommendations to conclude my thesis.

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[16] Western-trained health professionals in this study context are New-Zealand-trained and migrants sourced from the major English-speaking background OECD countries (Ministry of Business Innovation and Employment, 2019; Ministry of Health, 2016).

But first, in section 9.2, I give an overview of the study. In the next session, 9.3, I discuss the applicability of the decolonising theoretical framework which links to challenges in my invitation for a democratic participation and formulation of social action in this study research. Three socio-cultural dimensions that influenced the research processes are discussed: (1) interdependency and collective sharing; (2) mistrust; and (3) participation in research in a patriarchal society.

Important to note is the dearth of research in Aotearoa New Zealand to understand and address the healthcare needs of young African migrant women. This study, therefore, narrows this gap and contributes practical solutions and strategies to improve the health outcomes of the participants of existing youth health and social policies and programmes.

9.2 Overview of Study

I invited the participants to collectively work together to rewrite their narratives to reposition their knowledge to interact or negotiate with other systems of knowledge—the mainstream knowledge—on equal terms for the betterment of their health. I applied a decolonising theoretical framework informed by African epistemology (Ani, 2013; Anyanwu, 1983; McDougal, 2014; Udefi, 2014). I used the central tenets governing the assumptions, beliefs, and attitudes of African epistemology to frame the decolonising process and the identification of decolonising strategies within the scope of this research: 1) a challenge to dominant ideologies; 2) collective community validity of knowledge; 3) the significance of race and racism and their interconnectedness with gender; and 4) empowerment for social change. These central tenets merge and produce four major themes. The interaction between the four themes, namely ‘make meaning of health and wellbeing’ and ‘participation and collaboration’ through to ‘experiences and views of Aotearoa New Zealand healthcare’ and ‘recommendations’, are summarised next.

9.2.1 Summaries of the main findings

The **first theme**, ‘making meaning of our health and wellbeing’, shows similarities, but also stands in stark contrast, to existing international literature, as is also the case with the other themes. Participants' definitions of health and wellbeing concur with the WHO (1986; 1948) yet go beyond that to encompass an embodied experience of culture and religion and spirituality in complete physical, mental, and social wellbeing. The WHO (1986; 1948) does not acknowledge, for example, the role of culture and religion and spirituality in the wake of the current Sustainable Development Goals, which means that religion is an invisible social determinant (Haustein & Tomalin, 2021; Petersen, 2020; Tomalin & Haustein, 2019).

The **second theme**, 'young African women's experience and views of Aotearoa New Zealand youth health services', was branded with a culture of silence. The decision of what to share was met with critical reflections on and considerations of the impact on them and their families. For example, in Chapter Five, Ku's reason for withdrawing from participation was due to fears of breach of confidentiality and the implication that would have on her and her family. In Chapter Seven, the participants were 'silent' about their use of youth health services. I wondered if it was due to the effects of social desirability bias where participants tried to 'voice' but also avoided answers that have stigma attached or are considered shameful, as well as the possibility of lack of knowledge of youth health services. For instance, their apparent lack of knowledge about relevant youth health services and access exposed the pre-existing socio-cultural, political, or psychological complexities in the life worlds of the participants. In part, it may have been a case of the malfunctioning systems of the youth health services predicated by the youth health strategy of 2002 which had limited space for the voices of ethnic minorities (Ministry of Youth Development, 2009) and, therefore, did not address the complexity of identity formation and the wellbeing of migrants, paying particular attention to the role of gender in those domains. Thus, the shared experiences and perceptions of the participants were encounters with the mainstream or non-specialist healthcare system and providers. Nonetheless, the participants had little confidence in the Aotearoa New Zealand healthcare system, reporting the system to be not committed to culturally appropriate, accessible, or affordable services. There were tensions between the ideal expectation of services and treatment received from health services. Participants felt that, often, doctors: (1) diminished their realities of illnesses; (2) failed to refer them to either the correct treatment or specialist; and (3) did not provide sufficient information on the underlying medical reasons or causes of illness in a satisfactory manner. Reference in accessing health services was also made to their financial abilities; long waiting periods for consultation; where health professionals attained their training; health professional behaviours, values, and attitudes towards the participants; and the participants' attitudes towards their African health professionals.

In collectively assessing and looking for solutions, the participants produced multi-faceted strategies to improve their health outcomes; hence the **third theme**: 'participants' shared prosperity and aspirations for positive health outcomes'. The participants imagined a world where their health concerns, both current and anticipated needs, were acknowledged in a socio-cultural and medical encounter and promptly and responsively acted upon by relevant leadership, policy makers, or authorities deemed to be in key roles at the local and national levels, and within families and communities. The participants further experienced the process of creating a digital storytelling artefact entitled *Honest Conversations* as a means of effectively communicating with those parties mentioned earlier. *Honest Conversations* displays the collective critical thinking of the participants in uncovering their place in the society by discussing social oppressions, struggles, and power structures that lead to health inequities and inequalities. The other recommendations put forward involved: (1) creating an African health referral to African health professionals whose skills were not being utilised; (2) having a similar culturally led youth health model like other ethnicities, such as Māori and Pasifika; (3) and the educating of health professionals on the knowledge and skills of African youth health needs, health-seeking behaviours, and health service expectations; and (4) changing the racial categorisation of Africans in Aotearoa New Zealand.

The study experienced challenges in the participants' participation and collaboration. Hence, the **fourth theme**: 'barriers to democratic participation and collective action'. The life worlds of the participants—being a young Black African migrant, being a student, an employee, being from a low socio-economic status—required them to work in multiple arrangements which presented commitment challenges to their participation in this research. Initially, I expected the participants to invest three hours in each of the four sessions of their time. At the start of this study, most of the participants were committed to only three hours and continued virtually on the WhatsApp platform. Yet, due to unforeseen circumstances like the absence of a 'safe' space to share, most participants stopped participating on the Facebook page and in the research. I proactively looked for ways to remove barriers to participation. I further assessed if the methodology and/or African worldview provided a critical space for this dialogic epistemological stance to happen within this research practice. I found storytelling and the art of storytelling were profoundly important for the participants as has been found by other Indigenous and African communities (Chinyowa, 2001; Drawson et al., 2017; Geia et al., 2013; Kovacha, 2010; Lavallée, 2009; Tuwe, 2016); yet it had its challenges of mistrust amongst them. The participants believed working in small groups with participants from the same social circle was key to addressing mistrust issues. One participant further suggested the researcher to informally engage with individual participants for better engagement and commitment.

9.3 Insights into the Application of Assumptions, Beliefs, and Attitudes of African Epistemology to Health Research

The study findings show the participants' collective impression about cultural identity and migration status to influence the knowledge produced in their understanding and meaning of health and wellbeing and how that translates into informing equitable youth healthcare service delivery and health outcomes. The participants' knowledge formulation and belief systems on youth health were best understood in the spaces of culture and where religion and spirituality and health intersect. Previous research on the health of Black African ethnic communities in the UK, the USA, and Australia has also been noted to be influenced by religion and spirituality (Douglas & Watson, 2013; Reiner, 2010; Serrant, 2020). However, this study showed the application of the assumptions, beliefs, and attitudes of African epistemology to guide the decolonising processes failed to create a space for participants to participate in the research processes and speak of themselves in their own bodies. This is discussed in two parts: (1) African identity and alternative ways of knowing; and (2) the relevance and application of African philosophy in health research.

9.3.1 African Identity and Alternative Ways of Knowing

African identity and knowledge formulation within the parameters of African worldview is challenged by: (1) the negative impact of the colonial experience of domination and exploitation in Africa; and (2) the ethnocentric assertion of western scholarship to the denigration of anything that is African (Hegel, 1956; Outlaw & Lucius, 2017). In my study, I observed the following: first, among participants, regardless of divergent life experiences, an authentic African consciousness still pervaded African experience in the diaspora, which supports the findings of Mbiti (1990) and Creese (2014). The study participants were articulate in maintaining and believing in their retaining, to some degree, the basic principles of African value system of their homeland; for example, the moral expectation on the participants; hierarchical filial relationships; ideas of the interconnectedness of all things; their collective identity; the values of religious practice and spiritual beliefs. This has been confirmed by other studies (Arrey et al., 2016; Christou & Mavroudi, 2016; Serrant, 2020; Thabede, 2014).

The study also unearths the participants' worldviews to maintain or participate in the set of attitudes, behaviours, social structures, and ideologies that undergird the dominating group's power and privilege on knowledge systems (Bivens, 2005). For example, the participants questioned African health professionals' competence in clinical decision-making, suggesting participants perceived Africans not to be intellectual enough to produce knowledge. This is in conflict with their 'cry' for culturally appropriate healthcare services delivered by African health professionals discussed later in section 9.5.1. This socialisation process, both in the participants' countries of origin and in Aotearoa New Zealand, has shaped their ways of knowing and guided their interactions and healthcare preferences. This conflict of findings further warrants research on the examination of the cultural, social, and identity tensions inherent in the clinical competencies and skillsets of health professionals in Aotearoa observed in practice. Here, this call is for a critical dialogue, empathy, and willingness to reflect on sets of attitudes, behaviours, social structures and ideologies which privilege an ethnocentric assertion of western scholarship undercutting the knowledge and cultural expertise of health professionals from racialised backgrounds in delivering healthcare.

9.3.2 Relevance and Application of African Epistemology

In Chapter Three, I provided a detailed review of central tenets governed by prior assumptions, beliefs, and attitudes of African epistemology as presented by the authors I followed (Ani, 2013; Anyanwu, 1983; McDougal, 2014; Udefi, 2014). In critically examining the “system of knowing” linked to the worldviews of the participants within their socio-cultural situation and interpretation of their world, I found the participants’ knowledge making to be still confined within the two main constructs. The first is African belief systems[17] wherein the participants’ reality was defined either by their religious belief or their cultural intuition (refer to Chapter Five and section 9.4). The applicability of mythical knowledge remains a question of how relevant and useful it is for African migrants and changes in intergenerational family relationship expectations, which therefore warrants further research. Secondly, the participants showed a strong orientation to collective values observed through participants’ expression of the principles of communalism, namely interdependency and reciprocal interaction, as noted in the discourse of African epistemology (Anyanwu, 1983). Yet, at the same time, I observed these values seemed hard to achieve during the research process. The findings point to varying contextual socio-cultural dimensions that influenced the research processes: (1) interdependency and collective sharing; (2) mistrust; and (3) participation in research in a patriarchal society.

Interdependency and collective sharing

Participants contested the varying expressions of interdependency and collective sharing, confirming my observation of the absence of the spirit of ‘communalism’ which I found to decline or lose significance when people move to other countries. The participants’ perceived values of personal independency—individual freedom, success, and prosperity—as found in the Kiwi culture (Hofstede Insights, 2017; Triandis, 1995). Ewuoso (2021) exhibited collectivism and or unity with others through psychological approaches such as thinking of oneself as part of a “we” and acting in ways that will more likely improve the quality of life of others. Yet Mugumbate and Nyanguru (2013) explained the unity for a collective purpose to bind people within their own families, suggesting the spirit of unified collectivism may not be easily applicable to groups of people from diverse African nations upon migration to Aotearoa New Zealand, as seen with my study participants. The participants mostly came from Zimbabwe, Nigeria, DRC, and South Africa, which were under long years of colonial rule, depersonalising and isolating people from their culture, society and,

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[17] African knowledge belief systems are influenced by three distinct dimensions—intuitive, spiritual, and mythological (Ani, 2013). See Chapter Three.

likely, the spirit of communalism. Understandably, most participants saw their participation to edify my life one way or the other, that is attaining a doctoral degree that would create competition for scarce economic and social opportunities amongst Black people in Aotearoa New Zealand. This created difficulties for the participants to participate and collaborate in this study. Such competing interests and social divisiveness is documented elsewhere where past colonial experiences (Halloran, 2019), systemic poverty, lack of resources and infrastructure development, and political instability shape and form humanity towards Africans (Ani, 2013; Flahaux & De Haas, 2016; Mlambo & Mpanza, 2019; Outlaw Jr & Jeffers, 2017; United Nations Economic Commission of Africa, 2017). Yet, some participants admitted that the research dynamics would have been different if the study was conducted by a White researcher. They observed White researchers being fully supported in their research with no demands for 'koha'. Research on the influence of the race of the researchers on participants has been published elsewhere (Chadderton, 2012; Januszka et al., 2013; Kanengoni, 2020). These findings have implications for future research with African migrants in Aotearoa New Zealand.

Mistrust

For many participants, collective sharing brought about issues of mistrust and fears of potential information leaks. My published study (Kanengoni, 2020) concurs with other studies (Bergold & Thomas, 2012; Kanengoni, 2020; Pain & Francis, 2003) on the participants' need for a safe place to disclose their personal views, opinions, and experiences, demonstrating that issues of mistrust are not peculiar to any epistemology. Mistrust of the researcher is an obstacle to community entry and participation. On the contrary, findings in this study alluded to feelings of profound mistrust amongst participants, suggesting the insider–outsider discourse to be far more complex than the academic literature avers. Findings also show mistrust issues can be addressed by recruiting a small number of participants from the same social circle of friends. The four participants who completed the research project were of the same social circle, suggesting that a project of this nature is likely to move forward when working with a small number of participants from the same social circle. Although, this warrants further study, this finding is inconsistent with western literature which requires a certain number of research participants to ensure a good representation of the study population (Femdal & Solbjør, 2018; Halcomb et al., 2007). The study findings further prove the collective ethic as a valuable “pathway” tool to produce collective knowledge and shared insights on young African women’ experiences in health (Drawson et al., 2017; Lavallée, 2009). However, there is need for further research on how the act of collectivism can be applied in a manner that promotes collaboration and participation.

Participation in research in a patriarchal society

The participants’ reportedly felt culturally and or religiously inappropriate to discuss key health issues like sexual health, which were viewed to be issues for married women. The participants portrayed their participation to be influenced by patriarchal ideology and norms. This ideology and these norms silenced many voices in the storytelling circles, subtly confirming the difficulties African culture has in acknowledging young African women as sexual beings; its control over the sexuality of women, more so to preserve their honour by maintaining their virginity as documented elsewhere (Agu et al., 2016; Botfield et al., 2016; Botfield et al., 2018; Dune & Mapedzahama, 2017; Dune et al., 2017; Rade et al., 2018). These moral expectations of the implicit submission to patriarchy of the participants seem to apply across collective societies and cultures worldwide. Nwankwo (2006) describes it as the battle in which women “fight” against God and men—either at the same time or one after the other, which perpetuates the ideological oppression of women’s values in society (Imafidon, 2018). Nwankwo’s standpoint is in contrast with those of African male scholars such as McDougal (2014), who offered African beliefs and knowledge formulation to be ‘empowering and liberating’ and to dispute dominant ideologies by harnessing and enabling voices to be heard. Nwankwo (2006) shares the same feelings displayed by the participants of struggle in a culture that emancipated African males and White health professionals. From listening to and working together with the participants, I perceived the social nature positionings of social autonomy, relational autonomy and gender disparities to give more understanding of and insight into the relevance and application of African philosophies in research with African women.

(i) Social autonomy

In Chapter Four and Chapter Eight, I mentioned one participant who withdrew consent to participate citing the shame and disgrace she may bring to herself and her family if any of her shared experiences became known by her African community. This behaviour in African spheres reflects the existence of communism or the influence of what others coined "social autonomy" by Princewill, Jegede, Nordström, Lanre-Abass, and Elger (2017). The African community is well linked, and issues of privacy and trust are of paramount importance to the participants. Therefore, individual decision-making is approached with caution, lest it affects their community, family, and close social and cultural networks and vice versa. Kanengoni (2020) supported the work of Princewill et al. (2017) which underscores this type of diminished autonomy of women as a result of male dominance, culture, and religion.

(ii) Relational autonomy

Synonymous with social autonomy is relational autonomy where participants were found to be under the authority of their parents and, by their culture, are expected to obey their parents. This was particularly observed during the recruiting phase when some parents did not allow their daughters to take part in this study. The construction of African identity dismisses women's position by the acknowledgement of male dominance or acknowledges females in position of authority like the eldest aunty in the family (Montoya, 2008; Presbey, 2021; Walia, 2018). For instance, Presbey (2021) displays the epistemic ostracism of women by under exploring women's theoretical and practical perspectives on African philosophy. Further, relational autonomy is also evidence of the general acceptance of power and the valuing of authoritative figures, which in this study determined the participants' level of participation; that is, the valuing of authoritative figures to spearhead their proposed initiatives. This is consistent with Gomez (2013) and Nkomazana and Setume (2016), who found Africans to respect authority, and view hierarchy and power inequality as appropriate and beneficial, dating back to the era of African religion, colonisation under the banner of Christianity, and globalisation. While the study is limited in scope in that regard, the findings of this research provide researchers and policy makers with a clearer pathway in carrying out social action through a critical consciousness of the dynamics at play amongst young African migrant women.

(iii) Gender disparities

Chapter Six shows the participants to be guardians and/or custodians of acceptable behaviours and to bear the duty of morality. For example, as the duty bearers of morality, participants reserved their participation in storytelling circles. The archives of the collective experience and social suffering of the participants displays: (1) entrenched traditional African worldviews privilege men over women and, therefore, pose the neglect of the feminine epistemic perspective; and 2) participants constructed alternative ways of interacting with norms limiting their power over their autonomy, as is echoed by others (Chauraya, 2012; Imafidon, 2018; Moyo, 2004; Oyewumi, 2002; Presbey, 2021). The meaning-making of health and wellbeing and the level of participation in health research with young African women in Aotearoa New Zealand is consistent with expectations of culture, as found by Kanengoni (2020).

In a dispassionate look at African philosophy, written either by men or women, what is apparent is that African epistemology can only stand to be successful when applied to research with women if women are brought in to have key discussions about the philosophical constructs. This will change the character and quality of the philosophy, thereby promoting epistemic justice to African women and their typical concerns (Presbey, 2021). However, it is also important to mention at this juncture that though the tenets of African philosophy in research employed in this study are suggested for use with young African migrant women, they can also serve as a guide for research with other marginalised groups and Indigenous people because they address issues pertinent to most formerly colonised (and collective) societies. Further, the applicability of the tenets of African philosophy in research may hold for non-health-related research with young African migrant women – a gap in this study that requires attention.

The next section discusses how the four themes in 9.2.1 integrated as one.

9.4. Embodiment and Embodied Belonging

In comparison to African culture, Aotearoa New Zealand presents a different and challenging context in which participants shaped their concepts of health and wellbeing, illness, health treatment, and health-seeking behaviours. The notion of ‘embodiment’ and ‘embodied belonging’ as a prolific analytical tool in medical and psychological anthropology (Manderson, 2002; Mattes & Lang, 2021) assists in a more nuanced understanding of the participants’ collective, gendered, familial, and individual intergenerational continuum in light of circulating social capital and available social agency, yet encompassing two culturally derived distinct shared dimensions: (1) gender; and (2) religion, and spirituality. The participants’ positioning in society of embodied non-belonging is also demonstrated to have effects on health and wellbeing and equitable access to healthcare services. Maintaining health ‘resilience’ was seen to cut across these dimensions and to co-exist simultaneously.

9.4.1 Embodied Gender Norms and Associations with Health and Wellbeing

The participants’ collective approach to health and wellbeing was shaped by African gender expectations, norms, and values. The findings show gender norms were accompanied by clear principles, related beliefs and attitudes, expectations, social mores, and behaviour around sexuality, which made open discussions about sex and sexuality difficult, or made it difficult to work together to facilitate optimal sexual wellbeing. Therefore, participants spoke of learning ‘unspoken’ norms, ‘not disclosing’ and ‘secret-keeping’ when asked about their views or experiences of the sensitive and gendered nature of taboos. The influence of gender and related socio-cultural norms on health behaviour and perceptions of health and wellbeing are reported elsewhere (Kanengoni, 2020; Ministry of Social Development, 2008; Suárez-Orozco & Qin, 2006). The interactions of these gender norms further highlight the impact of social capital; that is, how the collective culture can shape the health and wellbeing outcomes of collective ethnic groups. Since no similar findings have been reported in the Aotearoa New Zealand studies, it is possible that health professionals whose cultural beliefs differ from those of participants may overlook or are ignorant of African cultural mores underlying the sexual health and wellbeing of young African women, as well as concealed cultural beliefs. Further research is therefore required to explore health provider knowledge, translation, and the communication of this knowledge when providing care to African youth.

Participants internalise accumulated vulnerabilities that come with being a female and begin to embody this socially devalued identity. Foucault, as described in Flynn (1987), wrote about the manifestation of bio-politics[18] in peoples' bodies and everyday practices, which can be observed in this study as participants' insecurities in acknowledging the role of gender and how their sexual and reproductive health-seeking and health-engagement behaviours were shaped as a result. Cultural contexts can, however, change the narrative by providing women with opportunities to achieve social power without reliance on empowering projects, as established by one study in Sweden (Gattario, Frisén, Teall, & Piran, 2020). Gattario et al. (2020) show Sweden's higher gender equity across the areas of health, education, economy, politics, and employment to improve the experience of worth in inhabiting and liberating women's bodies and the experience of agency in the world (Gattario et al., 2020). If research could establish that improving a society's level of gender equity and, accordingly, an active participation and advocacy in patriarchal migrant communities enhances individuals' positive experience of embodiment (and thereby also their wellbeing), this could motivate future youth health policy work to further prioritise the issue of health equity.

9.4.2 Embodied Religion and Spirituality

The participants' experience of stigmatisation and social exclusion engendered a sense of embodied non-belonging that significantly impacted their wellbeing. Often with the help of their spirituality and religion, they managed to counter these situations and rebuild a comforting sense of belonging. Previous research acknowledges spirituality expressed in religious activities as being part of African ethnic culture (Ajima & Ubana, 2018; Ani, 2013; Arrey et al., 2016; Asare & Danquah, 2017; Ngara, 2007; Omonzejele, 2008) which supported the process of participants giving meaning and purpose and connectedness to self, others, and the higher power and, ultimately, achieving positive health and wellbeing. Using mental health as a point of reference, the participants' accounts of religious practice and their associations with adverse mental health may parallel literature which supports evidence of high suicide rates in Aotearoa New Zealand (UNICEF, 2017) purported by the increase of New Zealanders

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[18] Biopolitics can be understood as a political rationality which takes the administration of life and populations as its subject: "to ensure, sustain, and multiply life, to put this life in order" (Flynn, 1987, pp. 65-84).

not identifying with religion up from 41.92% to 48.59% (Pollock, 2018; Statistics New Zealand, 2013c, 2018).

Many studies enforce the central importance of the everyday practices of spiritual recognition, connectedness and patient-centred approaches in primary care (Babatunde-Sowole et al., 2016; Isaac, Hay, & Lubetkin, 2016; Selman et al., 2018; WHO, 1998), to include the spiritualism also found in health belief models for Pasifika and Māori communities (Durie, 1985; Tiatia, 2008). Thus, Aotearoa New Zealand healthcare visions for health and wellbeing and targeted service delivery for African migrants should be framed by spiritual beliefs as a timeless reality of many ethnicities in Aotearoa New Zealand. While the participants depended on an invisible supernatural world to give them emotional comfort and solace, the mismatch of the current biomedical approaches and procedures in the Aotearoa New Zealand context is noteworthy.

Cultural resilience and health

My findings show participants' sense of belonging to be a source of resilience which, in turn, facilitated the shaping of their identity and culturally understood social capital for the life course (likened to social resilience) to provide a relief from or buffer to mental stresses brought about by the vicissitudes of the migrant life; that is, the life struggle, lack of employment opportunities (Mwanri & Mude, 2021), experiences of racism, and discrimination and marginalisation in health services and more generally (Assari, Moazen-Zadeh, Caldwell, & Zimmerman, 2017), along with many other tensions that came with being a young African immigrant woman. Similarly, Mattes and Lang (2021) found relationships, families, religious communities, and friendships to substitute for healthcare services and the intersection of these, contributing to migrants' meaningful ways of being-in-the-world and, at least partially, rebuilding belonging.

Findings show that one's health is an extension of family health (Ajima & Ubana, 2018; Omonzejele, 2008), but this also provokes controversial ideas and beliefs about disease, and health and wellbeing, to be a consequence of social learning and cultural transmission which provide an inheritance element (Halloran, 2019). This finding is at odds with individualistic approaches offered in general practices and sexual services, and therefore advocates for a family-centred approach in the delivery of healthcare as integral to patient health, satisfaction, and healthcare quality. This may encompass holistic care which acknowledges patients, families and staff as central to the delivery of a better healthcare "partnership," and "collaboration," and patients, families and staff as central to the delivery of better healthcare with families as "experts" to describe the process of care delivery (Frakking, Michaels, Orbell-Smith, & Le Ray, 2020).

From a policy perspective, partnering with African community groups to foster collaboration and an understanding of social resilience and what constitutes thriving can be crucial in promoting the wellbeing of youth in Aotearoa New Zealand. For instance, the continuing rise of mental disorders among the youth in Aotearoa New Zealand (UNICEF, 2017), poses a great economic burden of disease (Department of the Prime Minister and Cabinet, 2019) and an immense loss of human potential. My study contends that it is far more prudent to explore the extent to which socio-cultural resilience (factors, skills, values) can be translated to other models underpinning youth health in Aotearoa New Zealand like the Risk and Resilient model (Blum, 1998; Blum & Nelson-Mmari, 2003), and Te Whare Tapa Whā, an indigenous model designed by Durie (1985) for Māori health. This is in response to the uncovering of health issues and barriers including a lack of spiritual recognition and issues of structural racism, rather than implementing treatment strategies designed to 'fix' existing disorders among young people.

9.4.3 Embodied Belonging and Social Positioning

The participants surmised their health and wellbeing to be influenced by their social positioning within the Aotearoa New Zealand host society, where participants reported being treated as second class citizens. Being discriminated against and marginalised as young African Black migrant women often exacerbated the participants' structural and embodied vulnerability to suffering and jeopardised their integration in the community. This implies belonging is challenged by social factors such as ethnicity, migration status age, gender, class and race (Manderson, 2002; Mattes & Lang, 2021). For instance, employment has remained one key element for successful integration as it gives migrants sought-after economic emancipation (Kanengoni, 2020; Perumal, 2011; Statistics New Zealand, 2013a; Tuwe, 2018; United Nations Department of Economic and Social Affairs Population Division, 2017a), the lack of which has been reported by the participants to have ultimately informed differential access to societal resources and health determinants, in particular mental health outcomes as reported in a Aotearoa New Zealand study (Adelowo, 2012). The politics of belonging raises questions of citizenship, political rights, and the social entitlements and privileges of individuals and groups. Belonging, therefore, “whether at the level of the collective or the individual, is never free of dynamics of power” (Mattes & Lang, 2021, p. 302). The presence of such power dynamics affects young African migrant women who are caught between the present-day uncertainties of globalisation and coping with ascribed categories of social location which come along with their place or position in history and society. Therefore, further research is needed to capture structural factors such as blocked opportunities for minority migrant groups and the preferences of other ethnic groups in Aotearoa New Zealand to have a clear picture of health and social inequities amongst these groups (Ward & Masgoret, 2008). Other related potential areas of research are racial identities and how they may alter the embodied belonging of young African women’s response and vulnerability to discrimination (Polonsky, Renzaho, & Brijnath, 2011; Renzaho, 2007), in regard to which this study has already established a link between achieving health and wellbeing resilience as a buffer and the complexities of identity formation of migrant youth.

9.5 Contextualising Young African Women’s Healthcare Experiences

The study found disadvantages in being an ethnic minority in the utilisation of healthcare services. This section discusses how places of healthcare contribute to, and act on and enact embodiment, belonging and non-belonging as effects of: (1) unmet cultural and racial health needs; and (2) gene-culture and the embodied experience of disease. Here, the politics of racial biological markers aids stigma, bias, and the misdiagnosis of the otherwise excluded within the wider healthcare system.

9.5.1 Unmet Cultural Healthcare Needs

The participants viewed Aotearoa New Zealand’s healthcare structures and processes to be dominated by the cultural context of the Māori Indigenous people. The cultural differences inevitably cause friction and inequalities, as seen in this study when the participants expressed their inequitable access to healthcare services, when compared to the Māori and Pākehā, to include a non-ethnic inclusive health workforce, a leadership and governance which lack political will and an understanding of migrant health and, resultantly, an under-performing health information system which influences resource allocation for African ethnic minority (Kanengoni et al., 2020).

Findings showed the participants' illness had their varying aetiologies, oftentimes moulded to fit into a biomedical view of disease, where services of medically managed outcomes are predicated (Kleinman, 1978). This finding corroborates the study of Napier et al. (2014), which demonstrated the continuous medicalisation of illness to limit the role and expression of people's cultural beliefs within the context of their communities and their natural and normal responses to their illness experience. Participants confronted with such situations became compelled to fall back on their ethnic communities, online searches, home remedies, and backdoor services, potentially resulting in significant under-representation in healthcare utilisation among immigrants (Degrie et al., 2017; Lattof, Coast, & Leone, 2018; Puchner et al., 2018). This systematic disregard of the pivotal role of culture in all aspects of health and healthcare enables and legitimises structures of (dis)advantage based on culture or visible difference which were found to instigate stigma, implicit bias and misdiagnosis by doctors, leading participants to feel a sense of not being vulnerable enough, of not belonging, and thus not deserving of care. The embodied effect of non-belonging emerges and consists of somatic and psychological pain and distress which are worsened by delayed healthcare, deteriorated health conditions, and self-exclusion in an already exclusionary health system. This determinant in observable health inequalities among this population also violates concepts of social justice. Further research to identify what could make the healthcare culturally competent/safe and enable trust building congruent for young African migrant women is urgently needed and is consistent with other studies among Māori and Pasifika (Came et al., 2019; Harris et al., 2013; Sheridan et al., 2011; Teevale, Denny, Percival, et al., 2013). The overall implication, as also observed by Napier et al. (2014), is that health professionals can only be culturally competent if they are aware of the influence of professional or cultural elitism in contributing to cultural ignorance, and when and how they can learn to use the social capital of patients, families, and communities to achieve measurable clinical results.

9.5.2 Gene-Culture and Embodied Experience of Disease

Unawareness by western doctors of susceptibility of African women to certain diseases like uterine fibroids, in comparison to other ethnic groups (Medikare et al., 2011; Stewart et al., 2013), or their different responsiveness to certain medications reinforced cultural and racial biological markers to dominate the participants’ understanding of illnesses, aetiology, and treatment. Though there remains a paucity of studies on the ways in which people have responded to the broad changes that colonialism has wrought on bodies, there are studies that support societal norms of racism, class inequalities, sexual division of labour and the demographic equilibrium of women of different races that affect exposure, infection, illness and how treatment has changed the physical, mental and the genetic constitution of African bodies (Foucault, 1975; Halloran, 2019; Krieger, 1987, 2005; Manderson, 2002; Wilson & Grim, 1991), and been collectively transmitted from one generation to the other through time and space (Halloran, 2019). The stories the participants’ bodies tell about dissimilarities in biological characteristics across the Aotearoa New Zealand female populations encourage further research on what might be different about the young African migrant women’s societal settings that, in turn, is voiced in their bodily characteristics.

Further, racial biological differences can be construed in light of persistent disparities in healthcare and the exploitation of race as a biological variable to further racism. The clinical algorithm used for kidney analysis and treatment is one such example. Diao et al. (2021) found kidney treatment done through computing kidney function according to race resultantly reduced the proportion of Black patients’ eligibility for the kidney treatment. These findings are inconclusive; however, the struggle to interpret and apply the continuous but unclear and ever-changing messages that race is important to clinical practice reveals the uncertainty of using race as a basis for clinical decision-making. Various theories about illness will continue to emerge and become more familiar as their merits are studied. For instance, this study has established the bodies of these young women participants are products of behavioural, social, technological, and historical settings; and these can interact with a specific pathology towards enacting a disease as reported by Argentieri (2018). This study, therefore, recommends further research that explores embodied activities as a means of identifying and clinically addressing enactments of social inequality and disease. This allows going beyond a merely biologically deterministic way of understanding disease, while still allowing an understanding of how physiological states themselves are key to the embodied experience of disease.

9.6 Limitations

There are obvious weaknesses in this thesis, implying that the inferences and generalisability of findings obtained from this research may not be applicable to all young African migrant women in Aotearoa New Zealand. First, I aimed to arrive at results that could be transferred to young African women in Aotearoa New Zealand, but this cannot be the case as more than half of the participants did not fully participate in the research study. Moreover, the length of residence of the participants in Aotearoa New Zealand at the time of the data collection varied, ranging from 9 to 20 years, gave an important subjective sensitising touch to their experiences during their attempts at cultural assimilation in the host country. The small number of participants and the snowballing sampling method used to recruit some participants from the same circle may potentially introduce biases, yet the sampling methods had positive recruitment effects for this study. It has already been established that working with young African women coming from the same circle yields rich data due to mistrust issues not being a concern, as opposed to participants who responses were limited when they were in storytelling circles with ‘strangers’. This is consistent with some other studies (Kanengoni, 2020). However, the problem of representativeness or non-responses did not affect the study findings, recommendations, and conclusions. For instance, the participants collectively explained the crux of their health and wellbeing as cultural and spiritual, and the manifestation of their identities as a young woman, as Christian or Muslim, and as a Black African migrant within other intersections of their social, physical, mental, sexual, and biological contexts. These findings are consistent with existing studies (Ajima & Ubana, 2018; Ani, 2013; Arrey et al., 2016; Asare & Danquah, 2017; Ngara, 2007; Omonzejele, 2008)

Also, the issue of social desirability bias affects the content of the findings as participants avoided responses that had implications of stigma or shame. The study aimed to research interactions/encounters with youth health services, yet the findings provide data on generic and mainstream healthcare service delivery. Although measures were taken to reduce bias (e.g., self-reflexivity), I am aware that my interpretation of participants' behaviour, my values, beliefs, experiences, and interests still made me liable to some subjectivity, especially where I was under the impression that I was working with a racialised minority group. This process of 'identification with participants' could result from my own experience as a young African immigrant woman. Following from this was the default role of leadership placed on me as opposed to the participants being co-researchers, as the participants did not initiate strategies to engage and implement. In this case, I may have swayed the participants into a course of action that may not have aligned to their aspirations. In the same light, the methodological shortcoming witnessed in this study need to be addressed in future research.

This study recognises the primacy of Māori as the Indigenous people of Aotearoa and recognises the obligations which necessitate careful attention to ethnic health inequities facing this community, and the urgency for proactive measures (Marriott & Sim, 2014). That said, the relationship between African migrant communities and Māori are still unfolding as the local African community grows. This is an under-researched area that needs further development and is beyond the scope of this study. It is another limitation of this study that this solidarity was not more deeply explored.

Despite these inadequacies, the findings gathered have provided sufficient and novel results and scope for recommendations for improvements in future research, decolonising methodologies, migrant youth health development, and clinical practice.

9.7 General recommendations

The results from this thesis have theoretical, practical, and policy implications. First, though there is an ongoing debate on African philosophy and the application of its tenets in research, the findings of this study contend there are alternative ways of knowing that constitute a valid knowledge system to better understand health behaviours and health outcomes among non-western societies. Although some of the study findings are similar to the health experiences of other ethnic minority groups, such as Māori and Pasifika, what is particularly informative and novel is the revelation that religion and spirituality—a significant part of culture—with resilience embedded, forms a religion-cultural-resilience mix as the basis for interpreting their life worlds. The overall African perception of their life worlds consequently informed agency and capital and influenced healthcare-seeking behaviours and the particular ways they perceive and interpret health and wellbeing need to be addressed by health policy makers. The study findings therefore suggest the importance of an integrative healthcare model which encompasses spirituality and cultural identity within formal healthcare systems to underscore the existing biomedical approach as noted earlier in this chapter. Cultural identities and the reshaping of these, as characterised by their location in a health context before migration, were found to be important in delivering healthcare, as reported by other studies (Helman, 2007; Kanengoni, 2020; Napier et al., 2014). Hence, faith-based leaders can be partnered with as health guides/navigators to assist faith-based healthcare service users in taking up medical care in times of ill health. This recommendation is in support of other studies showing health interventions are more effective in culturally sensitive environments (Babatunde-Sowole et al., 2016; Isaac et al., 2016; Selman et al., 2018; WHO, 1998). Emphasis should also be on the education of postgraduate and undergraduate health professionals and interprofessional workers, especially youth mental and sexual health nurses, social workers, and youth workers, to ensure delivery of culturally safe and meaningful and religiously oriented appropriate healthcare services. This includes recruiting African health professionals, who bring to the forefront the visibility of intersectionality and the importance of religion and gender in social care.

Further to this is a recommendation for the government to recognise cultural contexts and beliefs which provide a deeper revelation when measured against important factors like gender when assessing healthcare-seeking behaviours. This recommendation aims to integrate already present informal treatment alternatives, which can be identified among African migrants and other ethnic groups, into the formal healthcare system and to ensure health equity is applied to African communities and extended to other ethnic minority immigrants. If this recommendation is implemented, the consequence is positive equitable health outcomes for all. To accomplish this, funding for research is needed on African migrant health within a cross-cultural space which will allow working definitions for the concepts like, for example, ‘spirituality’ and ‘resilience’ to be developed so as to be applicable to

Westerners and non-Westerners alike. It also requires political will to appropriate funding in practice to offer training in medical anthropology for medical nurses, allied health professionals, physiotherapists (etc.) as opposed to offering it as a speciality course. This addresses the clinical significance of how western clinicians mould the explanation of a patient's condition to make it fit a biomedical view of disease which assumes diseases as abnormalities in the structure and function of body organs and systems (Helman, 2007; Kleinman, 1978), in addition to diagnosing through a culturally stereotypical lens. It also considers the gene-culture healthcare embodiment which found the human body to be socially constructed; in other words, shaped through societal norms of racism, sexism, and class inequalities and other cultural practices that change the physical, mental, and genetic constitution of African bodies experienced in the days of slavery (Krieger, 1987; Wilson & Grim, 1991). This recommendation should be treated as highly important because the study findings demonstrate racial or ethnic groups are susceptible to certain diseases or respond differently to certain medications, reinforcing the need for different treatment for Africans from other ethnicities (Medikare et al., 2011; Stewart et al., 2013). This integrative approach is in line with the call of the 2030 Agenda for Sustainable Development to **"Leave No One Behind"**, where governments are encouraged to integrate the health needs of migrants into national plans, policies, and strategies across sectors and global perspectives of health and wellbeing.

The study also acknowledges Te Tiriti o Waitangi and the Crown partnership which strives for equitable outcomes for all citizens; yet, in doing so, the government fails to ensure equity for all. The consequence becomes a lack of a culturally diverse workforce in healthcare and the limited use of healthcare facilities, which has been already established in this study. To achieve equity, one main area the participants needed to see change is ethnic recognition and correct classification as echoed by other studies (Kanengoni et al., 2020; Perumal, 2011). This can be done by acknowledging Africans as population group in Aotearoa New Zealand and to include them in all healthcare service decision-making processes to achieve health for all, to provide for policy and direction on investment changes to make visible the unique health needs of African youth populations. The current system of ethnic and racial categorisation is in some sense 'not correct', with each not adequately capturing the complexity of a given population. Effective classification and measurement of the ethnic and racial identities of census respondents will support the setting up and accurate targeting of well-resourced support structures within Health New Zealand for planning, funding, service commissioning and the delivery of services for African communities. This is a key part of 21st century healthcare and efforts to achieve equitable health outcomes based on common good for all (Miramontes et al., 2015; Pottie et al., 2017).

On the methodological front, although this study recognises the shortcomings of applying some tenets of African knowledge systems, in particular the act of collectively working together to produce knowledge, the findings still recommend collectivism in gathering knowledge. This stance allows an understanding of the role of participants' perceived 'identity', individually or collectively shaped by their racial and cultural experience. For example, the participants were confronted with the possibilities of what should be and what could be, to support equalities related to emancipation and social transformation. Working collectively opened lines of inquiry regarding experiences with day-to-day discrimination, as well as on the roles of immigration policies in shaping immigrant health outcomes. These findings formulate policies characterised by the spirit of equity, social justice, and fairness in achieving equitable health outcomes for African migrant women and other racialised ethnic communities.

9.8 Conclusion

The aim of this study was to explore young African women's experiences, insights, ideas, and aspirations to inform youth healthcare services, policies and strategies to the betterment of their health and wellbeing. The conclusion drawn from this study is that participants have unique, idiosyncratic ways of understanding their health and wellbeing, which justify consequent health-seeking behaviours often in contrast to the expectations of youth health policy makers and programmers in Aotearoa New Zealand. The concept of health and wellbeing is a broad, multi-faceted and complex construct, and has specific meanings for different cultures, ethnicities, ages, genders and immigrant statuses. This study's finding provides an evidence-based definition of health and wellbeing for young African migrant women to combat a 'one-size-fits-all' definition which has implications for the design of a model of care for this group. The study also unearthed different social factors operating concurrently which, therefore, account for a dimension of non/belonging and its effects on the domain of health, illness, and healthcare delivery for migrants. For example, embodied non-belonging has been reported by the participants to ultimately inform differential access to societal resources and health determinants. The body engages actively and meaningfully with its environment in ways that derive from both a range of racial discourses and other cultural practices and representations. These concurrently shape people’s biological/genetic make-up and bodily presentation.

The study was also concerned with the identification and implementation of study design approaches and methodologies which are cultural safe. The decolonising theoretical framework governed by African epistemology put to the centre the participants’ positioning as females, as racialised ethnic minority group, and their experiences and culture which they themselves report as being applicable to and inclusive of their needs. Yet, the assumptions, beliefs, and attitudes of African epistemology used to frame the decolonising process and the identification of decolonising strategies within the scope of this research were not culturally appropriate and neither did they provide a safe space to explore the healthcare aspirations of the young African women migrants. The findings offer potent insights into values and ethical standards that promote inclusion, long-term participation, and collaboration, such as building trust amongst the participants and connection with the researcher, and working in small groups, possibly from the same social circle.

REFERENCES

Abbas, R., Bhatia, A., Kanengoni-Nyatara, B., Mpofu, C., Holroyd, E., Wong, G., . . . Jalili-Moghaddam, S. (2022). Why migrant and refugee women and children remain in the shadows of health reforms in New Zealand. *The Conversation*. Retrieved from https://theconversation.com/why-migrant-and-refugee-women-and-children-remain-in-the-shadows-of-health-reforms-in-new-zealand-186902. [Accessed 18 0ctober 2022]

Achebe, C. (1958). *Things fall apart*. London: Heinemann

Adelowo, A. (2012). *The adjustment of African women living in New Zealand: A narrative study*. Auckland University of Technology, Auckland. Retrieved from http://aut.researchgateway.ac.nz/bitstream/handle/10292/4601/AdelowoA.pdf?sequence=3&isAllowed=y

Adelowo, A., Smythe, L., & Nakhid, C. (2016). Deciding to migrate: Stories of African immigrant women living in New Zealand. *Aotearoa New Zealand Social Work Review, 28*(1), 52-59.

Adeyemo, O. F., & Enuku, C. A. (2014). Effectiveness of midwives' service scheme in the reduction of maternal and child mortality rate, Edo state, Nigeria. *West Africal Journal of Nursing, 25*(2), 27-36.

African Union. (2006). African Youth Charter. Retrieved from https://au.int/sites/default/files/treaties/7789-treaty-0033_-_african_youth_charter_e.pdf

Agu, J., Lobo, R., Crawford, G., & Chigwada, B. (2016). Migrant Sexual Health Help-Seeking and Experiences of Stigmatization and Discrimination in Perth, Western Australia: Exploring Barriers and Enablers. *International Journal of Environmental Research and Public Health, 13*(5), 485. https://doi.org/10.3390/ijerph13050485

Ahmed, S. M., & Palermo, A. S. (2010). Community engagement in research: frameworks for education and peer review. *American Journal of Public Health, 100*(8), 1380-1387. https://doi.org/10.2105/AJPH.2009.178137

Ahuriri-Driscoll, A., Lovell, S., Te Kawa, D., Te Ata o Tū McDonald, L., & Mathias, K. (2022). The future of Māori health is here – The 2022 Aotearoa New Zealand health reforms. *The Lancet Regional Health - Western Pacific, 28*, 100589. https://doi.org/https://doi.org/10.1016/j.lanwpc.2022.100589

Aina, O. F. (2004). Mental illness and cultural issues in West African films: implications for orthodox psychiatric practice. *Medical Humanities, 30*(1), 23-26. https://doi.org/10.1136/jmh.2003.000152

Airoboman, F. A., & Asekhauno, A. A. (2012). Is there an 'African' epistemology? *JORIND, 10* (3).

Ajima, O. M., & Ubana, E. U. (2018). The Concept of Health and Wholeness in Traditional African Religion and Social Medicine. *Arts Social Science Journal, 9*(388), 1-5. https://doi.org/10.4172/2151-6200.1000388

Akhtar, S. S., Heydon, S., & Norris, P. (2022). Access to the healthcare system: Experiences and perspectives of Pakistani immigrant mothers in New Zealand. *Journal of Migration and Health, 5*, 100077. https://doi.org/https://doi.org/10.1016/j.jmh.2021.100077

Akoorie, N. (2017). Waikato Hospital intern doctors stressed with overwork, understaffing and limited leave. *New Zealand Herald*. Retrieved from https://healthcentral.nz/waikato-hospital-intern-doctors-stressed-with-overwork-understaffing-and-limited-leave/

Allotey, P., Manderson, L., Baho, S., & Demian, L. (2004). Reproductive health for resettling refugee and migrant women. *Health issues, 78*, 12-17.

Allotey, P., Manderson, L., & Grover, S. (2001). The politics of female genital surgery in displaced communities. *Critical Public Health, 11*(3), 189-201. https://doi.org/10.1080/09581590110066649

Ameratunga, S., Tin Tin, S., Rasanathan, K., Robinson, E., & Watson, P. (2008). Use of health care by young Asian New Zealanders: findings from a national youth health survey. *Journal of Paediatrics and Child Health, 44*(11), 636-641.

Amuyunzu-Nyamongo, M. (2013). The social and cultural aspects of mental health in African societies. In *Commonwealth Health Partnerships 2013* (pp. 59-63): Commonwealth Secretariat. Retrieved from http://www.commonwealthhealth.org/wp-content/uploads/2013/07/The-social-and-cultural-aspects-of-mental-health-in-African-societies_CHP13.pdf

Ani, N. C. (2013). Appraisal of African epistemology in the global system. *Alternation, 20*(1), 295-320.

Anyanwu, K. C. (1983). *The African experience in the American market place a scaring indictment of western scholars and their distortion of African culture*. New York: Exposition Press.

Anyanwu, K. C. (1989). The problem of method in African philosophy. In *The substance of African Philosophy*. Washington D.C: Brooking Institute.

Argentieri, M. A. (2018). Embodiment and Ontologies of Inequality in Medicine: Towards an Integrative Understanding of Disease and Health Disparities. . *Body & Society, 24(3), 125–152. , 24*(3), 125-152. https://doi.org/https://doi.org/10.1177/1357034X17746468

Arrey, A. E., Bilsen, J., Lacor, P., & Deschepper, R. (2016). Spirituality/Religiosity: A Cultural and Psychological Resource among Sub-Saharan African Migrant Women with HIV/AIDS in Belgium. *PloS One, 11*(7), e0159488. https://doi.org/https://doi.org/10.1371/journal.pone.0159488

Asare, M., & Danquah, S. A. (2017). The African belief system and the patient's choice of treatment from existing health models: The case of Ghana. *Acta Psychopathol, 3*(4), 49.

Assari, S., Moazen-Zadeh, E., Caldwell, C. H., & Zimmerman, M. A. (2017). Racial Discrimination during Adolescence Predicts Mental Health Deterioration in Adulthood: Gender Differences among Blacks. *Frontiers in Public Health, 5*(104). https://doi.org/10.3389/fpubh.2017.00104

Auckland District Health Board. (2010). *Youth Health Improvement Plan Youth Health Improvement Plan 2010-2014. Enhancing health and well-being for young people in Auckland District Health Board*. Wellington. Retrieved from http://www.adhb.health.nz/assets/Documents/About-Us/Planning-documents/Youth-Health-Plan-2010.pdf

Australian Bureau of Statistics. (2019). Australian Standard Classification of Cultural and Ethnic Groups. Retrieved from https://www.abs.gov.au/statistics/classifications/australian-standard-classification-cultural-and-ethnic-groups-ascceg/latest-release

Babatunde-Sowole, O., DiGiacomo, M., Power, T., Davidson, P. M., & Jackson, D. (2020). Resilience of African migrant women: Implications for mental health practice. *International Journal of Mental Health Nursing, 29*(1), 92-101. https://doi.org/https://doi.org/10.1111/inm.12663

Babatunde-Sowole, O., Power, T., Jackson, D., Davidson, P. M., & DiGiacomo, M. (2016). Resilience of African migrants: An integrative review. *Health Care for Women International, 37*(9), 946-963. https://doi.org/10.1080/07399332.2016.1158263

Banks-Wallace, J. (1998). Emancipatory potential of storytelling in a group. *The Journal of nursing scholarship, 30 1*, 17-21.

Bartholomew, N. (2013). Culturally and Linguistically Diverse Populations and Health in Canterbury. Retrieved from https://www.pegasus.health.nz/wp-content/uploads/2018/05/Culturally-and-linguistically-diverse-populations-in-health.pdf

Baruah, T. D. (2012). Effectiveness of Social Media as a tool of communication and its potential for technology enabled connections: A micro-level study. *International Journal of Scientific and Research Publications, 2*(5).

Bassey, M. O. (2007). What Is Africana Critical Theory or Black Existential Philosophy? *Journal of Black Studies, 37*(6), 914-935. https://doi.org/10.1177/0021934705285563

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health, 60*(10), 854-857. https://doi.org/10.1136/jech.2004.028662

Beaglehole, A. (2013). *Refuge New Zealand: a nation's response to refugees and asylum seekers*. Dunedin: University of Otago Press.

Bécares, L., Cormack, D., & Harris, R. (2013). Ethnic density and area deprivation: Neighbourhood effects on Māori health and racial discrimination in Aotearoa/New Zealand. *Social Science and Medicine, 88*, 76-82. https://doi.org/https://doi.org/10.1016/j.socscimed.2013.04.007

Bergold, J., & Thomas, S. (2012). Participatory research methods: A methodological approach in motion. *Forum: Qualitative Social Research, 13*(1), 30.

Bernal, D. D. (2002). Critical Race Theory, Latino Critical Theory, and Critical Raced-Gendered Epistemologies: Recognizing Students of Color as Holders and Creators of Knowledge. *Qualitative Inquiry, 8*(1), 105-126.

Bhopal, R. S. (2006). The public health agenda and minority ethnic health: a reflection on priorities. *Journal of the Royal Society of Medicine, 99*(2), 58-61. https://doi.org/10.1258/jrsm.99.2.58

Bivens, D. (2005). What is internalized racism. *Flipping the script: White privilege and community building*, 43-51.

Blum, R. W. (1998). Healthy Youth Development as a Model for Youth Health Promotion. *Journal of Adolescent Health, 22*, 368-375.

Blum, R. W., & Nelson-Mmari, K. (2003). The health of young people in a global context. *Journal of Adolescent Health, 35*(5), 402-418. https://doi.org/10.1016/j.jadohealth.2003.10.007

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2016). Young people from culturally diverse backgrounds and their use of services for sexual and reproductive health needs: a structured scoping review. *Sexual Health, 13*(1), 1-9. https://doi.org/10.1071/SH15090

Botfield, R. J., Newman, E. C., Kang, M., & Zwi, A. B. (2018). Talking to migrant and refugee young people about sexual health. *Australian Journal for General Practitioners, 47*, 564-569.

Botha, L. (2012). Mixing methods as a process towards Indigenous methodologies. *International Journal of Social Research Methodology, 14*(4), 313–325. https://doi.org/https://doi.org/10.1080/13645579.2010.516644

Bradby, H., Lindenmeyer, A., Phillimore, J., Padilla, B., & Brand, T. (2020). 'If there were doctors who could understand our problems, I would already be better': dissatisfactory health care and marginalisation in superdiverse neighbourhoods. *Socioloy of Health and Illness, 42*(4), 739-757. https://doi.org/10.1111/1467-9566.13061

Brennen, B. (2012). *Qualitative Research Methods for Media Studies*: Taylor & Francis. Retrieved from https://books.google.co.nz/books?id=lTHbCgAAQBAJ

Brown, L. M., & Gilligan, C. (1992). *Meeting at the crossroads: Women's psychology and girls' development* [doi:10.4159/harvard.9780674731837]. Cambridge, MA, US: Harvard University Press. https://doi.org/10.4159/harvard.9780674731837

Buntu, B. O. (2013). Claiming self: The role of Afrikology in social transformation. *Scriptura, 112*(1), 1-12.

Burns, E., Fenwick, J., Schmied, V., & Sheehan, A. (2012). Reflexivity in midwifery research: The insider/outsider debate. *Midwifery, 28*(1), 52-60.

Cabinet Office. (2019). *Te Tiriti o Waitangi/ Treaty of Waitangi guidance*. Retrieved from https://dpmc.govt.nz/sites/default/files/2019-10/CO%2019%20%285%29%20Treaty%20of%20Waitangi%20Guidance%20for%20Agencies.pdf

Callahan, D. (1973). The WHO definition of 'health'. *The Hastings Center Studies, 1*(3), 77-87.

Callister, P. (2011). The Construction of Ethnicity and 'Belonging' in New Zealand: Where We Have Come From and Where We Might be Going. *The Journal of New Zealand Studies*(10). https://doi.org/https://doi.org/10.26686/jnzs.v0i10.156

Came, H. (2014). Sites of institutional racism in public health policy making in New Zealand. *Social Science and Medicine, 106*, 214-220.

Came, H., Doole, C., & McKenna, B. (2018). Institutional racism in public health contracting: Findings of a nationwide survey from New Zealand. *Social Science and Medicine, 199*, 132-139.

Came, H., McCreanor, T., Manson, L., & Nuku, K. (2019). Upholding Te Tiriti, ending institutional racism and Crown inaction on health equity. *New Zealand Medical Journal, 132*(1492), 7846.

Cassim, S., Kidd, J., Ali, M., Abdul, H. N., Jamil, D., Keenan, R., . . . Lawrenson, R. (2022). 'Look, wait, I'll translate': refugee women's experiences with interpreters in healthcare in Aotearoa New Zealand. *Australian Journal of Primary Health, 28*(4), 296-302. https://doi.org/10.1071/py21256

Cayir, E., Felder, T. M., Nkwonta, C. A., Jackson, J. R., & Dawson, R. (2022). Discovering New Connections: Insights From Individual and Collective Reflexivity in a Mixed Methods Study. *International Journal of Qualitative Methods, 21*.

Chadderton, C. (2012). Problematising the role of the white researcher in social justice research. *Ethnography and Education, 7*(3), 363-380. https://doi.org/10.1080/17457823.2012.717203

Chauraya, E. (2012). The African view on gender and its impact on implemented gender policies and programs in Africa. *Journal of Sustainable Development in Africa, 14*(3).

Chester, J., & Montgomery, K. (2008). Interactive food and beverage marketing: Targeting children and youth in the digital age. Retrieved from http://www.bmsg.org/resources/publications/interactive-food-beverage-marketing-targeting-children-and-youth-in-the-digital-age-brief-report/

Chile, L. M. (2002). The imported underclass: Poverty and social exclusion of black African refugees in Aotearoa New Zealand *Asia Pacific Viewpoint, 43*(3), 355-366.

Chilisa, B. (2012). *Indigenous Research Methodologies*. Thousand Oaks: Sage.

Chilisa, B., Major, T. E., & Khudu-Petersen, K. (2017). Community engagement with a postcolonial, African-based relational paradigm. *Qualitative Research, 17*(3), 326-339. https://doi.org/10.1177/1468794117696176

Chin, M. H., King, P. T., Jones, R. G., Jones, B., Ameratunga, S. N., Muramatsu, N., & Derrett, S. (2018). Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. *Health Policy, 122*(8), 837-853. https://doi.org/https://doi.org/10.1016/j.healthpol.2018.05.001

Chinyowa, K. C. (2001). The Sarungano and Shona Storytelling: an African Theatrical Paradigm. *Studies in Theatre and Performance, 21*, 18 - 30.

Christou, A., & Mavroudi, E. (Eds.). (2016). *Dismantling Diasporas: Rethinking the Geographies of Diasporic Identity, Connection and Development* (1st ed.): Routledge. Retrieved from https://doi.org/10.4324/9781315577586

Chukwuneke, F. N., Ezeonu, C. T., Onyire, B. N., & Ezeonu, P. O. (2012). Culture and biomedical care in Africa: the influence of culture on biomedical care in a traditional African society, Nigeria, West Africa. *Nigerian Journal of Medicine, 21*(3), 331-333.

Clark, T. C., Crengle, S., Sheridan, J., Rowe, D., & Robinson, E. (2014). Factors associated with consistent contraception and condom use among Māori secondary school students in New Zealand. *Journal of Paediatrics and Child Health, 50*(4), 258-265. https://doi.org/10.1111/jpc.12450

Clark, T. C., Robinson, E., Crengle, S., Fleming, T., Ameratunga, S., Denny, S., . . . Saewyc, E. (2011). Risk and protective factors for suicide attempt among indigenous Maori youth in New Zealand: The role of family connection as a moderating variable. *Journal of Aboriginal Health, 7*(1), 16-31.

Clark, T. C., Robinson, E., Crengle, S., Sheridan, J., Jackson, N., & Ameratunga, S. (2013). Binge drinking among Maori secondary school students in New

Zealand: associations with source, exposure and perceptions of alcohol use. *New Zealand Medical Journal, 126*(1370), 55-69.

Counties Manukau Health. (2019). *Annual report 2019*. Auckland: Countie Manukau District Health Board. Retrieved from https://countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/Annual-reports-and-plans/2019_CM_Health_Annual_Report.pdf

Crea, T. M., Lopez, A., Hasson, R. G., Evans, K., Palleschi, C., & Underwood, D. (2018). Unaccompanied immigrant children in long term foster care: Identifying needs and best practices from a child welfare perspective. *Children and Youth Services Review*. https://doi.org/10.1016/j.childyouth.2017.12.017

Creese, G. (2014). Gender, Generation and Identities in Vancouver's African Diaspora. *African Diaspora, 6*(2), 155-178. https://doi.org/https://doi.org/10.1163/18725457-12341245

Cumming, J. (2017). New Zealand's health service performs well, but inequities remain high. Retrieved from https://theconversation.com/new-zealands-health-service-performs-well-but-inequities-remain-high-82648

de Leon Siantz, M. (2013). Feminization of migration: a global health challenge. *Global advances in health and medicine, 2*(5), 12-14. https://doi.org/10.7453/gahmj.2013.065

Dedding, C., Goedhart, N. S., Broerse, J. E. W., & Abma, T. A. (2020). Exploring the boundaries of 'good' Participatory Action Research in times of increasing popularity: dealing with constraints in local policy for digital inclusion. *Educational Action Research*, 1-17. https://doi.org/10.1080/09650792.2020.1743733

Degrie, L., Gastmans, C., Mahieu, L., Dierckx de Casterlé, B., & Denier, Y. (2017). "How do ethnic minority patients experience the intercultural care encounter in hospitals? a systematic review of qualitative research". *BMC Medical Ethics, 18*(1), 2-2. https://doi.org/10.1186/s12910-016-0163-8

Department of the Prime Minister and Cabinet. (2019). *Child and youth wellbeing strategy*. Wellington. Retrieved from https://childyouthwellbeing.govt.nz/sites/default/files/2019-08/child-youth-wellbeing-strategy-2019.pdf

Diao, J. A., Wu, G. J., Taylor, H. A., Tucker, J. K., Powe, N. R., Kohane, I. S., & Manrai, A. K. (2021). Clinical Implications of Removing Race From Estimates of Kidney Function. *JAMA, 325*(2), 184-186. https://doi.org/10.1001/jama.2020.22124

Dodge, R., Daly, A. P., Huyton, J., & Sanders, L. D. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing, 2*(3).

Dooris, M., Farrier, A., & Froggett, L. (2018). Wellbeing: the challenge of 'operationalising'an holistic concept within a reductionist public health programme. *Perspectives in public health, 138*(2), 93-99.

Douglas, J., & Watson, N. (2013). Resistance, resilience and renewal: the health and well-being of black women in the Atlantic Diaspora – developing an intersectional approaach. *Critical Public Health, 23*(1), 1-5. https://doi.org/10.1080/09581596.2013.760724

Drawson, A. S., Toombs, E., & Mushquash, C. J. (2017). Indigenous Research Methods: A Systematic Review. . *The International Indigenous Policy Journal, 8*(2). https://doi.org/10.18584/iipj.2017.8.2.5

Dumount, J., & Lafortune, G. (2017). International migration of doctors and nurses to OECD countries: recent trends and policy implications In J. Buchan, I. S. Dhillon, & J. Campbell (Eds.), *Health Employment and Economic Growth: An Evidence Base*. Retrieved from https://www.who.int/hrh/resources/WHO-HLC-Report_web.pdf?ua=1

Dune, T., & Mapedzahama, V. (2017). Culture Clash: Shona (Zimbabwean) Migrant Women's Experiences with Communicating about Sexual Health and Wellbeing across Cultures and Generations. *African Journal of Reproductive Health, 21*(1), 18-29.

Dune, T., Perz, J., Mengesha, Z., & Ayika, D. (2017). Culture Clash? Investigating constructions of sexual and reproductive health from the perspective of 1.5 generation migrants in Australia using Q methodology. *Reproductive Health, 14*, 1-13. https://doi.org/10.1186/s12978-017-0310-9

Durie, M. H. (1985). A Maori perspective of health. *Social Science and Medicine, 20*(5), 483-486.

Edwards, S., McCreanor, T., & Moewaka-Barnes, H. (2007). Maori family culture: A context of youth development in Counties/Manukau. *Kōtuitui: New Zealand Journal of Social Sciences Online, 2*(1), 1-15. https://doi.org/10.1080/1177083X.2007.9522420

Elamin, W., & Mason-Jones, A. J. (2020). Female Genital Mutilation/Cutting: A Systematic Review and Meta-Ethnography Exploring Women's Views of Why It Exists and Persists. *International Journal of Sexual Health, 32*(1), 1-21.

Elshahat, S., Moffat, T., & Newbold, K. B. (2021). Understanding the Healthy Immigrant Effect in the Context of Mental Health Challenges: A Systematic Critical Review. *J Immigr Minor Health, 22*, 1-16. https://doi.org/10.1007/s10903-021-01313-5

Ewuoso, C. (2021). An African Relational Approach to Healthcare and Big Data Challenges. *Science and engineering ethics, 27*(3), 34-34. https://doi.org/10.1007/s11948-021-00313-w

Femdal, I., & Solbjør, M. (2018). Equality and differences: group interaction in mixed focus groups of users and professionals discussing power. *Society, Health & Vulnerability, 9*(1), 1447193. https://doi.org/10.1080/20021518.2018.1447193

Field, J., McClunie-Trust, P., Kearney, C., & Jeffcoat, J. (2020). Language and communication: A vital component of health for people with refugee backgrounds. *Kai Tiaki Nursing Research, 11*(1), 42-49.

Flahaux, M., & De Haas, H. (2016). African migration: trends, patterns, drivers. *Comparative Migration Studies, 4*(1), 1. https://doi.org/10.1186/s40878-015-0015-6

Fleming, T., & Elvidge, T. (2010). *Youth health services literature review. A rapid review of: School based health services, community based youth specific health services & General Practice health care for young people*: Waitemata District Health Board. Retrieved from http://www.waitematadhb.govt.nz/assets/Documents/service-planning/YouthhealthliteraturereviewFlemingElvidge2010.pdf

Fleury, A. (2016). Understanding women and migration: A literature review. *Global Knowledge Partnership on Migration and Development Working Paper, 8*.

Flynn, B. C. (1987). Foucault and the body politic. *Man and World, 20*(1), 65-84. https://doi.org/10.1007/BF01248633

Foucault, M. (1966). *The Order of Things. An archaeology of the human sciences*. Retrieved from https://is.muni.cz/el/1423/jaro2013/SOC911/um/Michel_Foucault_The_Order_of_Things.pdf

Foucault, M. (1975). *The Birth of the Clinic: An Archaeology of Medical Perception*: Vintage Books.

Frakking, T., Michaels, S., Orbell-Smith, J., & Le Ray, L. (2020). Framework for patient, family-centred care within an Australian Community Hospital: development and description. *BMJ Open Qual, 9*(2). https://doi.org/10.1136/bmjoq-2019-000823

Franks, T. M. (2016). Purpose, Practice, and (Discovery) Process: When Self-Reflection Is the Method. *Qualitative Inquiry 22*(1), 47-50.

Fregonese, F. (2018). Community involvement in biomedical research conducted in the global health context; what can be done to make it really matter? *BMC Medical Ethics, 19*(1), 44. Fregonese2018. https://doi.org/10.1186/s12910-018-0283-4

Fusch, P., Fusch, G. E., & Ness, L. R. (2018). Denzin's paradigm shift: Revisiting triangulation in qualitative research. *Journal of social change, 10*(1), 2.

Gallo, A., Weijer, C., & White, A. e. a. (2012). What is the role and authority of gatekeepers in cluster randomized trials in health research? *Trials, 13*(116). https://doi.org/https://doi.org/10.1186/1745-6215-13-116

Gattario, K. H., Frisén, A., Teall, T. L., & Piran, N. (2020). Embodiment: Cultural and gender differences and associations with life satisfaction. *Body Image, 35*, 1-10. https://doi.org/https://doi.org/10.1016/j.bodyim.2020.07.005

Geia, L. K., Hayes, B., & Usher, K. (2013). Yarning/Aboriginal storytelling: Towards an understanding of an Indigenous perspective and its implications for research practice. *Contemporary Nurse, 46*(1), 13-17. https://doi.org/10.5172/conu.2013.46.1.13

Gibson, P., & Abrams, L. (2003). Racial difference in engaging, recruiting, and interviewing African American women in qualitative research. *Qualitative Social Work, 2*(4), 457-476.

Glaser, B. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Global Migration Group. (2014). *Migration and Youth: Challenges and Opportunities*: UN. Retrieved from http://www.globalmigrationgroup.org/migrationandyouth

Gomez, M. A. (2013). Africans, Religion, and African Religion through the Nineteenth Century. *Journal of Africana Religions, 1*(1), 78-90. https://doi.org/10.5325/jafrireli.1.1.0078

Gooder, C. (2017). *Immigration, ethnic diversity and cities: A literature review for Auckland Council.* . Auckland: Auckland Council.

Goodyear-Smith, F., & Ashton, T. (2019). New Zealand health system: universalism struggles with persisting inequities. *Lancet, 3*(394), 432-442. https://doi.org/10.1016/S0140-6736(19)31238-3

Grossman, J. M., Lynch, A. D., Richer, A. M., DeSouza, L. M., & Ceder, I. (2019). Extended-Family Talk about Sex and Teen Sexual Behavior. *International Journal of Environmental Research and Public Health, 16*(3). https://doi.org/10.3390/ijerph16030480

Grossman, J. M., Richer, A., Charmaraman, L., Ceder, I., & Erkut, S. (2018). Youth Perspectives on Sexuality Communication With Parents and Extended Family. *Family relations, 67*(3), 368-380. https://doi.org/10.1111/fare.12313

Groth, S. W. (2010). Honorarium or coercion: use of incentives for participants in clinical research. *The Journal of the New York State Nurses' Association, 41*(1), 11-22.

Halcomb, E. J., Gholizadeh, L., DiGiacomo, M., Phillips, J., & Davidson, P. M. (2007). Literature review: considerations in undertaking focus group research with culturally and linguistically diverse groups. *Journal of Clinical Nursing, 16*(6), 1000-1011.

Halloran, M. J. (2019). African American Health and Posttraumatic Slave Syndrome: A Terror Management Theory Account. *Journal of Black Studies, 50*(1), 45-65. https://doi.org/10.1177/0021934718803737

Harding, S. G. (1987). *Feminism and methodology: Social science issues*: Indiana University Press.

Harris, L., & Watson-Vandiver, M. J. (2020). Decolonizing Race and Gender Intersectionality in Education: A Collaborative Critical Autoethnography of Hope, Healing and Justice. *Journal of Cultural Analysis and Social Change, 5*(2), 9.

Harris, R., Cormack, D., Tobias, M., Yeh, L., Talamaivao, N., Minster, J., & Timutimu, R. (2012a). The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Social Science and Medicine, 74*(3), 408-415. https://doi.org/https://doi.org/10.1016/j.socscimed.2011.11.004

Harris, R., Cormack, D., Tobias, M., Yeh, L., Talamaivao, N., Minster, J., & Timutimu, R. (2012b). Self-reported experience of racial discrimination and health care use in New Zealand: results from the 2006/07 New Zealand Health Survey. *American Journal of Public Health, 102*(5), 1012-1019. https://doi.org/10.2105/AJPH.2011.300626

Harris, R., Stanley, J., & Cormack, D. M. (2018). Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. *PloS One, 13*(5), e0196476. https://doi.org/10.1371/journal.pone.0196476

Harris, R. B., Cormack, D. M., & Stanley, J. (2013). The relationship between socially-assigned ethnicity, health and experience of racial discrimination for Māori: analysis of the 2006/07 New Zealand Health Survey. *BMC Public Health, 13*(1), 844. Harris2013. https://doi.org/10.1186/1471-2458-13-844

Harrison, R., Walton, M., Chauhan, A., Manias, E., Chitkara, U., Latanik, M., & Leone, D. (2019). What is the role of cultural competence in ethnic minority consumer engagement? An analysis in community healthcare. *International*

Journal for Equity in Health, 18(1), 191. https://doi.org/10.1186/s12939-019-1104-1

Harttgen, K., & Klasen, S. (2009). Well-being of migrant children and migrant youth in Europe. *Ibero America Institute for Economic Research, Discussion papers, 181*. Retrieved from https://www.econstor.eu/bitstream/10419/57328/1/608775002.pdf

Haustein, J., & Tomalin, E. (2021). Religion, populism, and the politics of the Sustainable Development Goals. *Social Policy and Society, 20*(2), 296-309.

Hawkey, A. J., Ussher, J. M., & Perz, J. (2021). What do women want? Migrant and refugee women's preferences for the delivery of sexual and reproductive healthcare and information. *Ethnicity and Health*. https://doi.org/10.1080/13557858.2021.1980772

Hawthorne, L. (2014). A comparison of skilled migration policy: Australia, Canada and New Zealand. *Canada and New Zealand (October 16, 2014)*.

Health Central. (2018). Overseas doctors frustrated they can't relieve GP shortage. Retrieved from https://healthcentral.nz/overseas-doctors-frustrated-they-cant-relieve-gp-shortage/

Healy, H. I., & Murphy, T. (2012). *Ngāpuhi speaks*. Network Waitangi Whangarei: Te Kawariki.

Hegel, G. W. F. (1956). *The philosophy of history*. New York: Dover.

Helman, C. (2007). *Culture, Health and Illness* (5th ed.). London: CRC Press. https://doi.org/https://doi.org/10.1201/b13281

Hensher, M., Price, M., & Adomakoh, S. (2006). Referral Hospitals. In D. T. Jamison, J. G. Breman, A. R. Measham, & e. al. (Eds.), *Disease Control Priorities in Developing Countries* (2nd Edition ed., pp. 1229-1244). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK11737/

Hesse-Biber (Ed.). (2012). *The Handbook of Feminist Research. Theory and Praxis* (2nd ed.). Thousand Oaks: Sage.

Higgs, P. (2010). Towards an indigenous African epistemology of community in education research. *Procedia Social and Behavioral Sciences, 2*(2010), 2414-2421.

Hofstede Insights. (2017). *The six dimensions of national culture. Hofstede Insights:*. Retrieved from https://www.hofstede-insights.com/country-comparison/new-zealand/

Holzer, J. K., Ellis, L., & Merritt, M. W. (2014). Why we need community engagement in medical research. *Journal of investigative medicine : the official publication of the American Federation for Clinical Research, 62*(6), 851-855. https://doi.org/10.1097/JIM.0000000000000097

Huddleston, T., Bilgili, O., Joki, A., & Vankova, Z. (2015). Migrant Integration Policy Index 2015. Retrieved from http://www.mipex.eu/new-zealand

Human Rights Commission. (2010). Human Rights 2010: Te Mana i Waitangi. *Rights for specific refugees*. Retrieved from https://www.hrc.co.nz/files/3914/2388/0522/HRNZ_10_rights_of_refugees.pdf

Ikpe, I. B. (2010). Rationalities and Clustering in African Philosophy. *Caribbean Journal of Philosophy, 2*(1).

Imafidon, E. (2018). Is the African Feminist Moral Epistemology of Care Fractured? *Synthesis Philosophica, 33*(1), 165-177. https://doi.org/10.21464/sp33110

Immigration New Zealand. (2017). *New Zealand Immigration Statistics*. Retrieved from http://www.migrationstats.com/nz/home

International Migration Outlook. (2015). Changing patterns in the international migration of doctors and nurses to OECD countries. In. Retrieved from https://www.oecd-ilibrary.org/docserver/migr_outlook-2015-6-en.pdf?expires=1554798690&id=id&accname=ocid41012844&checksum=BD8BA8B9B6026AF4F00ED0C84B01DC0C. https://doi.org/https://dx.doi.org/10.1787/migr_outlook-2015-6-en

International Migration Settlement and Employment Dynamics. (2011). *Competing for Skills: Migration policie and trends in New Zealand and Australia.* . Wellington

International Organisation For Migration. (2014). *Global migration trends: An overview*. Geneva: Migration Research Division, IOM.

International Organisation For Migration. (2017). *Migration in the 2030 agenda*. Geneva: International Organisation For Migration. Retrieved from https://www.iom.int/sites/default/files/about-iom/gender/Migration-in-the-2030-Agenda-SDGs-Achieving-Gender-Equality-through-Migration-Governance.pdf

International Organisation For Migration. (2018). *World Migrant Report 2018*. Switzerland: International Organisation For Migration.

International Organisation for Migration. (2019). *Key Migration Terms*. Retrieved 22 January 2019, from https://www.iom.int/key-migration-terms

International Organization for Migration. (2018). Social Determinants of Migrant Health. Retrieved from https://www.iom.int/social-determinants-migrant-health

International Organization for Migration. (2020). Social determinants of migrant health. Retrieved from https://www.iom.int/social-determinants-migrant-health

Isaac, K. S., Hay, J. L., & Lubetkin, E. I. (2016). Incorporating Spirituality in Primary Care. *Journal of religion and health, 55*(3), 1065-1077. https://doi.org/10.1007/s10943-016-0190-2

Issop Migration Working Group. (2018). ISSOP position statement on migrant child health. *Child: Care, Health and Development, 44*(1), 161-170. https://doi.org/10.1111/cch.12485

Jadad, A. R., & O'grady, L. (2008). How should health be defined? *British Medical Journal, 337*, 1363–1364.

Jaki, S. L. (2000). *The Limits of the Limitless Science*. Delaware: ISI Books.

Januszka, C. M., Lora, A. C., Wollard, K. K., & Rocco, T. S. (2013). Investigating race and ethnicity on data collection and analysis.

Jayan, P., & Dutta, M. J. (2021). Nobody cares about us: COVID-19 and voices of refugees from Aotearoa New Zealand. *Communication Research and Practice, 7*(4), 361-378. https://doi.org/10.1080/22041451.2021.1994686

Ji, M., Taibi, M., & Crezee, I. H. (Eds.). (2019). *Multicultural health translation, interpreting and communication.*: Routledge.

Johnson, R. (2009). *South Africa's brave new world: The beloved country since the end of apartheid*: Abrams Press.

Jolly, S., & Reeves, H. (2005). Gender and Migration Cutting Edge Pack: Overview report. Retrieved from https://archive.ids.ac.uk/bridge/bridge-publications/cutting-edge-packs/gender-and-migration.html

Kanengoni, B. (2020). Promoting the Health and Wellbeing of Young African Female Migrants Through Participation and Collaboration: Points to Consider in Knowledge Production With Ethnic Minority Populations. *SAGE Research Methods Cases: medicine and health*, 1-15. https://doi.org/https://dx.doi.org/10.4135/9781529741308

Kanengoni, B., Andajani-Sutjahjo, S., & Holroyd, E. (2018). Setting the stage: reviewing current knowledge on the health of New Zealand immigrants—an integrative review. *PeerJ, 6*(e5184). https://doi.org/https://doi.org/10.7717/peerj.5184

Kanengoni, B., Andajani-Sutjahjo, S., & Holroyd, E. (2020). Improving health equity among the African ethnic minority through health system strengthening: a narrative review of the New Zealand healthcare system. *International Journal for Equity in Health, 19*(1), 21. https://doi.org/10.1186/s12939-020-1125-9

Kaphagawani, D. N., & Malherbe, J. G. (1998). African epistemology. In P. H. Coetzee & A. J. P. Roux (Eds.), *Philosophy from Africa: a text with readings* (pp. 205): Routledge.

Kaunda-Khangamwa, B. N., Kapwata, P., Malisita, K., Munthali, A. C., Chipeta, E., Phiri, S. P., & Manderson, L. (2020). Adolescents living with HIV, complex needs and resilience in Blantyre, Malawi. *AIDS Research and Therapy, 17*.

Kawulich, B. (2005). Participant observation as a data collection method. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 6(2). doi:http://dx.doi.org/10.17169/fqs-6.2.466. *Forum: Qualitative Social Research, 6*(2). https://doi.org/doi:http://dx.doi.org/10.17169/fqs-6.2.466

Kee, J. W. Y., Khoo, H. S., Lim, I., & Koh, M. Y. H. (2018). Communication Skills in Patient-Doctor Interactions: Learning from Patient Complaints. *Health Professions Education, 4*(2), 97-106. https://doi.org/https://doi.org/10.1016/j.hpe.2017.03.006

Kennedy, J., Kim, H., Moran, S., & McKinlay, E. (2021). Qualitative experiences of primary health care and social care professionals with refugee-like migrants and former quota refugees in New Zealand. *Australian Journal of Primary Health, 27*(5), 391-396. https://doi.org/10.1071/PY20285

Kennedy, M. (2016). Putting our refuge hand up. *New Zealand International Review, 41*(5), 13.

Kerstetter, K. (2012). Insider, outsider, or somewhere in between: The impact of researchers’ identities on the community-based research process. *Journal of Rural Social Sciences, 27*(2), 99-117.

King, A., & Hoppe, R. B. (2013). "Best practice" for patient-centered communication: a narrative review. *Journal of Graduate Medical Education, 5*(3), 385-393. https://doi.org/10.4300/JGME-D-13-00072.1

Kisembo, B., Magesa, L., & Shorter, A. (1998). *African Christian Marriage*. Nairobi: Paulines Publications.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88*(2), 251-258. https://doi.org/10.7326/0003-4819-88-2-251

Kleinman, A. M. (1977). Depression, somatization and the "new cross-cultural psychiatry". *Social Science Medicine, 11*(1), 3-10. https://doi.org/10.1016/0037-7856(77)90138-x

Konadu, K. (2008). Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and Encounters with (Medical) Anthropology. *African Studies Quarterly 10*(2&3), 45-69.

Kovacha, M. (2010). Conversational Method in Indigenous Research. *First Peoples Child Family Review, 5*(1).

Krieger, N. (1987). Shades of difference: theoretical underpinnings of the medical controversy on black/white differences in the United States, 1830-1870. *International Journal of Health Services, 17*(2), 259-278. https://doi.org/10.2190/dby6-vdq8-hme8-me3r

Krieger, N. (2005). Embodiment: a conceptual glossary for epidemiology Journal of Epidemiology & Community Health. *Journal of Epidemiology & Community Health 59*, 350-355

Krupp, J., & Hodder, R. (2017). The New New Zealanders: Why migrants make good kiwis. Retrieved from https://www.nzinitiative.org.nz/reports-and-media/reports/the-new-new-zealanders/document/489

Kubota, R. (2019). Confronting Epistemological Racism, Decolonizing Scholarly Knowledge: Race and Gender in Applied Linguistics. *Applied Linguistics, 41*(5), 712-732. https://doi.org/10.1093/applin/amz033

Kukutai, T. (2004). The Problem of Defining an Ethnic Group for Public Policy: Who is Māori and Why Does it Matter? *Social Policy Journal of New Zealand*(23).

Kuzel, A. (Ed.). (1992). *Sampling in qualitative inquiry*. Newbury Park, CA: Sage.

Lattof, S. R., Coast, E., & Leone, T. (2018). Priorities and challenges accessing health care among female migrants. *Health services insights, 11*, 1178632918804825-1178632918804825. https://doi.org/10.1177/1178632918804825

Lavallée, L. F. (2009). Practical Application of an Indigenous Research Framework and Two Qualitative Indigenous Research Methods: Sharing Circles and Anishnaabe Symbol-Based Reflection. *International Journal of Qualitative Methods, 8*(1), 21-40. https://doi.org/10.1177/160940690900800103

Le Espiritu, Y. (2001). " We don't sleep around like white girls do": Family, culture, and gender in Filipina American lives. *Signs: Journal of Women in Culture and Society, 26*(2), 415-440.

Le Grange, L. (2001). Challenges for participatory action research and indigenous knowledge in Africa. *Acta Academica, 33*(3), 136-150.

Liamputtong, P. (2010). *Performing qualitative cross-cultural research*. Cambridge University Press.: Cambridge University Press.

Lorenzo, D. (2008). Current Applications. *Current Anthropology, 49*(6), 961. https://doi.org/10.1086/592443

Macdonald, A., & Worthington, R. (2012). The Role of Clinical Ethics in the Health Care System of New Zealand. Retrieved from https://www.hqsc.govt.nz/assets/Other-Topics/QS-challenge-reports/Clinical-Ethics-Network-Final-Report.pdf

Mahajan, R. (2015). Use of social media as a new investigative tool in marketing research for small business. *International Journal of e-Education, e-Business, e-Management and e-Learning, 5*(3), 129-135. https://doi.org/10.17706/ijeeee.2015.5.3.129-135

Mahohoma, T. (2020). Experiencing the Sacred. *Studia Historiae Ecclesiasticae, 46*, 1-17.

Mahony, C., Marlowe, J., Humpage, L., & Baird, N. (2017). Aspirational yet precarious: compliance of New Zealand refugee settlement policy with international human rights obligations. *International Journal of Migration and Border Studies, 3*(1), 5-23.

Manderson, L. (2002). *Sickness and the state : health and illness in colonial Malaya, 1870-1940*. Cambridge: Cambridge University Press.

Manderson, L., Cartwright, E., & Hardon, A. (2016). *The Routledge Handbook of medical anthropology*: Routledge.

Marlowe, J., Bartley, A., & Hibtit, A. (2014). The New Zealand Refugee Resettlement Strategy: implications for identity, acculturation and civic participation. *Kōtuitui: New Zealand Journal of Social Sciences, 9*(2), 60-69.

Marriott, L., & Sim, D. (2014). *Indicators of inequality for Māori and Pacific people. [Working paper 09/2014]. Victoria University*.

Mash, B. (2014). African primary care research: participatory action research. *African journal of primary health care & family medicine, 6*(1), E1-E5. https://doi.org/10.4102/phcfm.v6i1.585

Mashau, T. S., Kone, L. R., & Mutshaeni, H. N. (2015). Diversity in Africa: A Cause for Disunity? *Journal of Sociology and Social Anthropology, 6*(2), 235-245. https://doi.org/10.1080/09766634.2015.11885663

Mattes, D., & Lang, C. (2021). Embodied Belonging: In/exclusion, Health Care, and Well-Being in a World in Motion. *Culture, Medicine and Psychiatry, 45*(1), 2-21. https://doi.org/10.1007/s11013-020-09693-3

Mazrui, A. A. (1963). On the Concept of "We are all Africans". *American Political Science Review, 57*(1), 88-97. https://doi.org/10.2307/1952721

Mbiti, J. S. (1969). *The concept of God in Africa*. London: S.P.C.K.

Mbiti, J. S. (1975). *Introduction to African Religion*. Nairobi: East African Educational Publishers, Ltd.

Mbiti, J. S. (1990). *African religions & philosophy*: Heinemann.

McClure, M. (2016). 'Auckland region', Te Ara - the Encyclopedia of New Zealand. Retrieved from http://www.TeAra.govt.nz/en/auckland-region/print (accessed 12 November 2018)

McDougal, S. (2014). Africana Studies' Epistemic Identity: An Analysis of Theory and Epistemology in the Discipline. *Journal of African American Studies, 18*(2), 236-250. https://doi.org/http://www.jstor.org/stable/43525547

McKinlay, E., Morgan, S., Garrett, S., Dunlop, A., & Pullon, S. (2021). Young peoples' perspectives about care in a youth-friendly general practice. *Journal of Primary Health Care, 13*(2), 157-164.

McLintock, A. H. (1966). *'The Colombo Plan', from An Encyclopaedia of New Zealand, Te Ara - the Encyclopedia of New Zealand*. Retrieved from URL:

http://www.TeAra.govt.nz/en/1966/international-relations/page-4 (accessed 21 Jan 2019)

Medikare, V., Kandukuri, L. R., Ananthapur, V., Deenadayal, M., & Nallari, P. (2011). The genetic bases of uterine fibroids; a review. *Journal of reproduction & infertility, 12*(3), 181-191.

Meiring, T., Kannemeyer, C., & Potgieter, E. (2018). The gap between rich and poor: South African society's biggest divide depends on where you think you fit in.

Michael, A. G. (2013). Africans, Religion, and African Religion through the Nineteenth Century. *Journal of Africana Religions, 1*(1), 78-90. https://doi.org/10.5325/jafrireli.1.1.0078

Minister of Health. (2016). *New Zealand Health Strategy: Future direction*. Wellington: Minister of Health.

Ministry of Business Innovation and Employment. (2017a). *Migrant Youth: New to New Zealand – A statistical profile, 2001 to 2016* Wellington. Retrieved from https://www.mbie.govt.nz/dmsdocument/2836-migrant-youth-statistical-profile-pdf

Ministry of Business Innovation and Employment. (2017b). *The settlement outcome of migrant groups: A bibliography of New Zealand and international literature*. Retrieved from http://www.mbie.govt.nz/info-services/immigration/migration-research-and-evaluation/documents-and-images/settlement-outcomes-of-migrant-youth.pdf

Ministry of Business Innovation and Employment. (2017c). *Settling in New Zealand: Migrants' perceptions of their experience. 2015 Migrant survey*. Retrieved from http://www.mbie.govt.nz/publications-research/research/migrants---monitoring/migrant-survey-report-2015.pdf

Ministry of Business Innovation and Employment. (2019). *Building and keeping a health workforce*. Wellington: New Zealand Government. Retrieved from https://www.immigration.govt.nz/about-us/media-centre/newsletters/settlement-actionz/actionz3/building-and-keeping-a-health-workforce

Ministry of Business Innovation and Employment. (2021). *Settling in New Zealand: Migrant Survey Trends from 2015 to 2019*. Retrieved from https://www.mbie.govt.nz/dmsdocument/14729-settling-in-new-zealand-migrant-survey-trends-from-2015-to-2019

Ministry of Health. (2002). *Youth Health. A guide to action*. Wellington, New Zealand: Ministry of Health. Retrieved from https://www.health.govt.nz/system/files/documents/publications/youth-healthguidetoaction.pdf

Ministry of Health. (2006). *Asian Health Chart Book.* Wellington: Ministry of Health.

Ministry of Health. (2016). *Health of the Health Workforce*. Wellington. Retrieved from https://www.health.govt.nz/system/files/documents/publications/health-of-health-workforce-2015-feb16_0.pdf

Ministry of Health. (2017a). Annual Data Explorer 2016/17: New Zealand Health Survey. Retrieved from https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-update

Ministry of Health. (2017b). Children and Young People Living Well and Staying Well: New Zealand Childhood Obesity Programme Baseline Report 2016/17.

Ministry of Health. (2018). *Services for children and young people. School and pre school health services. Additional school based health services. Tier level three service specification*. Wellington, New Zealand: Author.

Ministry of Social Development. (2002). New Zealand's Agenda for Children. Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/planning-strategy/agenda-children/agendaforchildren.pdf

Ministry of Social Development. (2008). *Diverse Communities – Exploring the Migrant and Refugee Experience in New Zealand* Wellington. Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/diverse-communities-migrant-experience/migrant-experience-report.pdf

Ministry of Social Development. (2016). The profile of Pacific peoples in New Zealand. Retrieved from https://www.pasefikaproud.co.nz/assets/Resources-for-download/PasefikaProudResource-Pacific-peoples-paper.pdf

Ministry of Youth Affairs. (2002). *Youth Development strategy*. Wellington, New Zealand: Ministry of Youth Affairs. Retrieved from http://www.myd.govt.nz/documents/resources-and-reports/publications/youth-development-strategy-aotearoa/ydsa.pdf

Ministry of Youth Development. (2009). *Structured Youth Development Programmes: A Review of Evidence*. Wellington: Ministry of Youth Development. Retrieved from https://www.youthpolicy.org/national/New_Zealand_2009_Youth_Programme_Review.pdf

Mkhwanazi, N. (2016). Medical Anthropology in Africa: The Trouble with a Single Story. *Medical Anthropology, 35*(2), 193-202. https://doi.org/10.1080/01459740.2015.1100612

Mlambo, D., & Mpanza, S. (2019). Emerging determinants of youth migration from an Afrocentric perspective. *African Renaissance, 16*, 273-288. https://doi.org/https://doi.org/10.31920/2516-5305/2019/v16n1a14

Montoya, I. P. (2008). Gender-Based Discrimination as a Trigger for Cultural Hybridity in Tsitsi Dangarembga’s Nervous Conditions*Servizo de Publicacións.* Symposium conducted at the meeting of the Proceedings from the 31st AEDEAN Conference:[electronic resource]

Mortensen, A. (2007). *Review of Migrant and Refugee Regional and National Health Needs Assessment*. Retrieved from http://www.ecald.com/assets/Resources/Review-of-Migrant-and-Refugee-Regional-and-National-HNA.pdf

Mortensen, A. (2010). Cultural safety: does the theory work in practice for culturally and linguistically diverse groups? *Nursing Praxis in New Zealand, 26*(3), 6-16.

Mortensen, A. (2011a). MELAA Report Summary. *Nursing Praxis in New Zealand, 27*(1).

Mortensen, A. (2011b). Public health system responsiveness to refugee groups in new zealand: Activation from the bottom up *Social Policy Journal of New Zealand*(37), 1-12.

Mortensen, A., Lim, S., & Puddle, S. (2018). Pre and Post CALD Training Evaluation Study. . Retrieved from https://www.ecald.com/assets/Resources/Assets/2018-05-1-Final-eCALD-Survey-2018.pdf

Moyo, F. L. (2004). Religion, Spirituality and Being a Woman in Africa: Gender Construction within the African Religio-Cultural Experiences. *Agenda: Empowering Women for Gender Equity*(61), 72-78.

Mugumbate, J., & Nyanguru, A. (2013). Exploring African philosophy: The value of ubuntu in social work. *African Journal of Social Work, 3*(182-100).

Murdoch, S. (2017). Refugee resettlement and activism in New Zealand. *Forced Migration Review*. Retrieved from http://www.fmreview.org/resettlement/stephens.html

Mwanri, L., & Mude, W. (2021). Alcohol, Other Drugs Use and Mental Health among African Migrant Youths in South Australia. . *Int. J. Environ. Res. Public Health 18*(1534). https://doi.org/https://doi.org/10.3390/ijerph18041534

Nakhid, C. (2018). The coping strategies and responses of African youth in New Zealand to their encounters with the police. *Journal of Ethnicity in Criminal Justice, 16*(1), 40-56. https://doi.org/10.1080/15377938.2017.1413609

Nakhid, C., Azanaw, L., Essuman, K., Ghebremichael, N., Mukuhi Kimata Kamau, M., Kayitesi, T., . . . Puni, E. (2016). *African Youth. Experience with the Police and New Zealand Justice System*. Retrieved from http://www.communityresearch.org.nz/wp-content/uploads/formidable/African-youth-Experiences-with-the-police-and-New-Zealand-justice-system-Final-Report-March-2016-Nakhid-et-al.pdf

Napier, A. D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., . . . al., e. (2014). Culture and health. *The Lancet, 384*(9954), 1607-1639. https://doi.org/https://doi.org/10.1016/S0140-6736(14)61603-2

Neale, J. (2016). Iterative categorization (IC): a systematic technique for analysing qualitative data. *Addiction, 111*(6), 1096-1106. https://doi.org/10.1111/add.13314

New Zealand AIDS Foundation. (n.d.). *African Community*. Retrieved from https://www.nzaf.org.nz/services-programmes/your-community/african/

New Zealand Productivity Commission. (2021). *Impacts of immigration on the labour market and productivity. [NZPC Working paper No. 2021/05]. NZPC.* Retrieved from www.productivity.govt.nz/immigration-labour

Ngara, C. (2007). African Ways of Knowing and Pedagogy Revisited. *Journal of Contemporary Issues in Education, 2*(2), 7-20. https://doi.org/10.20355/C5301M

Nicholls, R. (2009). Research and Indigenous participation: critical reflexive methods. *International Journal of Social Research Methodology, 12*(2), 117-126. https://doi.org/10.1080/13645570902727698

Nichols, A. L., & Cottrell, C. A. (2014). What do people desire in their leaders? The role of leadership level on trait desirability. *The Leadership Quarterly, 25*(4), 711-729.

Nkomazana, F., & Setume, S. D. (2016). Missionary colonial mentality and the expansion of Christianity in Bechuanaland Protectorate, 1800 to 1900. *Journal for the Study of Religion, 29*, 29-55.

Nkulu-N'Sengha, M. (2005). *Encyclopedia of Black Studies*. Retrieved from https://omnilogos.com/african-epistemology/

Noble, H., & Heale, R. (2019). Triangulation in research, with examples (Vol. 22, pp. 67-68): Royal College of Nursing.

Nolan, B. (2009). *Promoting the well-being of immigrant youth*. presented at the meeting of the Paper for Jacobs Foundation Conference on The Potential of Immigrant Youth, Marbach.

Nwankwo, C. (2006). African Literature and the Woman: The Imagined Reality as a Strategy of Dissidence. *Meridians, 6*(2), 195-208.

Nyashanu, M., & Serrant, L. (2016). Engaging black sub-Saharan African communities and their gatekeepers in HIV prevention programs: Challenges and strategies from England. *Family Medicine and Community Health, 4*, 22-29. https://doi.org/10.15212/FMCH.2016.0130

O'Neil, J. D. (1989). The Cultural and Political Context of Patient Dissatisfaction in Cross-Cultural Clinical Encounters: A Canadian Inuit Study. *Medical Anthropology Quarterly, 3*, 325-344.

Obasi, C. (2012). Negotiating the insider/outsider continua: A Black female hearing perspective on research with deaf women and Black women. *Qualitative Research, 14*(1), 1-18.

Odukogbe, A. A., Afolabi, B. B., Bello, O. O., & Adeyanju, A. S. (2017). Female genital mutilation/cutting in Africa. *Translational Andrology and Urology, 6*(2), 138-148. https://doi.org/10.21037/tau.2016.12.01

OECD. (2019). Recent Trends in International Migration of Doctors, Nurses and Medical Students. Retrieved from https://doi.org/10.1787/5571ef48-en

Office of the Minister of Immigration. (2022). Three-year Refugee Quota Programme (2022/23 to 2024/25). Retrieved from https://www.mbie.govt.nz/dmsdocument/23331-three-year-refugee-quota-programme-2022-23-to-2024-25-proactiverelease-pdf

Ohm, F., Vogel, D., Sehner, S., Wijnen-Meijer, M., & Harendza, S. (2013). Details acquired from medical history and patients' experience of empathy--two sides of the same coin. *BMC Medical Education, 13*, 67-67. https://doi.org/10.1186/1472-6920-13-67

Omonzejele, P. F. (2008). African Concepts of Health, Disease, and Treatment: An Ethical Inquiry. *EXPLORE, 4*(2), 120-126. https://doi.org/https://doi.org/10.1016/j.explore.2007.12.001

Oruka, H. O. (1990). *Philosophy: Indigenous Thinkers and Modern Debate on African Philosophy*. Leiden: Brill

Outlaw, J., & Lucius, T. (Eds.). (2017). *The Stanford Encyclopedia of Philosophy*. Stanford University: Metaphysics Research Lab. Retrieved from https://plato.stanford.edu/archives/sum2017/entries/africana

Outlaw Jr, L. T., & Jeffers, C. (2017). The Stanford Encyclopedia of Philosophy. In E. N. Zalta (Ed.), *Africana Philosophy*. Stanford University: Metaphysics Research Lab, . Retrieved from https://plato.stanford.edu/archives/sum2017/entries/africana/

Oyewumi, O. (2002). Conceptualizing gender: The Eurocentric foundations of feminist concepts and the challenge of African epistemologies. *Jenda: A Journal of Culture and African Women Studies, 2*(1), 1-9.

Pain, R., & Francis, P. (2003). Reflections on Participatory Research. *Area, 35*(1), 46-54.

Palacios, J. F., Salem, B., Hodge, F. S., Albarrán, C. R., Anaebere, A., & Hayes-Bautista, T. M. (2015). Storytelling: A Qualitative Tool to Promote Health Among Vulnerable Populations. *Journal of Transcultural Nursing, 26*(4), 346-353. https://doi.org/10.1177/1043659614524253

Palaganas, E. C., Sanchez, M. C., Molintas, M. P., & Caricativo, R. D. (2017). Reflexivity in Qualitative Research: A journey of learning. *The Qualitative Report, 22*(2), 426-438.

Parackal, S., Ameratunga, S., Tin Tin, S., & Wong, S. T. (2011). *The health and wellbeing of secondary school students in New Zealand: Results for Chinese, Indian and other Asian Students*. Auckland: University of Auckland. Retrieved from https://researchspace.auckland.ac.nz/docs/uoa-docs/rights.htm

Park, C., Loy, J. H., Lillis, S., & Menkes, D. B. (2022). What stops Korean immigrants from accessing child and adolescent mental health services? *Child Adolesc Psychiatry Ment Health, 16*(1), 19. https://doi.org/10.1186/s13034-022-00455-0

Penrod, J., Preston, D. B., Cain, R. E., & Starks, M. T. (2003). A discussion of chain referral as a method of sampling hard-to-reach populations. *Journal of transcultural nursing : official journal of the Transcultural Nursing Society, 14*, 100-107.

Percheski, C., & Hargittai, E. (2011). Health information-seeking in the digital age. *Journal of American College Health, 59*(5), 379-386.

Perumal, L. (2011). *Health Needs Assessments for Middle East, Latin America and African people living in Auckland Region*. Auckland: Auckland District Health Board.

Petersen, M. J. (2020). Promoting Freedom of Religion or Belief and Gender Equality in The Context of The Sustainable Development Goals: A Focus on Access to Justice, Education and Health Reflections from The 2019 Expert Consultation Process.

Phillippi, J., & Lauderdale, J. (2017). A Guide to Field Notes for Qualitative Research: Context and Conversation. *Qualitative Health Research, 28*(3), 381-388. https://doi.org/10.1177/1049732317697102

Planning and Health Intelligence and Health Gain teams. (2019). *Auckland District Health Board health needs assessment* Auckland: Auckland District Health Board. Retrieved from https://www.adhb.health.nz/assets/Documents/About-Us/Planning-documents/ADHB-Health-Needs-Assessment-2017.pdf

Pollock, K. (2018). 'Child and youth health', Te Ara - the Encyclopedia of New Zealand. Retrieved from http://www.TeAra.govt.nz/en/child-and-youth-health/print (accessed 13 April 2021)

Story by Kerryn Pollock, published 5 May 2011, reviewed & revised 29 Nov 2018

Polonsky, M. J., Renzaho, A. M., & Brijnath, B. (2011). Barriers to blood donation in African communities in Australia: the role of home and host country culture and experience. *Transfusion, 51*(8), 1809-1819. https://doi.org/10.1111/j.1537-2995.2010.03053.x

Presbey, G. (2021). *African Philosophy and the Epistemic Marginalization of Women*

Priest, N., & Williams, D. R. (2018). Racial Discrimination and Racial Disparities in Health In B. Major, J. F. Dovidio, & B. G. Link (Eds.), *The Oxford Handbook of Stigma, Discrimination, and Health*. https://doi.org/10.1093/oxfordhb/9780190243470.013.7

Princewill, C. W., Jegede, A. S., Nordström, K., Lanre-Abass, B., & Elger, B. S. (2017). Factors Affecting Women's Autonomous Decision Making In Research Participation Amongst Yoruba Women Of Western Nigeria. *Developing World Bioethics, 17*(1), 40-49.

Public Health Association. (2007). *Generic competencies for public health in Aotearoa-New Zealand*: Ministry of Health. Retrieved from http://www.pha.org.nz/documents/GenericCompetenciesforPublicHealthMarch2007.pdf

Puchner, K., Karamagioli, E., Pikouli, A., Tsiamis, C., Kalogeropoulos, A., Kakalou, E., . . . Pikoulis, E. (2018). Time to rethink refugee and migrant health in Europe: moving from emergency response to integrated and individualized health care provision for migrants and refugees. *International Journal of Environmental Research and Public Health, 15*(6), 1100.

Puddifoot, K. (2019). Stereotyping patients. *Journal of Social Philosophy, 50*(1), 69-90. https://doi.org/10.1111/josp.12269

Rade, D. A., Crawford, G., Lobo, R., Gray, C., & Brown, G. (2018). Sexual Health Help-Seeking Behavior among Migrants from Sub-Saharan Africa and South East Asia living in High Income Countries: A Systematic Review. *International Journal of Environmental Research and Public Health, 15*(7). https://doi.org/10.3390/ijerph15071311

Rai, S. S., Peters, R. M. H., Syurina, E. V., Irwanto, I., Naniche, D., & Zweekhorst, M. B. M. (2020). Intersectionality and health-related stigma: insights from experiences of people living with stigmatized health conditions in Indonesia. *International journal for equity in health, 19*(1), 206-206. https://doi.org/10.1186/s12939-020-01318-w

Rasanathan, K., Ameratunga, S., Tin Tin, S., Robinson, E., Chen, J., Young, W., & Watson, P. D. (2008). Injury risk behaviours among young Asian New Zealanders: a national survey of secondary school students. *Australian and New Zealand Journal of Public Health, 32*(1), 66-72. https://doi.org/10.1111/j.1753-6405.2008.00168.x

Read, U. M. (2014). Medical anthropology and health inequalities in Africa: moving beyond culture. *Africa: The Journal of the International African Institute, 84*(3), 487-489.

Rechela, B., Mladovsky, P., & Devillée, W. (2012). Monitoring migrant health in Europe: A narrative review of data collection practices. *Health Policy, 105*, 10-16. https://doi.org/dx.doi.org/10.1016/j.healthpol.2012.01.003

Reiner, A. W. (2010). Literature review. Background paper for African Australians: A review of human rights and social inclusion issues Retrieved from https://www.humanrights.gov.au/sites/default/files/content/africanaus/papers/africanaus_literature_review.pdf

Remedios, J. D., & Snyder, S. H. (2018). Intersectional Oppression: Multiple Stigmatized Identities and Perceptions of Invisibility, Discrimination, and Stereotyping. *Journal of Social Issues, 74*(2), 265-281. https://doi.org/https://doi.org/10.1111/josi.12268

Renz, S. M., Carrington, J. M., & Badger, T. A. (2018). Two strategies for qualitative content analysis: An intramethod approach to triangulation. *Qualitative Health Research, 28*(5), 824-831.

Renzaho, A. (2007). *Providing Health Services to Migrants and Refugees Settling in Victoria, Australia: An Analysis of the Complexity, Cost and Policy Implications for Public Health* (Vol. 3). https://doi.org/10.1108/17479894200700021

Rezapour, N. R. (2018). Criteria of validity and reliability in qualitative research. *Journal of qualitative research in health sciences, 7*(4), 493-499.

Richard, L., Richardson, G., Jaye, C., & Stokes, T. (2019). Providing care to refugees through mainstream general practice in the southern health region of New Zealand: a qualitative study of primary healthcare professionals' perspectives. *BMJ Open, 9*(12), e034323. https://doi.org/10.1136/bmjopen-2019-034323

Rieger, K. L., Gazan, S., Bennett, M., Buss, M., Chudyk, A. M., Cook, L., . . . Schultz, A. S. H. (2020). Elevating the uses of storytelling approaches within Indigenous health research: a critical and participatory scoping review protocol involving Indigenous people and settlers. *Syst Rev, 9*(1), 257. https://doi.org/10.1186/s13643-020-01503-6

Rose, J., & Johnson, C. W. (2020). Contextualizing reliability and validity in qualitative research: toward more rigorous and trustworthy qualitative social science in leisure research. *Journal of Leisure Research, 51*(4), 432-451.

Rosen, L. T. (2021). Mapping out epistemic justice in the clinical space: using narrative techniques to affirm patients as knowers. *Philosophy, Ethics, and Humanities in Medicine, 16*(1), 9. https://doi.org/10.1186/s13010-021-00110-0

Ruch, E. A., & Anyanwu, K. C. (1984). *African Philosophy: An Introduction to the Main Philosophical Trends in Contemporary Africa*. Rome: Catholic Book Agency.

Rumbaut, R. G. (2004). Ages, Life Stages, and Generational Cohorts: Decomposing the Immigrant First and Second Generations in the United States. *International Migration Review, 38*(3), 1160-1205. https://doi.org/10.1111/j.1747-7379.2004.tb00232.x

Russell, E. (2018). South African GP with over 14 years' experience waits a year and a half to sit Kiwi medical exams. *New Zealand Herald*. Retrieved from https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12040593

Russell, M. L., Moralejo, D. G., & Burgess, E. D. (2000). Paying research subjects: participants' perspectives. *Journal of Medical Ethics, 26*(2), 126-130.

Saewyc, E., Clark, T. C., Barney, L., Brunanski, D., & Homma, Y. (2014). Enacted stigma and HIV risk behaviours among sexual minority Indigenous youth in Canada, New Zealand, and the United States. *A Journal of Aboriginal and Indigenous Community Health, 11*(3), 411-420.

Safekids Aotearoa. (2015). Child Unintentional Deaths and Injuries in New Zealand, and Prevention Strategies. Retrieved from https://www.moh.govt.nz/notebook/nbbooks.nsf/0/05ED778EE1B2C6D6CC257F4C007A779C/$file/Safekids%20Aotearoa%20Databook%20CIP%20NZ%20and%20Prevention%20Strategies.pdf

Said, A., Conn, C., & Nayar, S. (2018). New Zealand should intensify efforts to eliminate female genital mutilation by 2030: the views of women from communities that practice FGM/C. *Pacific Health, 1*(1), 1-7.

Sartourius, N. (2006). The meaning of health and its promotion. . *Croat Medicine Journal, 47*, 662-664.

Seehawer, M. K. (2018). Decolonising research in a Sub-Saharan African context: exploring Ubuntu as a foundation for research methodology, ethics and agenda. *International Journal of Social Research Methodology, 21*(4), 453-466. https://doi.org/10.1080/13645579.2018.1432404

Selman, L. E., Brighton, L. J., Sinclair, S., Karvinen, I., Egan, R., Speck, P., . . . Hope, J. (2018). Patients' and caregivers' needs, experiences, preferences and research priorities in spiritual care: A focus group study across nine countries. *Palliative Medicine, 32*(1), 216-230. https://doi.org/10.1177/0269216317734954

Senghor, L. S. (1964). *On African socialism*. London: Paul Mall Press.

Serrant-Green, L. (2011). The sound of 'silence': a framework for researching sensitive issues or marginalised perspectives in health. *Journal of Research in Nursing, 16*(4), 347-360. https://doi.org/10.1177/1744987110387741

Serrant, L. (2020). Silenced Knowing: An Intersectional Framework for Exploring Black Women's Health and Diasporic Identities. *Frontiers in Sociology, 5*(1). https://doi.org/10.3389/fsoc.2020.00001

Sfeatcu, R., Cernuşcă-Miţariu, M., Ionescu, C., Roman, M., Cernuşcă-Miţariu, S., Coldea, L., & Burcea, C. C. (2014). The concept of wellbeing in relation to health and quality of life. *European Journal of Science and Theology, 10*(4), 123-128.

Sharma, M. K., & Jain, S. (2013). Leadership management: Principles, models and theories *Global Journal of Management and Business Studies, 3*(3), 309-318.

Sheridan, N. F., Kenealy, T. W., Connolly, M. J., Mahony, F., Barber, P. A., Boyd, M. A., . . . Moffitt, A. (2011). Health equity in the New Zealand health care system: a national survey. *International Journal for Equity in Health, 10*(1), 45. https://doi.org/10.1186/1475-9276-10-45

Shrestha-Ranjit, J., Patterson, E., Manias, E., Payne, D., & Koziol-McLain, J. (2017). Effectiveness of Primary Health Care Services in Addressing Mental Health Needs of Minority Refugee Population in New Zealand. *Mental Health Nursing 38*(4).

Shrestha-Ranjit, J., Patterson, E., Manias, E., Payne, D., & Koziol-McLain, J. (2020). Accessibility and acceptability of health promotion services in New Zealand for minority refugee women. *Health Promotion International, 35*(6), 1484-1494. https://doi.org/10.1093/heapro/daaa010

Singer, M., & Baer, H. (2018). *Critical Medical Anthropology* Retrieved from https://doi.org/10.4324/9781315224862

Sium, A., & Ritskes, E. (2013). Speaking truth to power: Indigenous storytelling as an act of living resistance. *Decolonization: Indigeneity, Education & Society, 2*(1), I-X

Solano, G., & Huddleston, T. (2020). *Migrant Integration Policy Index 2020*. Barcelona/ Brussels: CIDOB and MPG. Retrieved from https://www.mipex.eu/new-zealand

Statistics New Zealand. (2013a). *The 2013 Census ethnic group profiles*. Wellington: Statistics New Zealand Retrieved from http://m.stats.govt.nz/Census/2013-census/profile-and-summary-reports/ethnic-profiles.aspx?request_value=24784&tabname=Age,%20sex

Statistics New Zealand. (2013b). *2013 Census Quick Stats about national highlights*. Wellington: Statistics New Zealand. Retrieved from www.stats.govt.nz.

Statistics New Zealand. (2013c). *Census QuickStats about culture and identity*. Retrieved from Retrieved from: http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstat s-culture-identity/languages.aspx

Statistics New Zealand. (2016). *New Zealand literature review of Māori groupings*. Wellington: Statistics New Zealand. Retrieved from http://infoshare.stats.govt.nz/methods/classifications-and-standards/current-classifications-and-standards-review/review-statistical-standard-iwi/nz-lit-review-maori-groupings/maori-identity.aspx#gsc.tab=0

Statistics New Zealand. (2018). *Census Ethnic group summaries: Africans*. Wellington. Retrieved from https://www.stats.govt.nz/tools/2018-census-ethnic-group-summaries/african

Stephens, M. (2017). Refugee resettlement and activism in New Zealand. *Forced Migration Review*(54), 43.

Stewart, E. A., Nicholson, W. K., Bradley, L., & Borah, B. J. (2013). The burden of uterine fibroids for African-American women: results of a national survey. *Journal of Women's Health, 22*(10), 807-816. https://doi.org/10.1089/jwh.2013.4334

Suárez-Orozco, C., & Qin, D. B. (2006). Gendered Perspectives in Psychology: Immigrant Origin Youth. *International Migration Review, 40*(1), 165-198. https://doi.org/10.1111/j.1747-7379.2006.00007.x

Tam, V., Edge, J. S., & Hoffman, S. J. (2016). Empirically evaluating the WHO global code of practice on the international recruitment of health personnel’s impact on four high-income countries four years after adoption. *Globalization and Health, 12*(1), 62. https://doi.org/10.1186/s12992-016-0198-0

Teevale, T., Chi-Lun Lee, A., Tiatia-Seath, J., Clark, T. C., Denny, S., Bullen, P., . . . Peiris-John, R. J. (2016). Risk and Protective Factors for Suicidal Behaviors Among Pacific Youth in New Zealand. *Crisis, 37*(5), 335-346. https://doi.org/10.1027/0227-5910/a000396

Teevale, T., Denny, S., Nosa, V., & Sheridan, J. (2013). Predictors of cigarette use amongst Pacific youth in New Zealand. *Harm Reduction Journal, 10*(1), 25. Teevale2013. https://doi.org/10.1186/1477-7517-10-25

Teevale, T., Denny, S., Percival, T., & Fleming, T. (2013). Pacific secondary school students' access to primary health care in New Zealand. *The New Zealand Medical Journal, 126*(1375).

Teevale, T., Robinson, E., Duffy, S., Utter, J., Nosa, V., Clark, T., . . . Ameratunga, S. (2012). Binge drinking and alcohol related behaviours amongst Pacific youth: a national survey of secondary school students. *New Zealand Medical Journal, 125*(1325), 60-70.

Thabede, D. (2014). The African worldview as the basis of practice in the helping professions. *2014, 44*(3). https://doi.org/10.15270/44-3-237

The Institute of Environmental Science and Research Ltd. (2018). *Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2015*. Porirua, New Zealand Retrieved from https://surv.esr.cri.nz/PDF_surveillance/STISurvRpt/2015/FINAL2015AnnualSTIReport.pdf

The UN Refugee Agency. (1951). Convention and Protocol relating to the Status of Refugees. Retrieved from https://www.unhcr.org/3b66c2aa10.html

Thomas, R. (2018). Foreign doctors struggling to get jobs in New Zealand. *Stuff*. Retrieved from https://www.stuff.co.nz/national/health/103932802/foreign-doctors-struggling-to-get-jobs-in-new-zealand

Tiatia, J. (2008). *Pacific cultural competencies: A literature review*: Ministry of Health Wellington, New Zealand.

Tomalin, E., & Haustein, J. (2019). Religion and the Sustainable Development Goals *Review of Faith and International Affairs, 17*(2), 102-118. https://doi.org/10.1080/15570274.2019.1608664

Triandis, H. C. (1995). Individualism and Collectivism. In H. C. Triandis & M. J. Gelfand (Eds.), *Converging measurement of horizontal and vertical individualism and collectivism* (Vol. 74, pp. 118-128). Boulder, Colorado: Westview Press.

Tuhiwai - Smith, L. (1999). *Decolonizing methodologies : Research and indigenous peoples* Dunedin, New Zealand.: University of Otago Press.

Tuhiwai Smith, L. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. London: Zed Books.

Turan, J. M., Elafros, M. A., Logie, C. H., Banik, S., Turan, B., Crockett, K. B., . . . Murray, S. M. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Medicine, 17*(1), 7. https://doi.org/10.1186/s12916-018-1246-9

Tuwe, K. (2012). *The challenges of health promotion within African communities in New Zealand*. Auckland. (Available from the Auckland University of Technology)

Tuwe, K. (2016). The African Oral Tradition Paradigm of Storytelling as a Methodological Framework: Employment Experiences for African communities in New Zealand Symposium conducted at the meeting of the African Studies Association of Australasia and the Pacific (AFSAAP).

Proceedings of the 38th AFSAAP Conference: 21st Century Tensions and Transformation in Africa, Deakin University, 28th-30th October, 2015.

Tuwe, K. (2018). *African communities in New Zealand: An investigation of their employement experiences and impact on their wellbeing using African oral tradition of storytelling as a research methodology*. Auckland University of Technology, Auckland. Retrieved from http://aut.researchgateway.ac.nz/bitstream/handle/10292/11906/TuweK.pdf?sequence=3&isAllowed=y

Udefi, A. (2014). The Rationale for an African Epistemology: A Critical Examination of the Igbo Views on Knowledge, Belief, and Justification. *Canadian Social Science, 10*(3), 108-117. https://doi.org/10.3968/4445

Ujomudike, P. O. (2015). Ubuntu Ethics [Ujomudike2014]. In H. ten Have (Ed.), *Encyclopedia of Global Bioethics* (pp. 1-14). Cham: Springer International Publishing. Retrieved from https://doi.org/10.1007/978-3-319-05544-2_428-1. https://doi.org/10.1007/978-3-319-05544-2_428-1

UK Office for National Statistics. (2017). *Number of Africans living in the UK*. Retrieved from https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/numberofafricanslivingintheuk

UNCHR. (2009). UNHCR Agenda for the Integration of Refugees in Central Europe. Retrieved from https://www.refworld.org/pdfid/4bfe72542.pdf

UNICEF. (2017). *Building the Future: Children and the Sustainable Development Goals in Rich Countries', Innocenti Report Card 14* Florence, Italy: UNICEF Office of Research. Retrieved from https://www.unicef-irc.org/publications/890-building-the-future-children-and-the-sustainable-development-goals-in-rich-countries.html

United Nations. (2007). Declaration on the Rights of Indigenous Peoples.

United Nations Department of Economic and Social Affairs. (2019). *International Migration 2019: Wall Chart* Population Division. Retrieved from https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2020/Feb/un_2019_internationalmigration_wallchart.pdf

United Nations Department of Economic and Social Affairs Population Division. (2017a). *International Migration Report 2017: Highlights*. New York: United Nations. Retrieved from http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf

United Nations Department of Economic and Social Affairs Population Division. (2017b). *Trends in International Migrant Stock: The 2017 Revision*. New York: United Nations, Department of Economic and Social Affairs, Population Division.

United Nations Economic Commission of Africa. (2017). *Situation analysis. Patterns, levels and trends of African migration*. presented at the meeting of the African Regional Consultative Meeting on the Global Compact on Safe, Orderly and Regular Migration, Addis Ababa, 26 and 27 October 2017. Retrieved from https://www.uneca.org/sites/default/files/uploadeddocuments/SocialDevelopement/Global-Compact-Migration-2017/situational-analysis-migration-report_english.pdf

Van Teijlingen, E., & Hundley, V. (2002). The Importance of Pilot Studies. *Nursing Standard, 16*, 33-36.

Ventevogel, P., Jordans, M., Reis, R., & de Jong, J. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Conflict and Health, 7*(1), 3. https://doi.org/10.1186/1752-1505-7-3

Vermeir, P., Vandijck, D., Degroote, S., Peleman, R., Verhaeghe, R., Mortier, E., . . . Vogelaers, D. (2015). Communication in healthcare: a narrative review of the literature and practical recommendations. *International Journal of Clinical Practice, 69*(11), 1257-1267. https://doi.org/10.1111/ijcp.12686

Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health. *Social Science Medicine, 75*(12), 2099-2106. https://doi.org/10.1016/j.socscimed.2011.12.037

Waitangi Tribunal. (2019). *Hauora report on stage one of the health services and outcomes inquiry*

Waitemata and Auckland District Health Boards. (2017). *Asian, Migrant & Refugee Health Plan 2017-2019*. Retrieved from http://www.waitematadhb.govt.nz/assets/Documents/health-plans/2017-19-Asian-Migrant-Refugee-Health-Plan-ADHB-WDHB-CPHAC-Final.pdf

Walia, S. (2018). The Pains of Colonialism: Examining Tsitsi Dangarembga's novella Nervous Conditions (1988). *SOCRATES, 6*(1), 1-11.

Walrond, C. (2015). Africans - Africans in New Zealand', Te Ara - the Encyclopedia of New Zealand. Retrieved from http://www.TeAra.govt.nz/en/africans/page-1

Ward, C. (2008). *The experiences of migrant youth: A generational analysis. Migrant and Refugee Youth Settlement and Social Inclusion Series*. Wellington, New Zealand. Retrieved from http://apyouthnet.ilo.org/resources/the-experiences-of-migrant-youth

Ward, C., & Masgoret, A. M. (2008). Attitudes toward Immigrants, Immigration, and Multiculturalism in New Zealand: A Social Psychological Analysis. *International Migration Review, 42*(1), 227-248. https://doi.org/https://doi.org/10.1111/j.1747-7379.2007.00119.x.

Werner, A., & Malterud, K. (2003). It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. *Social Science Medicine, 57*(8), 1409-1419. https://doi.org/10.1016/s0277-9536(02)00520-8

WHO. (1986). *The Ottawa Charter for Health Promotion*. presented at the meeting of the First International Conference on Health Promotion Ottawa, 21 November 1986, Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

WHO. (1998). WHOQOL and Spirituality, Religiousness and Personal Beliefs Symposium conducted at the meeting of the WHOQOL and Spirituality, Religiousness and Personal Beliefs, Geneva on June 22-24, 1998. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/70897/WHO_MSA_MHP_

98.2_eng.pdf;jsessionid=4E5D2AA59A039351CE22128EE8738407?sequence=1

WHO. (2010). *The WHO global code of practice on the international recruitment of health personnel*. presented at the meeting of the Sixty-third World Health Assembly, Geneva. Retrieved from http://www.who.int/hrh/migration/code/code_en.pdf.

WHO. (2014). New Zealand health system review *Health Systems in Transition, 4*(2). Retrieved from https://apps.who.int/iris/rest/bitstreams/1246728/retrieve

WHO. (2018). Health promotion for improved refugee and migrant health. *Technical guidance on refugee and migrant health*. Retrieved from https://www.euro.who.int/__data/assets/pdf_file/0004/388363/tc-health-promotion-eng.pdf

Wilkinson, C., & Wilkinson, S. (2017). Doing it write: representation and responsibility in writing up participatory research involving young people. *Social Inclusion 5*(3), 219-227. https://doi.org/10.17645/si.v5i3.957

Williams, J. L., & Deutsch, N. L. (2016). Beyond between-group differences: Considering race, ethnicity, and culture in research on positive youth development programs. *Applied Developmental Science, 20*(3), 203-213. https://doi.org/10.1080/10888691.2015.1113880

Wilson, T. W., & Grim, C. E. (1991). Biohistory of slavery and blood pressure differences in blacks today. A hypothesis *Hypertension, 17*, 122-128. https://doi.org/10.1161/01.hyp.17.1_suppl.i122

Woetzel, J., Madgavkar, A., Rifai, K., Mattern, F., Bughin, J., Manyika, J., . . . A., H. (2016). People on the move: Global migration's impact and opportunity. Retrieved from https://www.mckinsey.com/featured-insights/employment-and-growth/global-migrations-impact-and-opportunity

World Health Organization. (1948). *Constitution of the World Health Organization*. presented at the meeting of the International Health Conference, 19 June to 22 July 1946, New York. Retrieved from https://www.who.int/governance/eb/who_constitution_en.pdf

Wu, Q., Ge, T., Emond, A., Foster, K., Gatt, J. M., Hadfield, K., . . . Wouldes, T. A. (2018). Acculturation, resilience, and the mental health of migrant youth: a cross-country comparative study. *Public Health, 162*(2018), 63-70. https://doi.org/https://doi.org/10.1016/j.puhe.2018.05.006

Y., P., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., & al., e. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PloS One, 10*(9), e0138511. https://doi.org/https://doi.org/10.1371/journal.pone.0138511

Yancey, A. K., Ortega, A., N., & Kumanyika, S. K. (2006). Effective recruitment and retention of minority research participants. *Annual Review of Public Health, 27*, 1-28.

Youth Health Workforce Working Group. (2011). *Report on the youth health workforce service review*. Retrieved from https://www.health.govt.nz/system/files/documents/pages/youth-health-workforce-service-review.pdf

Zambrano, C. (2010). Health and Young Adulthood: Does Immigrant Generational Status Matter? *Field Actions Science Reports [Online]*(2).

APPENDICES

Appendix A: District Health Boards Location Boundaries

Appendix B: Participant Information Sheet for Co-researchers

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Participant Information Sheet for co-researchers

Date Information Sheet Produced:

08/02/2018

Project Title

Enabling African migrant female youth in New Zealand to better meet their health aspirations.

An Invitation

My name is Blessing Kanengoni and I greet you with sincere gratitude for taking your time to partner in my PHD research on the health of young African female immigrants in New Zealand. I am carrying out my studies at Auckland University of Technology. The research aims to explore the experiences and understanding of African female migrant health, and how services, programmes or policies can best meet and provide avenues for the betterment of their wellbeing. Your participation in this research is completely voluntary and you may withdraw at any time.

What is the purpose of this research?

- Invite participation and engagement of young female African migrants to share knowledge, aspiration and experiences related to their health and wellbeing.
- Provide a safe collective environment for young female African migrants to critically reflect on their health experiences, ideas and offer solutions to the betterment of African female health and wellbeing and future relevant programmes and policies
- Be able to contribute knowledge to the already limited literature on migrant youth health in New Zealand, and strengthening the existing knowledge base around migrant health thus informing policy and programme development;
- Invoke African indigenous knowledge embodied in languages, proverbs, folktales, stories and cultural experiences that bring new topics, themes, methods, processes and categories of analysis not easily obtainable from western methodologies.

How was I identified and why am I being invited to participate in this research?

The study is aims to build the capacity of young African female migrants to create relevant solutions that address the health needs of this visible ethnic minority group. The following categories are key participants who will be invited to participate in the research: (i) Young African female immigrants over 16 years of age who self-identify as being young migrants of African descents who have knowledge, aspiration and experiences related to their health and wellbeing in NZ to share; (ii) health professionals who have provided services to young African females; and (iii) Influential leaders of the African community. If you have identified yourself to be one of the following:

- An young African female aged 16 years and older;
- Have sound ability in communicating in English;

- A migrant who falls under the visible ethnic minority category and keen to share their experiences in this research;
- You know have ideas and solutions to the betterment of African female migrant health and wellbeing for future and relevant programmes and policies;
- You have communicated your interest in participating in this study by contacting the researcher

I would like to hear your ideas and solutions to the betterment of African female health and wellbeing in NZ.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible. If you agree to participate, may you contact me on the following details: Email: beekanengoni@yahoo.com or text or call on 0225739689 so that I send a Consent form to complete showing your agreement in taking part in the research. All information collected, including your personal information will be kept private and confidential. The data collected will only be used for the purpose it was intended for

What will happen in this research?

If you choose to participate, you will be part of the 20 young African female migrants' research participants. You are required to participate in a total of 16 hours over a duration of four months. Each workshop may take up to four hours each. You will be a part of a group who will have a say on the numbers of the workshops and the duration of each workshop and the time frame of the whole exercise. Depending on the group agreement and process, those 3-4 workshops will be conducted between 3-4 months period beginning March/April 2019. Places where data collection might occur, include NGO offices like Refugee as Survivors, community centres, AUT meeting rooms, or any places as advised by research advisory group. Details of the workshops as follow:

Workshop 1: Building partnership and ownership of the research project

In this workshop, researcher will engage with the African female youth to increase understanding of research and getting consent to participate, build trust and rapport as a means to encourage co-ownership of the research project. This means every aspect of the research will be worked out together and agreed by all the members of the group like the number of workshops that may be needed to complete the data collection processes. It is at this initial engagement that ground rules are set for the data collection processes. Three to four hours will be allocated for this exercise.

Workshop 2: Brainstorming the problems

You will be invited to use a combination of visual materials like cultural artefacts, symbols etc with verbal interactions such as oral testimonies and storytelling in a group formant. This phase aims to brainstorm and identify health problems amongst African female youth and to illustrate the barriers in achieving health and wellbeing.

Workshop 3: Developing the strategies

This phase invites you to share your ideas on innovative solutions to address the health and health related issues and means to action those solutions. You will be invited to present your solution with the wider groups and reflect on your solution.

What are the discomforts and risks?

There are no direct discomforts or risks involved. You will not be asked anything of a personal nature. If you feel that participating in the research would put you at risk of feeling embarrassed, anxious, depressed, lose your self-esteem and or respect from other participants, it is advisable that you do not participate. You can also leave during the research whenever you wish.

How will these discomforts and risks be alleviated?

I do not envisage any direct discomforts or risks involved in this study. I am aware that any discomfort or risk may arise during the interview, if you choose to discuss sensitive issues with the group. If you feel discomfort during the interviews, please let me know as soon as possible. If you feel that the research has caused you any discomfort, arrangements will be made for you to get free counselling sessions provided by AUT Counselling services. AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

Benefits to the participants

- This study *desires* to provide a collective framework and collaborative platform for African youth female migrants to give their voices, share ideas, express aspiration and creative strategies that *may* raise awareness of solutions to health problems pertinent to them.

Benefits to the cultural informants (ie. African leaders, elders and relevant health providers)

- Findings may assist in bridging ideas with their practice and leadership roles.

Benefits to wider migrant communities in New Zealand

- Findings of this research may add to the existing body of knowledge on migrant youth health

Benefits to the researcher

- This research contributes to the completion of a doctoral study. Experiences and knowledge gained from this research will enhance primary researcher's skills and expertise in research relevant to the world view of African culture and philosophical standpoint.
- Build professional and academic reputations including attaining a PHD qualification and publications resulting from the research findings;

How will my privacy be protected?

All your personal details will be kept confidential and locked in a filing cabinet in my supervisors' office. Your personal details will be separated from your data. I will be the only one who has access to your personal data.

What are the costs of participating in this research?

There are no financial costs to you. However, refreshments will be provided during the workshop and you will be given a token of appreciation for your time in the form of petrol voucher worth $20

What opportunity do I have to consider this invitation?

You will be given a week to decide whether you are interested to take part in the study or not. I will contact you after a week to re-confirm your participation. Any questions that you have may be directed to me or my supervisor.

Will I receive feedback on the results of this research?

Yes. You will receive a copy of the findings through email

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, Dr Sari Andajani-Sutjahjo on sari.andajani@aut.ac.nz and, 921 9999 ext 7738. Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows: Researcher Contact Details: Blessing Kanengoni, ***beekanengoni@yahoo.com*****, *0225739689.*** Project Supervisor Contact Details***:*** Dr Sari Andajani,sari.andajani@aut.ac.nz,

Approved by the Auckland University of Technology Ethics Committee on 14/12/2018, AUTEC Reference number 18/372.

Appendix C: Consent Form

Consent Form

Project title: **Enabling African migrant female youth in New Zealand to better meet their health aspirations.**

Project Supervisor: **Dr Sari Andajani-Sutjahjo**

Researcher: **Blessing Kanengoni**

Date: 09/03/2019

○ I have read and understood the information provided about this research project in the Information Sheet dated 09/03/2019.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential. While I, the researcher, will respect the confidentiality of all participant's information, I cannot promise or ensure that other participants will do the same. I will, however, strongly ask all participants in the study to respect the confidentiality of all participants.

○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: ....

Participant's name: ....

Participant's Contact Details (if appropriate):

....

....

....

....

Date:

***Approved by the Auckland University of Technology Ethics Committee on* 14/12/2018 *AUTEC Reference number* 18/372**

Note: The Participant should retain a copy of this form.

April 2018 page 1 of 1 This version was last edited in April 2018

Appendix D: Storytelling Discussion Guideline

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TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

STORYTELLING DISCUSSION GUIDELINE

DEMOGRAPHY

1. Nationalities of participants
2. Country of birth
3. Ages ranges
4. Age when they first came to New Zealand?
5. Years in New Zealand
6. Migrant background

Specific research questions

1. How do young African migrant women create meanings of their health and welling within the intersections of their gender, social, cultural, political and traditional context?
2. What factors can enable young African migrant women to express their health aspiration to future policy and initiatives to improve their health and wellbeing in NZ?
3. What are the best strategies for enabling youth female migrants to contribute to existing health, social or youth services?
4. What are the best ways to implement those strategies?
5. How do young African migrant women incorporate their subjective African way of participation, building collective knowledge and social transformation into the research process?

Introduction

Signing of Consent forms.

Signing of register

Building partnership and ownership of research project. What is PAR?

- What is your understanding of this research and your consent to participate?
- What are the ground rules in implementing this research?
- How should we build connection and a collective identity to remove interpersonal barriers that may discourage active participation of everyone?
- How should we promote inclusion and encouraging everyone to co-own the data collection processes?
- How can we balance the power dynamics between researcher and participants?

Role play.

Handbag and you are going out to a party. You have 6 things (condoms, morning after pill; Youth friendly services contact list, family picture, a pack of RTDs/alcohol and drugs, mobile phone) but you have to carry 4. Which are the 4 and why? Is there anything that is not listed here but is a must have?

Brainstorming the problems toward critical consciousness and collective shared knowledge

A. The meaning of positive health and wellbeing for young African women

- What is health for you?

- What is wellbeing for you?

Give the group a piece of paper and a pencil. Allow 5 minutes to draw a picture that conveys what health and wellbeing means without writing any words or numbers. At the end of 5 minutes the leader collects the pictures. Show the pictures to the group, one at a time, and have them try to guess what the picture says. Each artist can then explain their definition of what health and wellbeing is.

- Is health and wellbeing different?
- What factors influencing positive health and wellbeing for young African women in NZ? (social, political, economic, religion, environment)
- The role of culture, race and gender on the health and well-being of young African women?

[Probing question? Why, is one more important than the other? Why?]

Cultural values, assessing level of ethnocentrism

Invite them to use different methods to best answer those questions stories, poems, visual methods

B. **Young African females' view on health services**

- What are the specific health issues or needs for young African females? (This is to identify the specific health needs or issues for young African females).
- Which services are the most used? Why?
- How do young women best describe their experiences of those services? Tell stories or narratives through picture etc the experiences that have been meaningful and you want to share with your group or other female youth African migrants.
- What are the barriers to good health care? Why?

Developing and activation of their strategies to chosen audience

- What kind of services do young African female want? (e.g. sexual and reproductive health services • counselling • alcohol and drug services • general practitioner services).
- What does an ideal health service look like for you? What qualities need to be there? (e.g cultural appropriate)
- Do you have any specific issues or messages you want services or policy programme developers to hear?

Like our previous session, you are welcome to decide which tool you want to use, digital, storytelling, role play, drama, etc to best answer those questions

- Now it is time to think of who you want to deliver your message to. Choose a key stakeholder and why?
- What would be the best method to deliver your voice or aspiration?
- Why?
- Later we will reflect on your choice of method and stakeholder.

You are welcome as a group or individuals to choose your tools of expression.

Reflection and evaluation at the end of each session

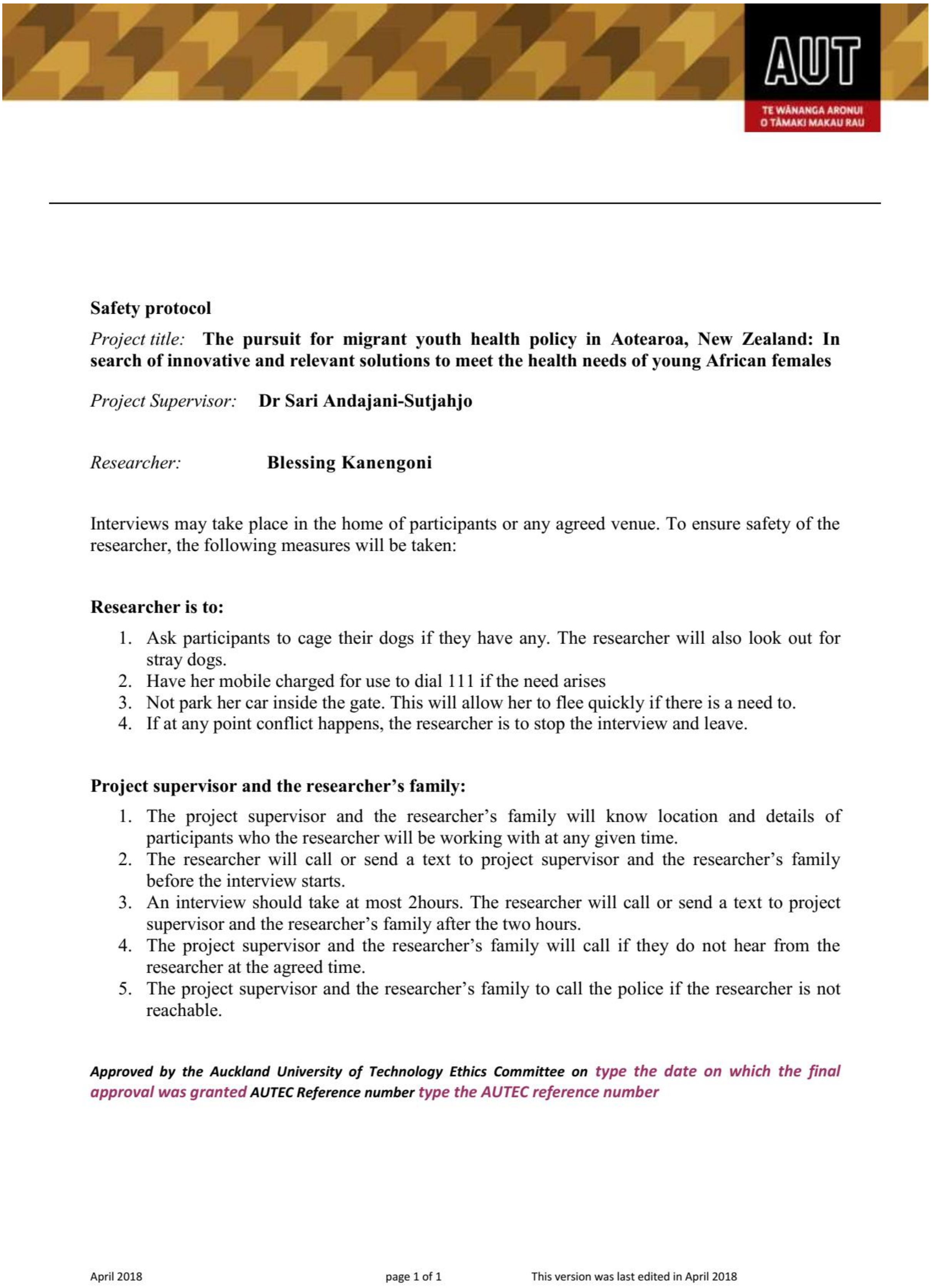
Now it is time for us to reflect on our time and activities, and actions together. Earlier we looked at steps in doing research that encourages participation and full ownership by you as my co-researchers. You all are key to this research, your feeling, opinions, feedback and reflection are important.

- Do you think this whole process encourage participation? In what way? How has it meant to you?
- How do you see these process relevant to our work with you as young female migrants of African background?
- How do the principles of collaboration, problem solving or participation and sharing experiences reflect our world view as African?
- If you want to change some of them, which one you want to change
- Which ones you want to keep? Why?

Guide to researcher

NB. The how questions by default ask you to record their capacity building, including knowledge, skills they learn from each other, their critical views on things and solutions offered, and when they tried out different methods to express their ideas

Appendix E: Safety Protocol



TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Safety protocol

Project title: **The pursuit for migrant youth health policy in Aotearoa, New Zealand: In search of innovative and relevant solutions to meet the health needs of young African females**

Project Supervisor: **Dr Sari Andajani-Sutjahjo**

Researcher: **Blessing Kanengoni**

Interviews may take place in the home of participants or any agreed venue. To ensure safety of the researcher, the following measures will be taken:

Researcher is to:

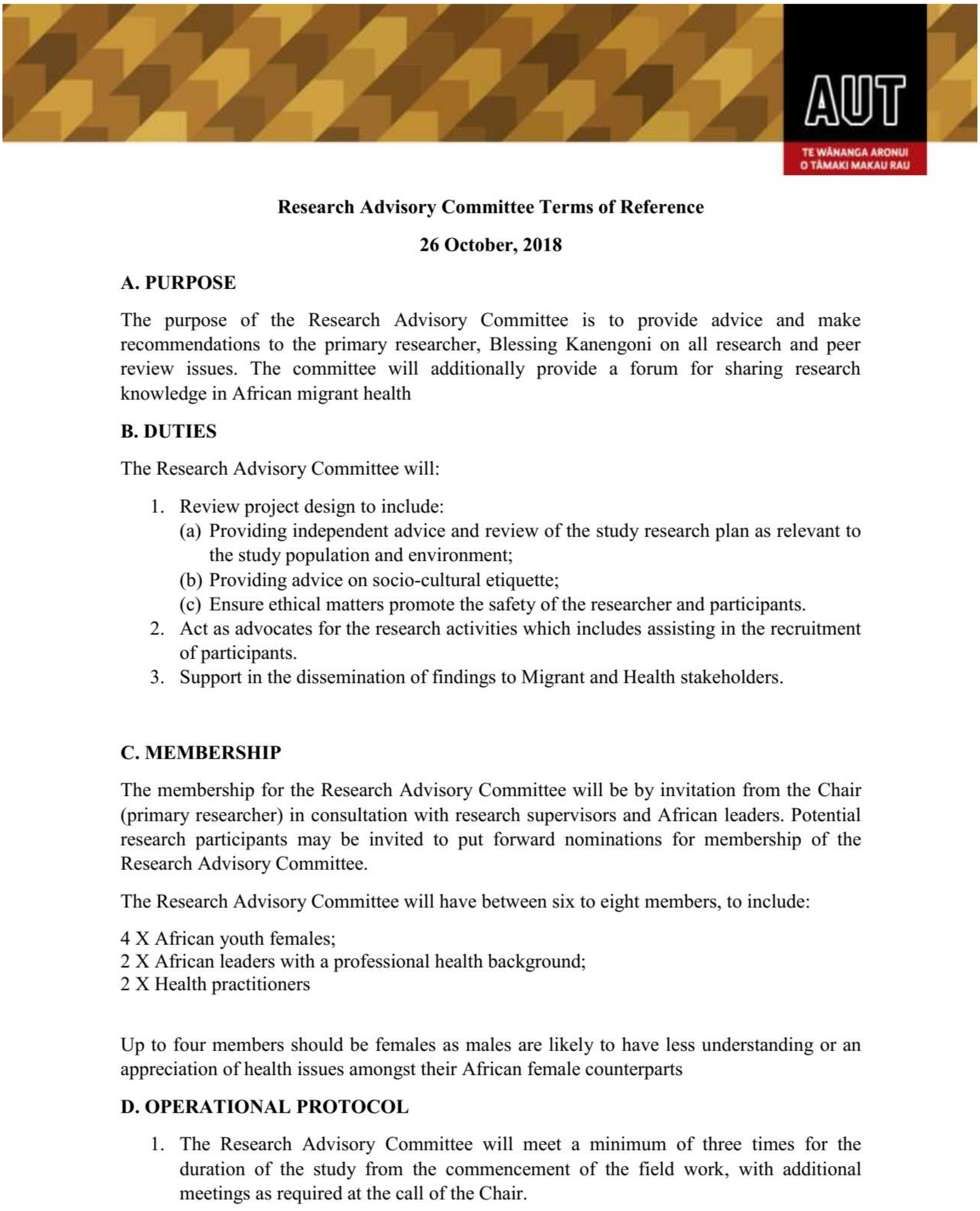
1. Ask participants to cage their dogs if they have any. The researcher will also look out for stray dogs.
2. Have her mobile charged for use to dial 111 if the need arises
3. Not park her car inside the gate. This will allow her to flee quickly if there is a need to.
4. If at any point conflict happens, the researcher is to stop the interview and leave.

Project supervisor and the researcher's family:

1. The project supervisor and the researcher's family will know location and details of participants who the researcher will be working with at any given time.
2. The researcher will call or send a text to project supervisor and the researcher's family before the interview starts.
3. An interview should take at most 2hours. The researcher will call or send a text to project supervisor and the researcher's family after the two hours.
4. The project supervisor and the researcher's family will call if they do not hear from the researcher at the agreed time.
5. The project supervisor and the researcher's family to call the police if the researcher is not reachable.

***Approved by the Auckland University of Technology Ethics Committee on** type the date on which the final approval was granted* ***AUTEC Reference number** type the AUTEC reference number*

Appendix F: Research Advisory Committee Terms of Reference



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TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Research Advisory Committee Terms of Reference

26 October, 2018

A. PURPOSE

The purpose of the Research Advisory Committee is to provide advice and make recommendations to the primary researcher, Blessing Kanengoni on all research and peer review issues. The committee will additionally provide a forum for sharing research knowledge in African migrant health

B. DUTIES

The Research Advisory Committee will:

1. Review project design to include:
   (a) Providing independent advice and review of the study research plan as relevant to the study population and environment;
   (b) Providing advice on socio-cultural etiquette;
   (c) Ensure ethical matters promote the safety of the researcher and participants.
2. Act as advocates for the research activities which includes assisting in the recruitment of participants.
3. Support in the dissemination of findings to Migrant and Health stakeholders.

C. MEMBERSHIP

The membership for the Research Advisory Committee will be by invitation from the Chair (primary researcher) in consultation with research supervisors and African leaders. Potential research participants may be invited to put forward nominations for membership of the Research Advisory Committee.

The Research Advisory Committee will have between six to eight members, to include:

4 X African youth females;
2 X African leaders with a professional health background;
2 X Health practitioners

Up to four members should be females as males are likely to have less understanding or an appreciation of health issues amongst their African female counterparts

D. OPERATIONAL PROTOCOL

1. The Research Advisory Committee will meet a minimum of three times for the duration of the study from the commencement of the field work, with additional meetings as required at the call of the Chair.

2. Additionally, a special meeting of the Research Advisory Committee may be convened upon the request of any member of the committee.
3. Time and duration of meetings will be determined by the Chair in consultation with committee.

Approval

V1	Prepared October 2016	Approved by AUTEC: Approved by Advisory committee:	Date: 14/12/18 Date:	Review Date:

Appendix G: Ethics Approval 14 December 2018

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

Sari Andajani
Faculty of Health and Environmental Sciences

Dear Sari

Re Ethics Application: **18/372 The pursuit for migrant youth health policy in Aotearoa, New Zealand: In search of innovative and relevant solutions to meet the health needs of young African females**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 14 December 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/research/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation, then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: blessing.kanengoni@aut.ac.nz; Eleanor Holroyd

Appendix H: Dissemination Strategy