Health Experiences, Help-seeking, and Healthcare System Utilisation From a Socio-cultural Perspective, Among Southern African Migrants to Australia

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CONTENTS

ABSTRACT

In Australia, research shows that some groups of minority migrants, after living in Australia for a period of time, experience health challenges, including in some cases declining health status, despite many of them enjoying good health when they first arrived. This disappearance of the 'healthy migrant effect' is due to many factors, including various barriers to access and utilise the available health services. To further illuminate issues affecting the health of migrants, this sociological research examined the health beliefs, health seeking experiences and health behaviour of Southern African migrants to Australia. The fieldwork was carried out from February 2018 to December 2018 in Melbourne, collecting data through dialogical interviews with 28 Southern African migrants and participant observation during 24 social gatherings. The study explored issues that exacerbate health problems among this cohort, including heavy financial obligations (for example, because of sending remittances back to family in home countries and paying tuition fees) which are met through excessive working. This was further compounded by being isolated from social networks that normally provide emotional and material support. Racism and discrimination also undermined participants' accessing of health services and limited the economic opportunities promotive of good health. All these issues also contributed to a sense of social exclusion, unbelonging and ambivalence. Yet, the health services available, especially for mental health problems, were of limited utility to the participants because the underpinning theories about mental health overlook the participants' beliefs. The issues were less problematic when they sought help for physical ailments, though the help was tactfully sought through approaching clinicians of similar background, and engaging their social networks working in the health sector. Using their agency, participants resourcefully created spaces locally and transnationally for accessing health services commensurate with their African Traditional Religion and African Pentecostal Religion beliefs. To access these health services, including biomedical services, participants relied on Ubuntu, an African humanistic philosophy. Ubuntu was also used as the study's analytical tool to interpret the findings. Thus, although some of the health initiatives were a response to the barriers encountered in utilising the biomedical health services, even without such barriers the indigenous health initiatives would still have been part of participants' holistic approach to health. These health practices (using multiple health interventions) also indicate that, while through acculturation participants were introduced to new ways of understanding their health problems, they still retained their previous health beliefs. This thesis provides health insights of

Southern African migrants to the body of knowledge which could be used as an empirical basis to inform practice that is culturally appropriate for their health needs.

STATEMENT OF AUTHORSHIP

By submitting an electronic copy of this thesis, I declare that this is my original work. Except where reference is made, the thesis does not contain materials published in any other work or extracted in whole or in part from a work submitted elsewhere for the award of a degree or diploma in any discipline. The work of other people has been duly acknowledged.

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CHAPTER ONE: INTRODUCTION

On various platforms, Australia's policy makers, academics, government agencies and commerce captains often remind us about the crucial importance of migration in buffering the effects of an ageing population, labour shortages and rescuing regional and rural communities suffering from the pernicious effects of depopulation (see Boese & Moran 2021; Boese, Moran & Mallman 2018) . Yet, the culturally and linguistically diverse migrants are still at the margins when it comes to accessing health and other social services (Matlin et al. 2018). This is not due to a dearth of services but an outcome of the various socio-cultural and economic barriers, among other reasons, when they attempt to utilise these services. Social science and health literatures show that minority migrants in Western societies encounter discrimination, exclusion and racism when they attempt to access services, with these difficulties often related to factors such as cultural differences, language barriers, and their residential status (Matlin et al. 2018). This thesis is a report of a sociological investigation of migration and health among skilled Southern African migrants to Australia: one of the recently arrived and smallest migrant groups. A perusal of literature reveals that there is little research specific to this community. Research on African migrants in Australia is relatively thin when compared with other migrant groups. Furthermore, most of these studies focused on recent migrants from Africa gravitated towards other African communities that have relatively higher numbers such as those from the Horn of Africa and the Eastern part of the continent (for example see Hornyang et al 2017; Muchoki 2011; Muchoki 2016: Nunn 2010; Shepherd 2017; Renzaho 2011; Wilson 2010; Drummond 2011; Tempany 2009; Tilbury 2009, Udah et al. 2019). This research is also distinguished from the most other studies with African migrants as the participants are primarily labour migrants rather than the seemingly most researched humanitarian migrants. As a cohort that arrived more recently in Australia, the knowledge about crucial cultural issues that impact health practices of Southern Africans is under-researched, thus making it harder for the healthcare system to be adjusted and become conscious of the specific health issues in these communities. Specifically, the study focuses on socio-cultural issues shaping health practices, behaviours and interventions. It remains important to interrogate the beliefs and philosophies that shape client-clinician and other health interactions in order to empirically suggest ways in which health services can be appropriately resourced to meet the needs of all the users in their diversities. This is of crucial importance, considering the declining health of migrants as their length of stay in host countries (most noticeably in wealthy, Western countries)

increases (Biddle, McDonald & Kennedy 2007; Jatrana, Richardson & Pasupuleti 2017; Renzaho 2016). Also, as the Australian society is increasingly becoming more multicultural and diverse, it is necessary to widen the body of knowledge, especially concerning the multiplicities of health beliefs and the roles these beliefs play in people's lives. This introductory chapter provides a brief discussion of the health of migrants in Australia, and the research objectives and significance of the present project. Firstly, discussing the broad history of Australian migration is necessary to set the context for understanding the general health of the migrants and to illuminate the myriad health difficulties experienced after migration.

Background: The Australian migration

Sociology and many other social sciences alert us to the fact that migration is not new; human beings have been migrating for many centuries in response to various push and pull factors. In the Australian context, in recent decades, migrants have been key contributors of both semi-skilled and highly skilled workforces (Cameron & Harrison 2013). In fact, together with Canada, New Zealand and the United States, Australia is regarded as an immigration country. As a nation, the country's history, demographics, socio-economic and cultural fabrics have been hugely transformed by immigration over the last 200 years (Renzaho 2016). Its migration can be summarised in major waves beginning with the resettlement of convicts from Britain around 1788–1825 (Manning 1992; Reid & Trompf 1990). The "new Britannia" policy, a scheme aimed at expanding the number of Britons in Australia to "Britainise" the continent between 1825-1850 constitutes the second wave (Renzaho 2016). The period between 1910 and 1930 is generally considered as the third wave. While the British people still dominated, Jews and other Anti Nazis and Christians also migrated to Australia (Jupp 2002; Windschuttle 2004). According to Petrilli and Ponzio (2009) as cited in Renzaho (2016), the migration of the British people was a huge success; between 1830 and 1940, 1,068,311 had resettled in Australia. The migration success of the British people and the demographic shaping of the country during the third wave can also be credited to the White Australia Policy enacted in 1901 after it was spearheaded by Prime Minister Edmund Barton. The policy is a term that encapsulates a set of historical policies that put ethnic identity of the Anglo-Celtic "breed" as an important determinant for migration (Larsen 2017). Through these policies the emergent nation largely mirrored the Anglo-Celtic values and culture

of Britain. While the policy remained the ideological backbone of the Australian identity, its grip on immigration politics weakened post Second World War (Larsen 2017).

Following Australia's becoming a founding member of the United Nations at the end of the Second World War, and joining the International Refugee Organisation, as well as their support for the Declaration of Human Rights (Henderson 1988), the signal to accept more migrants could not have been clearer (Renzaho 2016). Those that were considered easy to assimilate were targeted (Renzaho 2016). In addition to the Displaced Persons accepted from Southern and Northern Europe, which were non-English speakers, there was a slight expansion to embrace non-European migrants including some South Africans (Young 1991). It is, however, important to highlight majority of the South Africans were descendants of Europeans who had moved to Africa. The post war period (1947-1972) which constitutes the fourth wave of migration thus saw a considerable number of the culturally diverse people arriving in the country. After the dismantling of the exclusive White Australia Policy in the mid-1970s many people fleeing persecution in Asian countries notably Cambodia, China, and the Lebanese from the Middle East also moved to Australia in greater numbers (Jupp 2002). Although the Whitlam Labor government is often praised for dismantling the White Australia policy, the watershed policy change was a culmination of efforts by the successive federal governments (Jupp 2002).

Specifically in response to various crises in Sub Saharan Africa and in the Commonwealth spirit of assisting the African continent's efforts to improve their economies, a significant number of Africans arrived in Australia under the special initiatives introduced from the 1960s and the 1970s, for example, the Special Commonwealth African Assistance Plan (Udah et al. 2019). More recently, a particular focus by the Australian Commonwealth government to bring in people from war torn countries such as Somalia, Ethiopia and Eritrea (Horn of Africa) and Democratic Republic of Congo (DRC), Rwanda and Burundi (Great Lakes region), as well as Sudan and South Sudan (North East Africa) between 1996 and 2005 saw a huge rise in the number of African people calling Australia home (Nyland et al. 2009; Udah et al. 2019). Through the various initiatives to bring people to Australia, and the available economic opportunities, the number of foreign born Australians stood at 30 % in 2020 according to the Australian Bureau of Statistics (ABS) (ABS 2021). For context, in the early 1980s, 21 % of the Australians were born overseas (see Castles

1992). As Africans joined migration to Australia much later than people from Asia, the Middle East, the Asia-Pacific and Europe, their number is still lower but on a sustained upward trend (Udah et al. 2019). The 2016 census figures shows that there were over 35 thousand people specifically from Southern Africa living in Victoria (Government 2016). There are six states and two territories in Australia, however, the Victorian state is special because this study was carried out in Melbourne, the state's capital. Melbourne is also home to 70 per cent of Victoria's 6.681 million residents.

The health of migrants

The Australian migration policies have generally become more inclusive since the late 1960s and 1970s mainly because of the positively changing world. Blatantly exclusive policies such as the White Australia were abolished (see Mence, Gangell & Tebb 2017; Whittington 2012). At the same time, the healthiness of prospective immigrants clearly emerged as one of the central prerequisites for one to be eligible to immigrate to Australia (Mence, Gangell & Tebb 2017). Those who intend to migrate to Australia must undergo and pass a pre-migration health screening. This health policy was introduced by the Australian government to ensure that people with tuberculosis and the chronically ill, including those suffering from diabetes, arthritis, kidney and heart conditions do not settle in the country (see Renzaho 2016). The policy was a response to the disparities between the health of migrants and that of the broader Australian community with the former's health needs considered costly to the Australian community (Renzaho 2016). For example, around 1960, the tuberculosis incidences were four times higher in migrant communities compared to those born in Australia (Saint 1963). Between 1960 and 1965 pulmonary tuberculosis was twice higher among migrant young people than Australians of similar age (Krupinski 1984). However, the health screening initiatives have been criticised for perpetuating the centuries-old portrayal of migrants as importers of diseases such as malaria and tuberculosis, as well as disease spreaders because of their supposed indulgence in unhygienic behaviours (Guerri-Guttenberg et al. 2009; Hargreaves 2009; Jelinek et al. 2002; López-Vélez, Huerga & Turrientes 2003). This xenophobic viewing of health problems, however, originates in the Medieval times when outsiders were screened and quarantined for communicable diseases such as pandemic flu and tuberculosis as part of the public's health security (Zimmerman, Kiss & Hossain 2011).

Since the 1960s (the period in which Africans migrants were starting to arrive in Australia), international migration underwent some significant transformations (Castelli 2018). For example, health screening became more pronounced and an important determinant for one to migrate to Australia (see Mence, Gangell & Tebb 2017; Renzaho 2016). As a result of these changes, most migrants who arrive in Australia and other migrant receiving countries are in good health, although this health requirement is normally waived for humanitarian arrivals. There is a need to clearly highlight that the resettling of refugees and other humanitarian migrants is not affected by these health requirements. While the health screening policy ensured that the majority of those arriving in Australia satisfied the health threshold, the historical view that migrants carry and spread pathogens persist.

Despite this inaccurate (yet popular) portrayal of migrants as diseased people, the health of migrants is well documented. In literature it is known as the "healthy migrant effect", a scenario where the people from middle to lower income countries is usually better than those in their countries of origin and the mainstream community in their host countries (Renzaho 2016). Thorough health screening prior to the granting of visas, employers' desire to employ healthy workers and migrants' self-selection (the healthy and financially stable are likely to undertake intercontinental migration) account for the healthiness of migrants (Domnich et al. 2012; Jatrana, Richardson & Pasupuleti 2017; Renzaho 2016). The "cultural buffering theory" also shows that migrants from the so-called developing countries generally enjoy a healthier lifestyle than those in the host (Antecol & Bedard 2006; Domnich et al. 2012; Dunt 1982; McDonald & Kennedy 2004; Razum, Zeeb & Rohrmann 2000; Rust 1990). For instance, a study with the Vietnamese migrants in Britain reported lower cancer incidences and mortality in this cohort than the national mortality rates (Swerdlow 1991). A research study carried out in Denmark to assess the health of the migrants and the general population found that migrants had lower rates of stroke in the first five years than the Danish-born individuals (Norredam et al. 2014). However, the migrants' rates of stroke increased with their length of stay. This was also the case with diabetic incidences and breast cancer, and this changed after five years of living in the country according to the results of this Danish research. Similar to the findings from Denmark, research from both Canada and Australia also show that the health advantage declines and matches those of the host population (Biddle, McDonald & Kennedy 2007). As the healthy migrant effect wanes away, later in life migrants'

health becomes worse-off compared to the mainstream population. Domnich et al. (2012) describes this as the "exhausted migrant effect". In Australia the health advantage declines and matches those of the host population within the first 20 years (Biddle, McDonald & Kennedy 2007). Interestingly, while migrants from linguistically diverse countries have lower rates of chronic illness, English speakers from countries that are culturally and economically comparable with the host country have similar incidences of chronic illnesses with the host population. For instance, migrants from Australia, New Zealand, Ireland, and Britain who had similar chronic incidences with the mainstream population of their host country, Canada (see Renzaho 2016). Nevertheless, Renzaho (2016) writes that the healthy migrant effect requires further scrutinisation arguing that the methodical flaws associated with researchers' and service providers' poor understanding of cultural issues in the migrant communities may have glossed the findings. Also, the trend may not be the case with irregular migrants and refugees who may have long term health problems that developed prior to migration including living under inhumane conditions in holding camps (Renzaho 2016). Notwithstanding this, the waning away of the migrants' health as the length of stay increases remains an issue for further investigation as Jatrana, Richardson and Pasupuleti (2017) note.

Known factors that contribute to the disappearance of the healthy migrant effect

When migrants move to a new country, they undergo certain inevitable cultural changes which invoke psychological and socio-cultural stresses associated with new environments (Li 2013). For Khawaja, Ramirez and Prasad-Ildes (2013) these changes are triggered by the resettlement process, individual and family expectations, available social networks among others. Upstream factors (unemployment, poor shelter, language barriers) and various forms of discrimination have all been noted as contributing to poorer health in the culturally diverse communities among others (Bhugra 2004; Cantor-Graae & Selten 2005). The "access to health framework" proposed by Thiede, Akweongo and McIntyre (2007) alerts us that optimal health is determined by the availability, affordability and acceptability of health services. With its roots in the ideas of Penchansky and Thomas (1981), the framework highlights the multiplicity and interconnectedness of several dimensions in health access. Availability addresses the physical access, that is, if the nature and

quantity of services in existence meet the clients' needs (Penchansky & Thomas 1981; Trajkovski & Loosemore 2006), or the services being timely and available when they are needed (Thiede, Akweongo and McIntyre 2007, p. 108). The affordability dimension is generally associated with financial resources, medical aid and how the clients perceive the value-for-money aspect of services, particularly their understanding of the pricing and the total costs (direct and indirect) involved. Acceptability refers to cultural access, which is seemingly a more complex dimension, including the attitudes of the clients towards the healthcare system, and its cohesiveness or lack thereof with their beliefs. The same principle also works in reverse wherein the health care providers have their own parameters of the nature of behaviour from the clients they consider acceptable (Penchansky & Thomas 1981).

Certain cohorts of migrants in Australia have higher health problems than the rest of the population. For example, non-English speaking European groups have higher incidents of occupational injuries which is partly a result of having limited skills in using English language (Trajkovski & Loosemore 2006). The mental wellbeing of the Vietnamese tends to decline after one year of living in the country (Steel et al. 2002; Thompson et al. 2002). Those from the Middle East have lower cancer screening than the Australian born population (Taylor et al. 2003), while migrants from West Africa had lower utilisation of services due to fear of being judged by their social networks, the anxiety of being hospitalised, as well as logistical issues to access services (Drummond et al. 2011). The overrepresentation of migrants in casual jobs sometimes characterised by exploitative and unsafe working environments not only risks their health but also affects their ability to access services in a timely way, as they are not entitled to leave days (Nyland et al. 2009). As will be later shown during the findings' discussion, temporary migrants, especially international students, constituted this cohort. Lubman et al. (2014) among others report that migrants face difficulties in navigating the barriers of complex Western health systems. The below optimal health outcomes among migrants have also been associated with healthcare providers' lack of knowledge about what the culturally appropriate services effectively constitute (Rao, Warburton & Bartlett 2006). Hence, Stolk et al. (2014) argues that migrants' lower usage of services is mostly unrelated to the lower health needs, rather it evidences the lack of customised services to meet their ethnocultural health needs. Through examining health issues from a socio-cultural perspective among a cohort of culturally diverse recent migrants to Australia, this study

builds on earlier studies in examining health issues in migrant communities. It is through such studies that suggestions can be made to enhance the health access and wellbeing of the migrant communities, as well as addressing a plethora of social and economic challenges associated with poor health.

Study objectives

The research's overarching objective was to examine the health experiences of migrants from Southern Africa in Melbourne, exploring what shapes these experiences from a socio-cultural perspective. This included examining the prior beliefs, experiences in Australia, access to health and other services, or lack thereof.

In order to generate empirical insights into these issues, the research had the following objectives:

1) To address factors that enhance, as well as factors that undermine wellbeing of Southern Africans in Melbourne.
2) To understand Southern Africans' health beliefs and the socio-cultural barriers to their help-seeking and healthcare system utilisation.
3) To examine Southern Africans' coping strategies, health initiatives and the spaces in which health needs are sought and met.

To address these objectives, the research was guided by the following main questions:

1) What are the resettlement experiences and factors that enhance and factors that undermine the wellbeing of Southern Africans?
2) How are health and illness perceived by Southern Africans, and in what ways do these perceptions influence their help-seeking and healthcare system utilisation?
3) What services do Southern Africans use to deal with health problems, and how accessible are these services?

Significance of the study

The socio-economic benefits of migration, especially the counteracting of the adverse impact of an aging population and the fostering of economic growth in advanced societies are beyond questionable (AboElsoud, AlQudah & Elish 2020). Many Western countries have considerable health investments to ensure that their people enjoy good health, however, good health is not

uniformly enjoyed. A number of factors including class/socioeconomic status, rurality, ethnicity and places of origin contribute to create disparities (Islam 2019; Jordan et al. 2004; Palloni & Arias 2004). It remains crucial to further explore how healthcare systems can be enhanced to ensure equitable health access by every member of the society irrespective of one's country of birth, social position, and cultural and religious belongingness. Not only will this assist in examining factors contributing to the disappearance of the healthy migrant effect, but also generate data that can be useful for understanding that Southern African migrants have experiences that are detrimental to their health, and the varying understandings of health which are currently not adequately addressed in the Australian context. As Llácer et al. (2007) argue, the success of a healthcare system is measured through its ability to ensure equitable access regardless of the social, cultural and material position in society. Examining social factors influencing access or lack thereof, and cultural ideologies shaping health beliefs among the "invisibles" of the society is a fundamental step towards ensuring that their health needs are understood in order to resource services reflective of the socio-cultural realities of a contemporary Australia. This will assist in fostering the lowering of the disease burden. That is, the morbidity, mortality and financial cost associated with the health problems.

In this research culture is at the centre of health behaviours, therefore it is crucial to define it. Cross et al. (1989) describe culture as the human beings' beliefs, values, customs and their integrated behaviours shaped by their institutions that manifest in their actions, thoughts and language. Concerning the health matters of the Southern African communities, the indigenous framework that principally associates illness with supernatural forces is central in shaping health behaviour. Obviously as culture is dynamic, the health behaviours are also being informed by the Western health systems which have dominated the health services across the world. Therefore, the contemporary health culture among Southern African communities is pluralistic, comprising both indigenous and Western initiatives. In demonstrating the importance of culture on health matters, Patel, Mutambirwa and Nhiwatiwa (1995), Waldron (2010) and Mokgobi (2014) among others explain the cultural boundedness of health and illness manifestation especially in societies that externalise causational phenomena, taxonomical bifurcating of normality and abnormality using cultural idioms and cultural beliefs. The broader argument is that people experience, express and attach meanings to their illness and afflictions within their cultural contexts (religious, traditions

and social injunctions guiding reporting and behaviour) (Hwang et al. 2008; Kirmayer 2004; Patel 1995; Patel, Mutambirwa & Nhiwatiwa 1995) Napier 2014; Mackenzie 2019). In order to widen understanding and enhance a comprehensive (physical, spiritual, psychosocial and religious) view of health and to strengthen the interventions, it remains important to further examine specific socio-cultural issues in migrant communities. Thus, this research is useful in widening the knowledge of the health meanings, health beliefs and health behaviours of a cohort that is still recent to Australia. As the research particularly focuses on the health beliefs, it enriches the knowledge on the ideological frames that shape health understanding, symptoms reporting and help-seeking among other issues. The African literature used in this study shows that Southern Africans have various health ideologies and beliefs, some of which are not addressable through health services available in Australia. The following chapter emphasises this through discussing the religiously-embedded health rituals such as the use of sacred ancestral places, "holy" places and various cultural rituals (slaughtering of an animal, traditional beer brewing) mediated by traditional healers (Essien 2013). It was particularly interesting for this thesis to investigate how these health spaces and practices were utilised postmigration as they remained important aspects of the health beliefs (as explored in Chapter six). Considering that there are generally fewer studies exploring socio-cultural issues in minority migrant communities (Michelson & Sclare 2009), due to smallness of their number, language issues and cultural barriers to participating in research, Southern Africans in Australia are likely to be one of the most disenfranchised from services and less covered in literature.

Notwithstanding the fact that the few empirical studies that researched the health and wellbeing of Africans in Australia have produced exceptional work, they have seldom focused on people from Southern Africa compared to those from West, East and Horn parts of Africa who have a longer migration history in Australia (see Hornyang et al 2017; Muchoki 2011; Nunn 2010; Shepherd 2017; Renzaho 2011; Wilson 2010; Drummond 2011; Tempany 2009; Tilbury 2007, Udah et al. 2019). Africa is a continent of not less than 50 countries with each country home to people of multiple tribes, therefore the transferability of the findings conducted with Africans from other parts of the continent may be limited. Moreover, it seems most of these studies have been conducted with people who have a refugee background. Thus, considering the heterogeneity of

African migrants to Australia (including also skilled workers and tertiary students) there is a strong likelihood that their health experiences, health beliefs and the challenges they encounter vary.

It is worth mentioning that for decades, Southern Africa has been a relatively peaceful region on the continent, and South Africa offered many economic, humanitarian and education opportunities for its neighbours undergoing economic and political turmoil (Crush & Frayne 2007). For its relative stability, the region has also been used as a springboard by other Africans for intercontinental migration (Segatti & Landau 2011). However, in the last two decades, the political and economic instability in countries such as Zimbabwe (Gwenhamo, Fedderke & de Kadt 2012), and rising xenophobic violence (Hayem 2013; Mutanda 2017) increasingly push Southern Africans to migrate intercontinentally. While South Africa was the main migrant recipient in Southern Africa, Matthews and Van Wyk (2018) also observe that in the last two decades there has been an accelerated change in the social, pollical and economic landscape which has exacerbated poverty thus limiting opportunities for foreigners, as well as stoking nationalist politics. Labonté et al. (2015) discuss the low remuneration, the poor living and working conditions, lack of career development, as well as unsustainable cost of living and economic insecurity in recent decades as driving out professionals in Southern Africa to western countries.

Southern Africa

Southern Africa is the southernmost region of the continent of Africa. It comprises of 16 countries, namely Angola, Botswana, Comoros, DRC, Eswatini (previously known as Swaziland), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe (Rosenberg, Strauss & Isaacs 2021). It is useful to highlight that while there are still debates about whether some countries such as Comoros, Mauritius, Madagascar and Seychelles are actually from Southern Africa (see Somerville 2021), this is not the case for the countries at the centre of this research. The participants in this research are from Zimbabwe, Zambia, Botswana, Malawi, Mozambique and South Africa. For centuries, these countries have forged closer social, political, cultural and economic ties through economic dependencies, political struggles and interventions (see Hammer, McGregor & Landau, 2020). Also there are fundamental historical commonalities of colonial repression (Mlambo 2016), centuries' old regional migration, historical tribal connections, shared health beliefs,

communal life orientations and the social connectedness among these countries (Aina & Morakinyo 2011; Matoane 2012; Muga & Jenkins 2008; Patel 1995). Thus, while people from Southern Africa themselves are not a homogenous group as they have their own cultural and traditional specificities, these broad shared values provide a solid base for incorporating people from various Southern Africans as a single cohort in a study exploring issues that are to some extent socially and culturally mediated. Importantly, focusing on regional migrants also provides an opportunity for much smaller communities in Australia such as the Malawians and Mozambicans to participate in this study.

Thesis outline

This thesis has seven chapters. Chapter two provides an account of the health beliefs and practices, and health systems, in Southern Africa, which continue to shape the health practices and access to services of Southern Africans after migrating to Australia. The chapter also engages the literature of the African diaspora living in Western societies to explore how these communities potentially fashion and address their health issues. As a result of limited studies specific for people from Southern Africa in Western countries, and generalisation in literature, in some cases the review will use "Africans" to discuss issues that potentially shape the behaviour of Southern Africans. The chapter concludes with a description of Ubuntu perspective which is the study's main "interpretive tool".

Chapter three details the processes by which this qualitative research was conducted; it discusses the methods used to collect, analyse and interpret the data. Participant observation and dialogical interviews were considered the most appropriate to understand the people's experiences, attitudes, behaviours and practices. In explaining the fieldwork experience and the methods used for data collection, I discuss my positionality as an insider researcher especially its role in the issues encountered and its importance in navigating through the research process. The chapter also discusses post fieldwork activities, measures put in place to ensure objectivity and believability of the findings, as well as providing an account of how all the ethical procedures were followed.

Chapter four draws on secondary research and interview data to explain the environmental and contextual factors that put participants at an elevated risk of health problems because of their

disadvantaged social position, as well as the financial obligations that shape their workstyles and subsequently undermine wellbeing. Living in Australia meant that participants are largely isolated from their extended families and other social networks that they normally rely upon for their daily needs, which brings financial pressure because they have to use formal services to fulfil these roles. At the same time, they struggle with racism, discrimination and exclusion which create a sense of unbelonging, hopelessness, and ambivalence. These issues elevate the participants' vulnerability to various illnesses.

Chapter five discusses the participants' beliefs, knowledges and philosophies that shape their understanding and interpretations of mental health difficulties. The dissimilarities between Western conceptualisations of mental health difficulties and their Southern African beliefs and ideologies, which renders the utility of the available biomedical services of limited utility, is discussed. Instead of using Western, biomedical services, participants embedded themselves in their communities to produce and access their own culturally appropriate services to address mental health difficulties, including utilising the cultural services back home. Although through acculturation and socialisation participants embraced, to some extent, biomedical interpretations in relation to their mental health difficulties, these services were still of limited utility due to the healthcare workers' overlooking of the participants' cultural issues.

Similar to the approach in Chapter five, Chapter six examines health beliefs and practices, but focuses more on the physiological aspects of health and illness. It also indicates a more pronounced medical pluralism than evident in the discussion of mental health in the previous chapter. There was a clearer utilisation of both biomedical and indigenous health services in accordance with their holistic approach to health. This was not the case when there were mental health issues. However, in utilising the biomedical services to maximise health needs, the chapter demonstrates that participants tactically engaged the healthcare workers from their countries without necessarily visiting healthcare places to minimise the disruption in their routine activities, as well as utilising clinicians they viewed as culturally more friendly. The chapter concludes with a discussion of transnational health seeking as part solution to their difficulties in accessing appropriate health services. Participants also showed agency through creating their own space for producing

indigenous interventions locally and a continuous insertion in their social networks to continue accessing health services back home, making use of Ubuntu.

Chapter seven, which concludes the thesis, sums up the key arguments made on the issues that elevate Southern Africans' susceptibility to health issues, the participants' health philosophies, beliefs and health behaviours particularly their role in the utilisation of the services or lack thereof. What can be learned from this research, policy suggestions and opportunities for future research and study limitations are also covered in this chapter.

In this chapter I have set the scene by discussing the general history of, and most recent trends in, Australian immigration, in order to provide an overall picture of the healthiness of migrants when they first arrive in Australia (the "healthy migrant effect"). I have provided a brief introduction to the health challenges people face postmigration. The project's overarching objectives, the related research questions that guide the thesis and the significance of the study have been pitched. The following chapter largely draws on the African literature (mainly literature focusing on Africa and health and health systems on that continent) as I discuss the health beliefs, ideologies and practices and the healthcare system in Southern Africa, which will assist in understanding the research findings. I also draw on the health experiences of other African diaspora communities.

CHAPTER TWO: HEALTH BELIEFS AND HEALTHCARE SYSTEMS IN SOUTHERN AFRICA AND POST MIGRATION HEALTH EXPERIENCES

Introduction

When problematising the health issues of the culturally diverse migrants, several scholars discuss migrant groups' respective health traditions, practices and philosophies in their home countries for contextualising how illness can be explained postmigration. For Southern Africans, indigenous health philosophies that associate illness with religion and spirituality, in addition to scientific explanations have remained central in making sense of their illness even when they migrate. This chapter is largely an account of Southern Africans' health beliefs, philosophies, knowledges and practices in order not only to provide a grounded understanding of how health and illness are culturally constructed, but is also useful in gaining insights into some of the health behaviours of people from Southern Africa postmigration. The African Traditional Religion (Okeke, Ibenwa & Okeke 2017) and African Pentecostal Christianity (Gifford 2008) are particularly discussed as the well-established indigenous frames used to interpret the illness, as well as the role of these beliefs in shaping health intervention. The latter is also known as African Pentecostalism (Asamoah-Gyadu 2004; Kalu 2008). The later parts of the chapter expand the discussion around some of the known health access barriers introduced in the previous chapter. However, considering that various literatures generally discuss all people of African origin as simply "Africans", the chapter has a considerable amount of literature that is drawn from the African diaspora in general in discussing how Southern Africans ethnoculturally interpret their health problems. In order to further contextualise the health challenges likely to be faced by Southern African migrants, the chapter has a brief critique of the health systems in Western societies especially around their cultural appropriateness for people that are from culturally diverse backgrounds. The chapter wraps up with a discussion of Ubuntu, an Afrocentric perspective which is deployed to interpret the findings. For a study that sought to explore the issues that are mostly culturally and religiously mediated, utilising Ubuntu, a perspective developed in the traditions, ideologies, practices and thoughts of the Southern Africans (Metz & Gaie 2010) assists in developing a more contextualised analysis.

Healthcare systems in Southern Africa

Indigenous and biomedical healthcare systems operate throughout Southern Africa. A definition of indigenous medicine covers the total of skills, knowledges and practices that are informed and specific to a culture's beliefs, philosophies and experiences that have a role to maintain health, and to protect against ill health and to diagnose and treat illnesses (Mahomoodally 2013). Gurib-Fakim (2006) views the African traditional health intervention as holistic because it addresses both the spiritual and physiological aspects of the illness through various rituals unlike other interventions. Important to highlight is that even though Christianity is a foreign religion in Southern Africa (it was introduced by the European missionaries and was actually established oppositional to the African Traditional Religion) (Mbiti 1990), because of the massive transformation, refinement and tailoring to the African context and ideologies it has undergone (Green & Makhubu 1984; Van der Merwe 2016), as well as its philosophical commonalities with the African Traditional Religion, it is discussed under the indigenous ideologies shaping health practices. This therefore entails that the prophets from charismatic African Pentecostal churches are discussed as indigenous healers alongside traditional healers, herbalists and spirit mediums. Biomedical approach to health involves addressing of an illness in an individual through using biological and natural-science principles to clinical practice (Germov 2014). The model works on the assumption that an illness is a result of foreign microorganisms entering the body uniformly and predictably thus a universalised approach to cure and intervention can be adopted (Germov 2014). Notwithstanding the acrimonious conditions under which it was introduced on the continent, biomedicine went on to become one of the germane healthcare systems for people in Southern Africa. Discussing these as the health philosophies and healthcare systems that people from Southern Africa are familiar with helps to understand some of their health behaviours postmigration.

Traditional health beliefs and practices in Southern Africa

Of course, there is no attempt in this discussion to homogenise a cohort of people from 16 Southern African countries who among themselves have diverse cultures, religions, ideologies, traditions, histories, beliefs and norms and values. Nonetheless, the many shared cultural commonalities on health beliefs, emotional vitality, bereavement rituals, collective survival and interdependence, the cultural functionality of the elderly, perception of time, oral traditions, shared regional histories,

rites of passage and marriages and ancestry beliefs (Aina & Morakinyo 2011; Matoane 2012; Muga & Jenkins 2008; Patel 1995) create commonalities and a platform for assembling them in a study concerned with the sociocultural issues of health. Moreover, there are specific health similarities in the region including the belief that an illness is a disabling bodily condition that is supernaturally instigated as a punishment from God, ancestors or through witchcraft by malevolent spirits (Kale 1995; Truter 2007). At the same time, as the preceding chapter indicated, the smallness of the Southern African community in Australia such as Malawians and Mozambicans makes it harder to group them separately, thus scoping the study around Southern Africans in general extends the opportunity for people from these much smaller communities to also share their stories.

According to Mbiti (1990) Africans are famously religious. Most of the life occurrences, from the death of a family member, imprisonment, retrenchment from work and illness are interpreted as conditions or fortuitous events caused by and instigated supernaturally (Eagle 2005; Nwoye 2015). Therefore, an illness in Southern Africa is principally viewed as evidencing a breakdown of the complex relationship involving the social, physical and spiritual relationships; if one or more of these relationships are compromised, an equilibrium is lost leading to an illness (Kale 1995; Truter 2007). Three major supernatural forces are normally identified for the illness; God as the Supreme being; the "living-dead" (ancestors); and the wicked powers such as the witches (Eagle 2005; Shizha & Charema 2012). Essentially this entails that every illness in an individual, one way or another, is perceived as a disruption between the human beings and their ancestors and/or with the supreme being, God. In elaborating these beliefs, Peu, Troskie and Hattingh (2001) stress the interconnectedness of "all things in the universe" and the harmonious unity of all the life forces including one's body (intrapersonal), between people (interpersonal) and between one's physical environment and the spiritual world which all have an effect in the wellbeing of individuals. Harmony within these forces causally brings good health or wholeness (Peu, Troskie & Hattingh 2001). Therefore, an illness in an individual is not only symbolical of a disruption of mutuality of existence in the physical order/ body functioning or interpersonal relationships (fellow humans), but also symptomatic of disharmony and disequilibrium between an individual and the spiritual forces. In other words, a person's good health in Southern Africa is a product of many (natural and

supernatural) forces, a result of one's harmonious coexistence with their family, community, nature and the supernatural forces.

In discussing the collectivistic cultural embeddedness of health in Southern Africa, De Craemer (1983) stresses the importance of one's family, clan members (both the living and the dead), as the network of relationships that primordially ensures the social and health wellbeing. Kpanake (2018) summarises Africans' views of health as transcendingly beyond the mere absence of a disease in an individual, rather, in a collectivistic society the harmonious state of wellbeing must be shared by all family or community members. In line with this, pan African scholars (Chukwuneke et al. 2012; Mbiti 1990) emphasise the holisticness of African traditional healing, because it considers and includes of people's relationship with the superhuman (God and ancestral spirits), with the environment (through symbolic importance of sacred places and the functionality of inanimate materials in healing rituals) and cohesion and harmony with the other human beings. In explaining the functionality of the supernatural world relating to the health matters of the living, Mzimkulu and Simbayi (2006) position ancestors as the "living-dead", a part of the family hierarchically above the human beings who primarily ensure the wellbeing of the living clan members. Traditional beliefs of several Southern African tribes confirm this. Notably, Zimbabweans (Shona people) believe that *Varoyi* are wicked individuals who can bewitch people but their efforts may only succeed if there is no ancestral protection (Shizha & Charema 2012). The Zulu people in South Africa have similar views, witches are known as *Abathakathi* (witches) according to the same author.

As already shown, an illness in these indigenous tribes is functionally and symbolically communicative of the society's disequilibrium between the living and the dead, if ancestors withdraw their protection for whatever reason then an avenue for illness has been created (Shizha & Charema 2012). Therefore, as agentic entities, the living sustain their relationship with the supernatural powers through adhering to the ethical and moral codes prescribed for them, and shunning socially unacceptable behaviours (incest, theft, bestiality, disrespecting parents and elders) in order to remain supernaturally connected (Mbiti 1990). The African Traditional Religion's positioning of the supernatural powers as existential forces superior to the living that ensures social cohesion and order in the affairs of the living through prescribing a sacrosanct set

of shared morals and norms in order to enjoy good health, echoes Durkheimian sociology. For Durkheim, religion "is an interdependent system of beliefs and practices regarding things which are sacred, that is to say, apart forbidden, beliefs and practices which unite all those who follow them in a single moral community…" (Durkheim 1965). Thus, the desire to maintain good health becomes a key feature of the important agencies for promoting moral values and gluing society together (see Durkheim 1965, p.62); if one transgresses, they undermine solidarity resulting in an illness. For the transgressor to recover, a rehabilitative ritual, especially a cleansing ceremony mediated by social order custodians (prophets and traditional healers), is required (Kamwaria & Katola 2012). Rituals such as slaughtering of an animal, akin to the animal sacrifices of the Old Testament are part of communicating with the ancestors (Gumede 1990).

Traditional healers and their healing

Neba (2011) asserts that traditional African healthcare systems have sustained scathing criticism for centuries from Western medical journals, including unsafety allegations, and being brutally judged using the worst-case scenarios. However, the system is rich and comprehensive, and it has its own specialised field and has capacity to meet a multiplicity of health problems including gynaecological, paediatric, reproductive and mental illness (Mokgobi 2014). The work of Shizha and Charema (2012) also shows that traditional healers' utility extends to people troubled with infertility, unemployment and mental disorders while others proactively "immunise" themselves against evil powers through seeking being foretold about the future events, and routine annual "check-ups". While fertility may be differently viewed in other societies, in Africa it is highly valued with most African communities considering procreation as the main purpose for people to get married (Hollos 2003). Thus, failure to conceive often brings marital problems among several psychological consequences (Ombelet et al. 2008). Other duties of traditional healers include conflict resolution roles, in families, children nurturing, grooming and governance (Shizha & Charema 2012), and interceding to the spiritual powers for healing, harmony and peace among the people (Solomon & Wane 2005).

Mokgobi's (2014) work highlight the richness of the indigenous healing system. They discuss that when one is ill, they are usually referred to a specialist by a less sophisticated healer when the illness deteriorates to a point of warrantying the services of a more experienced traditional healer.

The referral is usually to an *Izangoma* or a Diviner, a traditional healer considered as a highly knowledgeable expert. The diviner possesses the capacity to communicate with the ancestors through divination to identify the disease and map the intervention including the reconfiguring of the circumstances causing the illness spiritually (Kale 1995; Nelms & Gorski 2006; Sobiecki 2012). They are initiated into the medical field through ancestral calls which endow them with skills to throw bones, use dreams or access the spiritual world through trance-like states when communicating with the ancestors (Truter 2007). Traditional *Izinyanga* or traditional herbalists are also healers who acquire their knowledge through apprenticeship/ being an assistant to an experienced herbalist. Once the veteran herbalist endorses them, they graduate and work on their own. Within this specialty, plants, animals' ingredients and other objects symbolically seen as possessing medicinal properties are used during the healing rituals (Sobiecki 2012). The third cohort is traditional midwives. Women who are post menopause, experienced witnessing and assisting in giving birth over the years, can become traditional midwives responsible for traditional birth attendance (Mokgobi 2014). Other roles they perform include traditional massaging during and after delivery, ritual disposal of the placenta, teaching child rearing skills, sourcing of healing medicine, dealing with behavioural issues during pregnancy and ritual bathing (Truter 2007). Nevertheless, some traditional healers can integrate various treatment rituals into their healing procedures (see Mokgobi, 2014).

Prophets (A*bathandazi or Abaprofiti)* are Christian faith healers who belong to the independent African churches (a subbranch of African Pentecostalism). They provide their healing through rituals such as sprinkling of holy water on the individual and by laying of hands on the head of the sick person (Kale 1995). They are a product of the religious movements who sought to Africanise Christianity (Van der Merwe 2016). They sought to bring religious independence from mainstream churches through infusing indigenous knowledges and traditions and interpretations in their religious practices (Green & Makhubu 1984). The healing and prophetic prowess in these churches is a major factor in attracting millions of African believers. In South Africa majority of the Christian believers belong to these churches (Anderson 2008 as cited by Mokgobi 2014). Interestingly, despite having a same theory of health and illness with fully fledged traditional healers (Mokgobi 2014), prophets from independent Christian churches actively distance their religious practices from the traditional healers. They juxtapose the "Godliness" and "pureness"

and the "evilness" of traditional healers of the African Traditional Religion. Indeed, Hirst (2005) draws similarities between African Pentecostalism and the African Traditional Religion as both systems of thought and practice especially the association and similarities between the African Traditional Religion and evil spirits and Satan in Christian Pentecostalism. Prophets belonging to a Christian Aladura church (Nigeria) who use water and prayers to effect healing (Rinne 2001) also use the Christian Holy Spirit with the spirits of ancestors. Ancestral spirits are a central feature of the African Traditional Religion. Further, the South African Traditional Health Practitioners Act categorises prophets as traditional healers (see Mokgabi, 2014). Biri (2012) also reports that prophets in Zimbabwean Pentecostal churches reject the African traditional healing because of the alleged darkness associated with it, yet embed their healing practices in the African traditional healing. In his assessment, Mndende (2009) argues that this is reflective of people who have stripped their identity through colonisation and the imperialistic tendencies of Christianity which argued for the rejection of the indigenous sociocultural and religious practices for civility. In order to be accepted in Christian circles African healers describe and identify with Christianity yet construct their theology and healing rituals in the African Traditional beliefs (Magezi & Banda 2017).

Traditional healers mediate between human beings and their ancestors, have historically been located within people's vicinity (Shizha & Charema 2012). They are also expected to provide their services through cultural and ethical codes for healing and recovery to take place (Pretorius 1995). As spiritually endowed individuals, traditional healers serve their clients humanely and compassionately through providing the best possible care regardless of one's ability to pay and standing in the society (Neba 2011). Through similar cultural codes applied on traditional healers, the patient and their families have a cultural obligation of consulting traditional healers with a token of appreciation. According to Neba (2011) items one might bring include chickens, goats, money or other basic goods to appreciate the healer. These items are thus largely symbolical of one's communicative effort to appreciate the help given rather than a materialistic value.

Congruent with the Southern African broader communitarian and collectivistic values, illness is collectively viewed, that is, an illness of an individual is interpreted as an unwellness of the entire family (Kpanake 2018; Mbiti 1990). Therefore, when dealing with an individual, the scope of

intervention is beyond the ailing individual but to be inclusive of the entire family. This also requires coordinated efforts and collaboration from the adult family members who among other duties search for the appropriate traditional healer, accompanying the ill person to the traditional healer. Other duties include providing background information about the illness manifestation, the deterioration rate, and participating in the healing rituals (slaughtering of a beast, drinking of traditional beer, singing and dancing) to invoke a healer to enter a trance state and in order to tap in to the supernatural world for healing information (Berg 2003; Mzimkulu & Simbayi 2006). These are of particular importance because, as Prinsloo (2001) and Kpanake (2018) explain, the African healers not only associate diseases with specific body functionalities through physical examination, but are also concerned with a holistic approach factoring in the patient's spirituality and religiosity, their transacting with nature and other human beings. Family elders or community leaders are often resourced to provide this account. When intervening, the African explanatory models interrogate the causes of the illness including where they have erred, the nature of the illness and the required remedial action (Ross & Deverell 2010).

When diagnosing, less focus is on the symptom grouping compared to the causes of the illness and meaning of the illness. People with widely differing symptoms might get a similar diagnosis (Swartz & MacGregor 2002), or those with similar symptoms diagnosed differently (Shizha & Charema 2012). Apart from using observational tests for diagnoses, indigenous healers use casting of bones, apply cola nuts and "reading an egg" and the application of traditional medicine and natural products such as oils, animal parts, insects, leaves and roots as part of the healing techniques (Card et al. 2020; Lassetter & Callister 2008). Depending on the gravity of the illness, it is also unusual for the ill person to be an "in-patient" at the homestead of the healer for weeks or months. Family members are expected to constantly visit and get regular updates (Ensink & Robertson 1999; Pretorius 1995). Traditional healing methods are considered socially, culturally and religiously grounded and compatible with the system users through their complete treatment and their holistic addressing of the whole person as a physical, psychological, spiritual and social and cultural entity (Pretorius 1995; Truter 2007). While a romanticised picture of African healers is apparent in several pan-African literature, there is anecdotal evidence showing that traditional healers have reportedly abused their patients, although some have argued that what can be interpreted by outsiders as an act of abuse is actually part of the healing art.

Threats to indigenous health systems: Christianity and biomedicine

The history of political and cultural subjugation through colonialism and Christian missionaries in the 19th century is a tragic and traumatic era for the African cultural and political systems, many pan-African scholars (Mbiti 1990; Mndende 2009; Mokgobi 2014; Mzimkulu & Simbayi 2006; Pretorius 1995) write. The indigenous institutions were considered inferior, backward, and inefficient, and as these institutions were "savagely" dispossessed and replaced with the foreign systems, Africans lost their confidence as a people with a right to self-determinate (Viriri & Mungwini 2010). Tilley (2016) expounds that as part of the colonising agenda, biomedicine was a potent tool used for the imperialists to discredit the traditional African beliefs, values and its medical theories. Also, as part of the colonising mission, localised peoples were dispossessed of their ancestral lands, and historical roots thus symbolically undermining their transactions with their ancestral environments. This removed autonomy in order to facilitate quickened conformity to the foreign cultures for survival (Tilley 2016). At the same time, the lack of written records and manuals to constantly refer to, for example, a Bible and a Koran, and celebrated personalities, such as Jesus in Christianity, and Muhammed in Islam also meant the African Traditional Religion (which informs indigenous health interventions) stood little chance to withstand the highly marketed foreign religions (Mbiti 1990) and the well documented health benefits of Western medicine (Neba 2011). The chastisement and the undermining of the indigenous systems had nothing to do with the often-cited safety issues, but everything to do with the hegemony of biomedicines and the politics shaping knowledge production in the health field (Neba 2011). Similarly, Baronov (2008) sees the scope of medicine much transcending beyond combating diseases but also a political and "civilisation" weapon deployable to enforce Western sociocultural ideology in order to get rid of the African "incivilities". Turshen (1984) as cited in Baronov (2008) elaborates that biomedicine and Christianity, and other scientific inventions, philanthropic humanism, economic enterprise, and Christian education surreptitiously imposed in prescientific Africa, tried to throttle out the life breath of the Africa belief system.

Through ideological and cultural subjugation, using claims about inferiority, dangerousness and incivility by the western health practitioners on one hand, and condemnation of heathen and barbaric culture by Christian missionaries on the other hand (converting to Christianity was conditional upon renouncing these practices) (Peu, Troskie & Hattingh 2001). Therefore, Africans

embraced Western health practices not only for their supposed superiority, but also as part of converting to Christianity. Christian missionaries were also actively involved in the building of schools and hospitals ,and notwithstanding their philanthropic intentions, in the process they spread western values and undermined indigenous ideologies (Biri 2012). While some Africans converted to Christianity by choice (Nigosian 2015), it is also worth noting that western institutions used various ways to enforce Africans into their systems and abandon their ancestral practices and converted them into Christianity. For example, Mokgobi (2014) discusses how the apartheid government in South Africa made it harder to be enrolled a primary school unless one has a Christian name. The arrival of biomedicine also had a pernicious effect as it transferred the power of traditional institutions to western trained professionals as knowledgeable and legitimate healthcare providers. They not only suddenly lost their legitimacy and respect, but also were criminalised and outlawed as witchcraft and witchdoctors (Richter 2003; Simmons 2000). Hassim, Heywood and Berger (2010) discuss the outright banning of indigenous healthcare systems in South Africa by the Medical Association in 1953. The 1957's Witchcraft Suppression Act also made it illegal to practice indigenous healing in South Africa. The social order and the traditional institution responsible for the regulation and support of the profession were disrupted (Ahlberg 1991). In ordering Christian converts to dismiss indigenous practices deemed superstitious, as idolatry and erroneous (Sanou 2015), and embrace desirable western culture, almost all the early missionaries were western instruments of colonialism (Ferguson 2004; Pobee 1979) actively participating in the displacement paradigm as they did not see anything Godly in non-Christian religions including traditional health institutions (Smit & Mouton 2009). Yet, Chavunduka (1994) stresses that it is difficult to separate the healing systems in Africa from the traditional practices, thus disrupting those institutions automatically meant undermining the traditional African healthcare system. While civil and criminal courts were used to marginalise indigenous African therapeutics and advance biomedicines (Tilley 2016), their dominance did not entirely usurp the localised healing systems (Lock 2003). As Tilley (2016) stresses, despite getting many legal protections, massive funding from colonial governments, as well as setting the agenda for what constitutes acceptable medicine, biomedicine failed in entirely deposing traditional medicine.

Medical pluralism in Southern Africa

The previous section has shown that the arrival of colonists and Christian missionaries in the 19th century brought a pernicious campaign and decimation on the indigenous health system on the basis of primitivity, barbarism, ineffectiveness, dangerousness and lack of proof. Christianity juxtaposed indigenous practices as heathen, evil and ungodly; thus, conversion to Christianity (which was also attractive as it came with material benefits such as schools, employment, infrastructure) was conditional upon renouncing these. Therefore, through coercion and lure (as missionaries also promoted biomedicines), Southern Africans embraced western health theories. However, they did so without entirely disconnecting from their ancestral beliefs. This birthed a pluralistic medical system in Southern Africa.

Cant (2020) defines medical pluralism as the coexistence of ideas, practitioners from differing medical traditions and distinctive worldviews occupying the same therapeutic space in society. Medical pluralism was not only politically embedded to somewhat defend the space and importance of non-scientific healing practices in a world where western medicines increasingly gained traction, but also a response to the inadequacies of the biomedicine that overlooks other health knowledges and beliefs (Hörbst, Gerrets & Schirripa 2017). While the historical developments in Southern Africa show that simultaneous use and combining of different healthcare system is centuries-old, medical pluralism, as a concept was coined by Charles Leslie (1976, 1980), and was originally used to the contexts of South Asian medical revivalism in the 1970s (Penkala-Gawęcka 2016). In this study it is a useful concept used to elaborate on how the Southern African healthcare systems have been reoriented since the 19th century which helped to understand the health beliefs, attitudes, practices and approaches of people from Southern Africa postmigration.

Factors contributing to the resilience of indigenous health systems in Southern Africa

Despite the concerted efforts by western medicine to directly and insidiously destroy and alienate the African indigenous people of their traditional health beliefs and practices (Neba 2011), many Southern Africans still rely on their traditional and ancestral medicine (Peu, Troskie & Hattingh

2001). Strong embeddedness in ancestral practices, the exorbitant cost of biomedical health, religious beliefs, and rurality (where western services are limited) have all accounted for the resilience of traditional medicine (Mokgobi 2014). While the number of people using traditional medicine remained higher (70-80 per cent) in some countries (Peltzer et al. 2008), in recent years the number of people utilising indigenous health practices may even be further rising. More people resuscitate their ancestral religions, healings and traditions by returning to their sacred cultural doctrines and ideologies, as western health services are fit only for certain purposes, as the chapter later shows. At government and inter-governmental levels, there have also been attempts to promote indigenous medicines. For example, 2000-2010 was proclaimed a period for reviving the African indigenous medicines by the African Union. Following this pronouncement, 31 countries developed health policies specific for traditional medicine (previously there were only eight), and 18 countries developed traditional medicine strategic plans (Ahlberg 2017). In 2003, Southern and Eastern Africa also convened a meeting on how to strengthen traditional medicine systems in fighting health challenges bedevilling the region (Chinsembu 2009).

Through these efforts, many (if not all) Southern African countries now have a well-formalised dual health system recognising both the biomedical and traditional interventions (Moshabela et al. 2017; Moshabela et al. 2011; Pantelic et al. 2015). A notable case is the South African Traditional Health Practitioners Act (2004) strengthened the role of indigenous specialists in mental health (Janse van Rensburg 2009). Several other organisations such as the Congress of Traditional Healers African Dingaka Association and the Southern African Traditional Healers Council (Kale 1995), both in South Africa, are empowered to register healers in terms of the Companies Act. Similar to the colonial administrations who used medicine as an ideological tool to advance their ideologies (Ferguson 2004; Pobee 1979), the Zimbabwean government's swift professionalisation of the indigenous medicines through establishing the Zimbabwe National Traditional Healers Association (ZINATHA) after the political independence in 1980 was a crucial step of reasserting the legitimacy of indigenous healthcare systems (Cavender 1988). This professionalisation of the traditional healers was a correction of the institutional suppression of indigenous health practices by previous colonial governments (Shoko 2018). Regardless of the political, cultural or efficacy motives involved in Southern Africans' fight for restoration and recognition of their indigenous health system and approaches (Ahlberg 2017), these dynamics and developments further created

a people with fluid health beliefs, who oscillate between different, philosophically oppositional, health beliefs. Pretorius (1995) describes them as "westernised people", "traditional people" and "inbetweeners".

The access to health literature focusing on "spatial access", that is the distance between the community and healthcare providers (Rosero-Bixby 2004), importantly helps in further illuminating the resilience of indigenous health practices. The concept describes the nearness (distance or time) of medical services demand in space or the size of the demand that may compete for the available services (Barcus & Hare 2007). In many rural communities of Southern Africa, formal hospitals and clinics are scarcely available compared to traditional medicine, thus people utilise the readily available traditional services (Kale 1995). For example, in South Africa there are 25 000 biomedically trained doctors compared to 200 000 traditional healers (Kale 1995; Pretorius 1995). In one of South African studies, Shizha and Charema (2012) noted one traditional healer for 700 to 1,200 people, while the ratio for biomedical doctors was one per 17,400. In the 1980s in Malawi, 80 per cent utilised traditional medicines for their health needs according to Peltzer (1988). Shizha and Charema (2012) report around 45,000 indigenous medicine practitioners to 1,400 biomedical doctors in Zimbabwe which evidently indicated that traditional healers are more reachable than biomedical doctors. 90 per cent of Zimbabweans are estimated to be using traditional healers (Shizha & Charema 2012). In Mozambique one in every 50,000 visited a biomedical doctor while one in every 200 consulted traditional healers. In Swaziland, by 1990 one in every 1000 consulted a traditional healer, and the ratio for western-trained doctors was one in every 10,000. 60 per cent of South African rural dwellers consulted traditional healers before utilising western services (Shizha & Charema 2012). All these findings demonstrate the vast presence of traditional healers in Southern Africa compared to biomedical services.

Even though traditional healers are private practitioners, because of the humanistic philosophy guiding their practice, they avail themselves to be consulted at any time and are flexible to travel to the patient's homestead if they cannot make it to the shrine (Puckree et al. 2002). While accessibility, availability and affordability have been identified as important factors for a greater usage of traditional interventions (Abbo 2011; Shizha & Charema 2012), some scholars report that people situated in convenient places, notably urban centres and who have a private health medical

aid (mainly provided by their employers), still preference traditional medicine. This is because their illness beliefs are more consistent with the traditional explanatory illness interpretation compared to the western reductionist approach western doctors are known for (Peu, Troskie & Hattingh 2001; Puckree et al. 2002). In interpreting this practice among the middle-class urbanites, Shizha and Charema (2012) stress the ingraining of the African mythical cosmology, the functionality of the supernatural within the ethno-psychology of many African countries in legitimating their illness regardless of a person's social standing, education, pastoral or urbanised lifestyle or religious affiliation, as key factors in the flourishing of traditional medicine.

Pretorius (1995) stresses that western interventions are considered less satisfactory in some parts of Southern Africa because western healing rituals ignore the patient's supernatural and religious aspects of the illness, therefore lowering usage of such interventions. In another study, Ross and Deverell (2010) discovered that South Africans were mainly motivated to consult traditional healers not because they lacked financial resources to consult western services as previously reported, but because they considered it holistic due to its embracing of traditions, culture, indigenous ideologies and religious beliefs. In a study comparing the satisfaction rates between western and traditional health interventions in South Africa, 80 per cent of the people used both traditional and western interventions for severe mental illness problems, but reported better outcomes with traditional interventions (Abbo 2011; Mzimkulu & Simbayi 2006). Also among the South African healthcare system users, for physical illness, Kale (1995) reports that traditional interventions were considered more effective for diarrhoea, joint pains and headaches than western expertise, while complicated cases required western specialists' services. These cases demonstrate that even though in principle the relationship that exists between biomedicine and traditional medicine is acrimonious, characterised by conflictual and hostile ideological positions (Richter 2003; Simmons 2000), users ignore these ideological /positions to maximise efficacy.

However, in explaining the main difference of illness and health constructions between the Western medicine (biomedical) and the African (traditional) models, Ross and Deverell (2010) emphasise the scientific grounding and constant refining through rigorous criticism of evidence in order to maximise efficacy as a hallmark for the western model. Biomedical advocates, thus, believe they have a justifiable cause to vocally criticise and regulate traditional medicine due to

the latter's lack of a body of knowledge to reference and substantiate its practices scientifically (Mokgobi 2014). On the other hand, the African indigenous system as a distinct approach, embeds and preserves expert information in specific people's indigenous knowledges, religion and tradition and passes it on orally, unconsciously and uncritically, as merely the normal practices or the usual way of doing things intergenerationally (see Akibu, Peter, & Aramide 2017).

Postmigration health beliefs

Various reasons, including health beliefs, have been discussed in the previous section to explain the flourishing of traditional medicines in Southern Africa. This section draws on the studies of other African groups with related traditions in western countries to not only further stress their pluralistic health approaches, but to also underscore the resilience of the traditional health beliefs postmigration. Studies from other countries that are culturally and institutionally closer to Australia notably the United States, Canada and Britain are useful for a broadened understanding, as well as for highlighting the globality of the phenomenon the research explores. A discussion of the health experiences faced by the African diaspora shows that most health challenges they face in Western societies are connected to the systems' overlooking of the specific cultural needs of various minority groups. This therefore also further illuminates the importance of the project especially the users' experiences.

Postmigration literature reveals that the African diaspora retain their health beliefs, philosophies and practices. A study by Barbee (1994) with an African community in Massachusetts, United States, reports few distinctions between her participants' conceptualisations of health problems and the religious explanations of similar problems in their home countries. Similarly, in other parts of the United States, Madu (1996) reports that the African diaspora who grew up in rural areas were more oriented towards indigenous beliefs of voodoo and witchcraft to explain their illness. Those that experienced both rural life, and were later further acquainted to western healthcare systems when they moved to the cities, also maintained Indigenous religious beliefs but used Christian frames to interpret their health problems (Madu 1996). The African diaspora also perceive their health difficulties, especially mental illness, as a punishment for the sins they have committed, the illness is therefore interpreted as a justified pain inflicted to the transgressor by the supernatural

authorities (Sow 1980). While these studies with the African diaspora stress the resilience of health and illness beliefs postmigration, in most cases the congruent traditional interventions were unavailable in the host countries (Baker 1994; Barbee 1994).

Interestingly in his examination of cross-cultural diagnosis, Sow (1980) identifies similarities between what Africans refer to as the effects of sorcery and what western practitioners describe as anxiety attacks; and depression was a western version for explaining somatic complaints (headaches, sensations of heat). What largely differed was the underpinning interpretations. For instance, schizophrenic labels were attached by western clinicians to African migrants while the community disagreed, opting for a cultural and religious explanation (Garretson 1993). The Somali community in Britain complained that healthcare providers blindly interact with them and were ignorant of their health beliefs, including the reporting styles and help-seeking processes, hence the failure of many targeted interventions (Whittaker et al. 2005). Indeed, here is an argument showing that certain behaviours mean different things when analysed from various cultures, thus the importance of perceiving issues from the specific consumer's worldview (Kirmayer 2004). Failure to do so results in under-recognition of health conditions and illnesses and misdiagnosis. Major implications of these failures include people avoiding the available western services and placing greater trust in informal networks such as friends and community, and use of herbal remedies and religious rituals (including going to church to repent and pray for the divine intervention) (Baker 1994). The latter practices also underscore the agency of migrants in the production and consumption of appropriate health services. Specifically, Thomas (2010) discusses access to local markets and importing of indigenous medicines among Southern Africans in Britain to satisfy their health needs. Similarly, Southern Africans in Australia still value these Indigenous remedies, based on their beliefs. However, Britain is geographically close to Southern Africa, and has more air and human traffic than Australia, as well as being "less strict" in the movement of artefacts, plants, fruits and artefacts that have medical significance than Australia, so Southern Africans in Australia have less access to indigenous medicines. As Chapter six explicitly shows, strict biosecurity laws, longer geographical distance and the smallness of the Southern African community in Australia contribute to this.

Postmigration health access difficulties

In most cases Indigenous health initiatives commensurate with the health beliefs of Africans are not locally available in western countries yet they have lower usage of the mainstream services for mental health services save for involuntary incarcerations. For example, studies show that Black Africans and Black Caribbean people comparably have a higher rate of involuntary usage of services than other cohorts of people (Barnett et al. 2019; Bhui et al. 2003; Halvorsrud et al. 2018). Additional to the unavailability of appropriate services, the stigma and stereotyping experienced by these communities also contribute to lower usage. Notably, mental illness in many African societies is associated with a curse, jinx, sin and weakness among other labels (Araya 2001). The community may therefore miss out on the benefits of regular screening, early detection, and timely interventions to mental health problems. At the same time, Boyd (1990) notes that silence and other internalised coping mechanisms among the African diaspora may be part of the cultural training in resilience, strength and maturity and autonomy yet at the same time are detrimental to their wellbeing. Boyd (1990) further reports that while Africans have used western medicine prior to their relocation to western countries, they discontinue using these services postmigration out of frustration as western healthcare workers may view their indigenous health beliefs as pathological. White and Chalmers (2011), discuss the less adherence to health advice by those who may feel alienated by the healthcare system as partly a way of protesting against the system's cultural insensitivity. The same researchers add that some are reluctant to disclose certain health issues to western clinicians, not only because they perceive clinicians as lacking awareness and understanding of their cultural values, but also that these clinicians harbour stereotypical attitudes towards them. Healthcare workers, on the other hand, may interpret these failures to disclose health issues as evidence that culturally diverse minorities are less cooperative and ungrateful because they lack the will to integrate (see Christ et al. 2013), one of the common misconceptions in some multicultural societies.

Some of the difficulties faced by minority migrants in western countries result from the disagreements and contradictions between the migrants' long held ethno-specific beliefs, traditions and practices on one side and the scientifically based clinical approaches defining western medicine on the other side (Whittaker et al. 2005). Although the ideological clashes between the two are well-recorded, the African health literature shows that the two also operate alongside each

other (as shown above). Nevertheless, the arbitrariness in dismissing the utility of the traditional models in western societies is a result of the superiority, hegemony of the biomedical services (Kirmayer 2004). While at face value biomedicine logically insists on a standardised diagnosis and intervention due to biological commonalities, it critically overlooks the fact that each society has its specific and subjective cultural theories and ideologies that set the normality and deviant parameters (Waldron, 2010). Yet these are of paramount importance in shaping the norms of reporting, the conditions under which help is sought and one's responses and attitudes to interventions among other factors (Waldron, 2010). Some of the obvious implications of this cultural bias are the different health outcomes; those who share culture with those manning the health services or who belong to a culture in which the healthcare system was developed enjoy better health access outcomes while those of different orientations are sidelined. As a result of their belonginess to "unusual, strange and weird culture" (Waldron, 2010), minorities suffer discrimination through discourteous and impatient treatment, are accorded less time during the clinical interaction, and receive less information for additional services while the mainstream are more attentively cared for (Crush & Tawodzera 2014). For example, Crush and Tawodzerwa discuss triaging, a snap judgement by healthcare workers to assess patients' credibility and the severity of their conditions as also determined by categories such as ethnicity, nationality and language.

Even though multicultural societies such as Canada and Australia have made strides in ensuring health inclusivity through awareness of religious and cultural differences (Spitzer et al. 2019), there is still a tendency of importing their own cultural beliefs (what they individually consider proper) by some healthcare workers. This and other practices by healthcare workers, including assuming that migrants are ignorant of the healthcare system as some would have attempted to use specialist hospital services at their first instance, is a form of institutionalised prejudice White and Chalmers (2011) note. While approaching secondary and tertiary health services may be the case considering the difficulties of navigating the complex health services, this could be the case among healthcare users regardless of one's nativity or foreignness. Kim (2000) also argues that in cross cultural interactions, some healthcare providers tend to compare the culture of their clients to their own worldview and use their verticalised positionality to implicitly impose their own culture as a template for defining and mapping the appropriate interventions. This has also been explained by

others as an example of biomedicine's blinkered approach; assuming an anthropological evolution and replacement of traditional beliefs with modern (western) beliefs across all cultures (Dein, Alexander & Napier 2008).

Mishler (1984) criticises the hegemonic framing of the biomedical model also from a Foucauldian perspective, arguing that recent claims of refinements to be culturally sensitive in their service charters are more of an example of public relations rather than genuine cultural accommodations. Mishler further argues that at operationalisation and through the medical interview process, enormous power is exercised through determining the content to be asked and capturing the responses considered relevant biomedically (explanations that do not agree with the doctor's perspective are tactfully downplayed), and thus the powerless remain marginalised. As a result of this power disparity (even if the patient has the liberty of responding in their own way), it is the physician who frames the questions, and interprets and records the responses given (Horton 2020; Mishler 1984). Mishler (1984) refers to this as the "voice of medicine". Building from Mishler, Dew, Kirkman and Scott (2016) write about the initiating of a new topic and capturing responses deemed relevant biomedically, and the hurrying of the clinical questions as a procedural formality rather than getting the fundamental insights for an impactful person-centred approach.

Similarly, Stacey et al. (2009) note that most clients' encounters with their doctors are asymmetrical (interactional submission) due to their lack of power to refute what they are told in the doctor's offices even if they have "solid" information to the contrary. As a result of this, others report that instead of following the clinical advice they explore ways (normatively or otherwise) to address health problems compatibly with their own beliefs (Broom 2005). Corroboratively to Mishler's voice of medicine, Freidson (1986) is concerned that some western practitioners manage "problematic clients" (including those that have a different belief system) through conventional means notably disclosing less information. For Chu (1998), the voice of medicine normally has nothing to do with the efficacy of the healthcare systems, but everything to do with the superiority assumptions and inaccurate ranking and labelling of different healthcare systems and cultures rooted in a flawed system that uses popularity, marketing capabilities, and hegemony for credibility. Therefore, the healthcare system and clinicians might arbitrarily dismiss the minorities' whole set of knowledges, beliefs and

practices as archaic, naive, and insufficient. This also illustrates what Foucault (1980) terms the "subjugated knowledges." Dew, Kirkman and Scott (2016), nevertheless report that the voice of medicine is increasingly being challenged through clients' agency to disregard the paternalistic advice, instead they follow what is compatible with their own beliefs and values. Mishler (1984) describes this as the "voice of the lifeworld." Furthermore, the healthcare systems in western countries have been transformed in recent years, especially in terms of the emphasis on the rights based and humanising approaches (McCormack, McCance & Klopper 2017) which is continuously empowering to the users.

However, through historical subjugation and cultural training (including age-related and gender-related appropriate roles), some African migrants lack the cultural and social power to raise concern when the need arises (Viriri & Mungwini 2010). The work by Johnson et al. (2004) and Levinson et al. (2005) among others demonstrate that migrants are reluctant to participate in the community feedback process through questionnaire tools and patient satisfaction surveys, whistleblowing and/or speaking about an issue of public concern and, often lack the ability to register displeasure when dissatisfied with a particular service. While this can be generally explained using Hofstede's power distance phenomena. That is the relational gap between those who hold power such as healthcare workers (nurses, doctors) and those with no or little power (vulnerable patients) (Claramita et al. 2019), critical race theorists such as Franz Fanon (2008) and Steven Biko (2015) would explain the behaviour of African patients as a product of the century-old social role training by the colonial systems. Specifically, the clinical encounter in Africa was imbued with a hierarchical patient-clinician relationship which not only asserted the superiority of the western systems, but also expressed the symbolic middle-class status of workers trained with a western orientation (Crush & Tawodzera 2014). These power-riddled historical experiences create a people with inferiority complex, low self-esteem, and negative self-evaluation (Priest et al. 2013) which might shape their health behaviours postmigration. As a result of these issues among other reasons, literature records African migrants as a cohort that engages in several health initiatives including religious activities, some of which are discussed in the following section.

Religion as a coping mechanism to the health problems and barriers

Studies of the African diaspora in western societies reveal the particular importance of religion because it is closely connected to their explanatory health interpretations (Adelowo 2012; Adelowo, Smythe & Nakhid 2016; Adogame 2004; Clarkson Freeman et al. 2013; Simmelink McCleary et al. 2013). A study by Kamya (1997) with African migrants in America showed that their participation in organised religious activities instilled a sense of positivity and hope to cope with their various stressors. Adelowo (2012) reports that several Christian churches in Auckland, New Zealand among others, the Redeemed Christian Church of God and Christ Revival Church and have become symbolical for meeting emotional and spiritual needs of the African communities. In those churches, analogies of other immigrants from the biblical teachings such as Joseph in Egypt and Daniel in Babylon and how God fought for them in foreign lands are invoked for strength and endurance. Financial support, sharing information on employment opportunities and helping international students with accommodation (Adelowo 2012), the Africans in New Zealand used religion to rebirth the communalistic support and collectivistic values they enjoyed prior to migration to meet their needs beyond health issues. Wong (2000) reports that though African migrants lived in Canada for several decades and had become separated from their home countries through time and space, religion remained an important connecting force not only in their local communities, but also to connect with their spiritual healers for healing through Information Communication Technologies (ICTs). More importantly, because of the Africans' indigenous beliefs especially the conflation of illness with a spell or jinx, religious spaces have gained traction for producing access to appropriate services among the African diaspora (Odera 2007). However, the jinx stigmatisation in African communities especially when dealing with mental difficulties can also hinder the use of religious and other ethno-cultural services for the sake of preserving one's integrity as it symbolically evidences one's transgressions and deviations that brought about the illness (Araya 2001).

The effects of racism, discrimination and mistrust in accessing health services

Individuals who suffer racially motivated discrimination and prejudice not only lack the space to voice their concerns, but they also experience anxiety and depression as they anticipate similar negative encounters as well as heightened susceptibility to diseases linked to excessive smoking

and drinking including diabetes and cardiovascular disease (Ferdinand, Paradies & Kelaher 2015; Horyniak et al. 2017). Also, the interacting upstream factors (unemployment, poor housing, social exclusion) further exacerbate conditions conducive to poor health. In their study with the African community in Melbourne, Australia, Horyniak et al report negative perception with the police as they were perceived to heavy handed and targeted them which may sow seeds of mistrust and creates a negative perception, thus shaping future interactions with other public agencies. Correa-Velez, Gifford and Barnett (2010) report that migrants with a history of torture and trauma have trust issues with service providers, with avoidance being higher when an immigration decision has not been determined yet. While in general minority communities, the Black, Asian and Minority Ethnic (BAME) in countries such as Britain have been reported to suffer from various institutional discriminations, those coded black Caribbean and Sub-Saharan Africa communities) bear the brunt more. There is a widespread synonymising and conflating of the darker skin pigmentation with criminality and illegality among other negative evaluations (Mapedzahama & Kwansah-Aidoo 2017). Irregularity and illegality of the immigration status are factors that undermine service usage, as a result of prosecution and deportation fears generally (Crush & Tawodzera 2014). African migrants in western societies, with or without the legal right to stay and work are regularly suspected and profiled (see Horynyang et al 2016). Moreover, as a result of the negative evaluations they receive from certain media and politicians they struggle to secure employment and other life opportunities, thus buttressing and extrapolating the perception that they are not only illegal entries but also a burden to the welfare services (Gee, Kobayashi & Prus 2004; McLaren 2007; Nunn 2010). In his conflict perspective, Randall Collins (1975) demonstrates the exploitability of the recessive part by the dominant particularly the latter's utilisation of the scarcity of resources in racialised and gendered societies to preserve their material, access and power resources (Collins & Guillén 2012). Consequently, Africans alongside other cohorts of migrants tend to be overrepresented in unemployment and casual work, poor housing and working in exploitative and dangerous sectors (Auer, Bonoli & Fossati 2017) which will inevitably mean they have higher health needs than the mainstream cohort. For Barnett (2004), African migrants lack the confidence and trust that healthcare workers can ensure the privacy of their health records particularly regarding stigmatised ailments such as HIV/AIDS and mental illness thus jeopardising one's employment, being separated from their loved ones and the fear of compromising their on-going visa applications leading to deportations.

Afrocentric worldview: Ubuntu

This section covers the key principles of Ubuntu theory (Prinsloo 2001; Wilson & Williams 2013), an Afrocentric framework which is used in this study to help not only explain the way health problems are conceptualised, but also what motivates other health behaviours among the Southern African people. Ubuntu is embedded in the African culture; the collective shared values, attitudinal inclinations and capabilities, art, beliefs, moral codes and practices that characterise Africans, behaviours (material and non-material) in their daily living (Thompson & Azibo 2003). The research capitalises on the theory's particular ontological situatedness in the Southern African epistemologies, traditions, norms and value systems for a more grounded interpretation. As a concept, Ubuntu is a set of beliefs, values and expectations that are embedded in the indigenous Southern African traditions and cultures of collectivism, dependence and humanity for meeting people's daily needs (Schiele 2000). For Prinsloo (2001) it is a philosophy concerned with the "beauty" and quality of humanity, that which makes humans "abantu" — desirable human beings who daily create harmony through love expression. Thus, Ubuntu is an advocation of harmonious interactions that are beneficial to the individual and their community through examining one's transactions with others, the environment, the supernatural powers and through life experiences to produce the best of human responsibilities, potentialities and to develop their essence (Hanks 2007; Schiele 2000).

The term *Ubuntu* (pronounced u-Boon-too) is a Zulu (South African) term which plainly describes the essence of being human (Khoza 2012; Ramose 1999). Similar terms are used across Southern African countries. In Shona language (Zimbabwe) it translates to *Unhu* (Hapanyengwi & Shizha 2013); in Tumbuka and Chichewa (Malawi) it is known as *uMunthu*; *Utu* for the Swahili speakers in Tanzania; in Central Southern Africa (DRC) it is known as *Bomoto*; and *Vumunhu* for the Mozambican people (Sambala, Cooper & Manderson 2020). While it is difficult to capture the full gamut of Ubuntu in other languages (Letseka 2011), several scholars sum Ubuntu as a process of "becoming", one's engagement with inner self, fellow human beings, surroundings, and the spiritual world for one to be legitimised as a "human being" (Manyonganise 2015; Van Norren 2014). Mbiti (1990, p.106) described Ubuntu as, "I am, because we are; and since we are, therefore I am*"*. This is fully captured by Chisale (2018, p.4); "Because I am ontologically connected to other people therefore, I am obligated to care for their well-being". When describing Ubuntu as a

reference point for the Truth and Reconciliation Commission in South Africa after the fall of the apartheid government, Desmond Tutu said,

> …It speaks to the very essence of being human. When you want to give high praise to someone we say, '*Yu, u Nobunto*'; he or she has Ubuntu. This means that they are generous, hospitable, friendly, caring and compassionate. They share what they have. It also means that my humanity is caught up, is inextricably bound up, in theirs. We belong in a bundle of life. We say, 'a person is a person through other people' (in Xhosa *Ubuntu ungamntu ngabanye abantu* and in Zulu *Umuntu ngumuntu ngabanye*). I am human because I belong, I participate, and I share. A person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good; for he or she has a proper self-assurance that comes with knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed or treated as if they were less than who they are (Tutu, 1999: 34-35).

Therefore, Ubuntu focuses on ensuring that every person's life and identity is recognised through their belongingness, connection, consciousness, and competency in relationship with others, an individual is not self-sufficient, he/she necessarily relies on the goodwill, assistance and the relationships of others to satisfy their most basic needs— "I am because we are" (Wilson & Williams 2013). The social cohesion is produced through common good values (Poovan, Du Toit & Engelbrecht 2006). Gade (2012) describes Ubuntu as a communitarian humanist ideology that drives people to create allegiances with one another. Positioning one's "wholeness" through the others — a person cannot be a human through himself/herself — one's community therefore is the epicentre of a relational context for humanity authentication. In other words, community's rights and interests such as empathy, caring, sacrificing and sharing supersede the rights of individuals (Poovan, Du Toit & Engelbrecht 2006), and one's humanness or ethical codes are approved and authenticated by others through exhibiting an accepted behaviour that can be described as Ubuntu (Meiring 2015). Through adhering to and following these traditional expectations, one earns their personhood as an ongoing process as they participate in communal life and playing socially and culturally accepted roles (Menkiti 1984). It is important to point out that personhood in Southern Africa is a developmental state, an ongoing process progressively achieved through life stages and role fulfilling (De Craemer 1983). The Southern African thought can only legitimate an individual

as a "person" if their behaviour is continuously commensurate with the expectation, or their "personhood" is lost (through transgression from the social rules). Broodryk (2002) stresses that the actions, thoughts, feelings and emotions of Southern Africans are influenced if not determined by Ubuntu. Its values have been intergenerationally sustained and transferred orally through established traditional institutions such as family, kinsmen and local communities. For Bell and Metz, as a cosmology, Ubuntu is therefore the "harmonic intelligence" that is an intrinsic part of the indigenous Southern African community, an African humanness philosophy which is unique from other humanist philosophies such as Kantianism or Confucianism. From this discussion it can be seen that Ubuntu has many dimensions that include spirituality, solidarity, oral tradition, harmony and unique expression which can be used to explain its invocation and an ideological practice (Hanks 2007; Randolph & Banks 1993). However, only a few of these aspects, particularly important for this study, are briefly discussed.

Metz and Gaie (2010) used the sociological concept of *Solidarity* to elaborate on and describe Ubuntu (ism) ethos and principles that shape the interpersonal relationships and expectations. This takes place through a collective and collaborative responsibility for survival through inculcating a sense of sympathy, empathy and sacrificial actions to help others. Therefore, the life security and "insurance" is principally placed in the traditional institutions, social networks and those around them. *Spirituality* is another useful dimension of Ubuntu important in this study. It accounts for one's connection and relationship with the universe and cosmos— solidarity bonds, codes and values for morality developed and sanctioned by spiritual beings (gods and ancestors), thus people are expected to model their behaviour in accordance with the spiritual world's dictates (Metz & Gaie 2010). It is believed that when one transgresses against these spiritually sanctioned codes of conduct, the ancestors as the 'living-dead' and the omnipresent God can punish human beings through sickness (Jagers et al. 1997). Likewise, when one is ill (which might be a sign that one has sinned against the spiritual being), religious invocations through prayers, songs, petitions and other rituals are followed in order to balance relationships and restore good health. This requires corporatism, cooperativeness, mutual support from other community members who are culturally expected to willingly engage in the healing rituals as an expression of social duty, hence strengthening interdependence through the concept of "Communalism" (Thompson & Azibo 2003). Using the participants' cultural frames is particularly important in the interpretation of their

health seeking places, their practices and the role of the supernatural beliefs on health issues seems logical. Thus, deploying Ubuntu not only helps in understanding the ways in which Southern Africans sustain their connections with the supernatural forces so as to cope with their health problems, but also a way of actively maintaining their wellbeing and meeting their health needs appropriately.

Responding to Wim van Binsbergen, a Dutch anthropologist's criticism of Ubuntu for being an "irrelevant concept" to interpret the daily life transactions among Africans except only for seasonal cultural rites and isolated conflict settlements (Binsbergen 2001), Ubuntu advocates such as Letseka (2011), Bell and Metz (2011) dismiss his assertion as a shallowly framed argument that sought to separate the obviously religious parts of the community from the everyday life practices. Ubuntu, they argue, is the basis of religious expressions that permeates all spheres of life—it is part of that which is inculcated in people that enables the human being to take responsibility for the well-being of others (Gade 2012; Metz & Gaie 2010). In stressing the collectiveness and consciousness of interpersonal relationships as an Ubuntu identity, Ruel Khoza describes the African personality as religious, one that is bound by the gods and other supreme beings expressed through the foundational principles defining the shared interconnectedness through caring, empathy, equal treatment of people and universal brotherhood (Khoza 2012). Tutu integrates Ubuntu and Christianity (an originally foreign religion) to demonstrate its utility beyond the Southern African philosophies while retaining its core values (Metz & Gaie 2010). Considering the Christian religiosity of some people from Southern Africa, Ubuntu can also usefully make sense of the health spaces among the Christian participants.

The African literature discusses the utility of collectivism (Ubuntu) to negotiate various social challenges through locating emotional and material securities and belongingness in familial connections, kinship ties and neighbours (Skinner 1977). Mental wellbeing in the African communities is predicated on one's community connections and their social and cultural ties which is indicative of the importance of indigenous philosophies in cushioning and supporting health needs (Sorsdahl et al. 2009). Also, migration and resettlement studies stress the importance of shared ethnicity, nationality, culture and religion as social categories for creating and strengthening belongingness and identity across many diaspora communities (Boyd 1990; Granovetter 1973;

May 2011; Nannestad, Lind Haase Svendsen & Tinggaard Svendsen 2008; Vertovec 2001). Since Ubuntu is one important specific ideological commonality shared by many in the Southern African diaspora, which they draw on to navigate social and cultural life, there is logic in deploying it in a study concerned with socio-cultural issues and health. Furthermore, notwithstanding the effect of contextual factors and the influence of acculturation in the host country, migrants retain and sustain their cultural norms and values over time (for example, see Omar et al. 2015; Thomas 2010). This demonstrates that their traditional and cultural values continued to shape their social behaviour and expressions of their human functioning, including health reporting and initiatives to address their health challenges. While Ubuntu emphasises the importance of ancestral sacred places for ritualistic engagements, traditional healing and the role of family elders and spiritually endowed individuals in communicating with the supernatural forces (Holdstock 2000), through practices such as transnational health seeking (discussed in Chapter six), Ubuntu still provides a space to access these health services while living in Australia.

Moreover, in the African epistemology, knowledge of reality exists if people are part of it (Etta & Offiong 2019; Higgs 2010; Myers 1987) which may not be the case with other groups. Thus, considering how the African epistemology with its cultural foundation differs from the Western theories in terms of philosophical integration and understanding, Ubuntu theory's embeddedness in Southern Africa benefits the study through a provision of a more contextualised tool. Also, happiness, fulfilment and life satisfaction are embedded and connected with cultural factors (Fernando 2012). For example, an individual with an affiliation towards western values including internalising factors and privatising inner emotions of wellbeing differs with those of collective societies that value interdependence and interpersonal connections for their wellbeing. Therefore, utilising Ubuntu was useful for a more contextualised behaviour of the participants which in turn had an effect on their wellbeing. At the same time, given the growing number of the African diaspora and the revival of the importance of the "spirit world" in the life of people in recent years (Glendinning 2009), Ubuntu as a broad and traditional philosophy broadly covering the religiosity and spirituality brings richness to this study. Finally, utilising Ubuntu perspective in elucidating people's behaviours is responsive to the clarion call in scholarship to use interpretive models grounded in the cultures, values and norms of the group of which they are applied (Adams & Salter 2007).

Conclusion

For a context of the study, this chapter has utilised various sociological, and anthropological literature that demonstrate the ideological and philosophical differences between indigenous Southern African health systems and western health systems. The literature demonstrates that the socio-cultural construction of health problems from both the African Traditional Religion and the African Christian Pentecostalism as supernaturally instigated, is prevalent among Southern African populations. These ethnocultural beliefs locate illness as a disruption and instability of the relationships existing between the living and the spiritual beings caused by the living's deviation from the supernaturally sanctioned norms, values and responsibilities. In order to restore good health, rituals, such as sins confessions and repenting and reviewing their relationships and correcting errors with fellow human beings and the supernatural powers, are important. Legitimating health problems through these orthodox frames situates spiritually endowed individuals in the form of traditional healers, herbalists, prophets and spirit mediums at the centre of the intervention. At the same time, historical experiences of colonialism and early Christian missionaries exposed Southern Africans to the biomedical health system for centuries. While from the time of its inception in Southern Africa, biomedicine regarded itself superior and was wholly dismissive of indigenous methods as archaic, primitive, dangerous and ineffective, it did not entirely uproot the indigenous health system. Partly this was because of the Southern Africans' strong embeddedness in their indigenous traditions, especially the spiritual and religious elements of health. The resilience and popularity of indigenous medicines is also correlated with rurality and scarcity of western services and affordability issues associated with these western services. However, being introduced to biomedicines through historical developments and the resilience of Indigenous medicines meant that there is a variety of therapies Southern Africans could use. Thus, medical pluralism became part of their health behaviours, utilising both as part of the holistic approach to health or oscillating between the two for efficacy maximisation among other reasons. What this shows, is that although there are philosophical differences and contradictions and a troubled relationship, the two in some instances can form a "therapeutic alliance".

The evidence used also shows that when Africans move to Western countries, they still interpret their health problems using their explanatory cultural and religious frames in addition to using the biomedical explanations to illness. Most Western countries have well-developed healthcare

systems; however, it is the ethno-cultural services that are largely unavailable. Matched to this "structural discrimination", literature further reveals racism, immigration status as some of the most important barriers to access to healthcare services. Nevertheless, this happens against well-documented evidence of elevated susceptibility to health problems of the cultural minority groups because of various upstream factors such as social exclusion, racism, discrimination, unemployment and poverty. Evidence from other societies and of other African migrants position the African diaspora community as an agentic cohort that respond to the unavailability of services through producing and sourcing of culturally appropriate health services. Similarly, Southern Africans in this study retained their health beliefs and sought to create culturally appropriate services to cope with their health needs that were not provided by the mainstream services as will be shown in Chapters four, five and six. The final section of the chapter discusses Ubuntu theory which is the main analytical tool to interpret the data findings. Its selection is informed by its origin, development and operationalisation in the Southern African cultures and traditions. Methodology Chapter which follows details the process by which the research was conducted.

CHAPTER THREE: RESEARCH DESIGN AND METHODS

Introduction

This chapter details the processes by which this research was conducted; it discusses processes involved to collect, analyse and interpret the data, as well as the instruments and techniques used in these processes. It begins with an overview of the qualitative research methodology which I considered the most suitable for understanding people's experiences, attitudes, behaviours and practices in this thesis project. This is followed by a description of the study sample and the sampling procedures, and how the field was accessed, including the challenges encountered in the process. In sketching these, there is a considerable coverage of dialogical interviews (Frankenberg 1993), a method which was deployed after I was less successful in generating adequate data when using the traditional semi-structured interview approach. An interest in the investigation of health issues and from a socio-cultural perspective required an examination of certain practices such as healing sessions at church events. Thus, participant observation was also utilised for collecting data in these places, and for data that could not be gathered through the interviews. For a clearer context of the fieldwork challenges encountered, I also discuss my positionality as an insider researcher. Notwithstanding the challenges that came with my insider positionality, this research demonstrates that there are many benefits when the researcher is a member of the group they study. Following a discussion of the various strategies used to ensure objectivity and believability of the research, the data analysis procedures including coding as an interpretivist technique are described. The chapter concludes with the laying out of the procedures followed to ensure that all the ethical considerations were met and any possible form of harm to the participants and other stakeholders was minimised.

Interpretivist qualitative research

Qualitative research is "an umbrella term for an array of attitudes towards and strategies for conducting inquiry that are aimed at discovering how human beings understand, experience, interpret, and produce the social world" (Sandelowski 2004, p. 893). The broader aim of the research was to examine health beliefs, and help seeking and healthcare system utilisation, from a socio-cultural perspective through documenting the challenges Southern Africans face, and the

initiatives they engage to meet their health needs culturally. Hence, a qualitative approach seemed logical to use for a nuanced understanding of the participants' attitudes, beliefs, experiences and meanings of practices. Within the broader qualitative paradigm, the research used an interpretivist approach to understand the participants' socio-cultural beliefs and practices aimed at enhancing and maintaining their wellbeing.

As a discourse, an interpretivist approach is concerned with the ways in which the knowledge and understanding are social constructs developed by a specific people, and it challenges other research approaches that rely on externally constructed knowledge in understanding particular groups or cultural realities (Ritchie et al. 2013). It is a form of analysis in social sciences representing profound scepticism towards claims to universal truth, objectivity and a privileged access to knowledge and raises questions about its assumptions (Clarke 2009). The central goal of using the interpretivist approach, therefore, is to ensure that human behaviour is understood from the participants' worldview. As a minority group with health beliefs that are, to some extent, different to the mainstream population in Australia, an interpretivist approach was crucial for examining the subjective meanings and cultural specificities of health beliefs and health seeking approaches. This assisted in communicating the findings from the lenses of the participants, as well as suggesting some of the interventions to enhance wellbeing and health needs of people from Southern Africa. Further, considering my insider positionality (which I discuss in this chapter), an interpretivist approach was important for acknowledging the mutual flow of information and influences between the researcher and the researched (Ritchie et al. 2013).

Study sample, recruitment process and field access

The overarching objective of the project was to research on the health beliefs, and help seeking and healthcare system utilisation from a socio-cultural perspective among the migrants from Southern Africa in Melbourne. As part of the broader objective, the research extended to examining resettlement experiences that might have had negative effects on their health, health initiatives and practices such as spiritual interventions which required an observation in their social milieu. Originally traditional semi structured interviews alongside participant observation were considered a suitable data collection method. However, semi structured interviews were less productive in collecting data therefore dialogical interviews (Frankenberg 1993) and participant

observation were eventually utilised for data gathering. Over a period of 11 months (February-December 2018), 24 social events were attended to observe events and practices useful for the study. Within the larger sample of the participants, a total of 28 individuals were interviewed. The following table presents the key these participants' demographic information.

Table 1. Participants' demographic information

Country of origin	Age group	Gender	Visa/citizenship status in Australia	Occupation	Length of stay in Australia	Minimum tertiary Education Qualification
Zimbabwe	56-60	Male	Citizen	Academic	21 years	Bachelor's degree
Zimbabwe	46-50	Female	Citizen	Nurse	15 years	Bachelor's degree
Zimbabwe	36-40	Male	Temporary	Nurse	5 years	Bachelor's degree
South Africa	46-50	Female	Permanent resident	Nurse	7 years	Bachelor's degree
Zimbabwe	36-40	Female	Temporary	Aged care worker	5 years	Bachelor's degree
Zimbabwe	31-35	Male	Temporary	Disability support worker	3 years	Bachelor's degree
Botswana	56-60	Female	Citizen	Academic		Bachelor's degree
Mozambique	36-40	Male	Temporary	Self employed	4 years	Diploma
Zimbabwe	51-55	Male	Citizen	Teacher	20 years	Bachelor's degree
Zambia	46-50	Male	Temporary	Community leader	6 years	Bachelor's degree
Zimbabwe	46-50	Male	Citizen	Pastor	9 years	Bachelor's degree
Zimbabwe	31-35	Female	Temporary	Pastor	5 years	Diploma
South Africa	41-45	Male	Citizen	Accountant	14 years	Bachelor's degree

South Africa	21-25	Female	Temporary	Student	2 years	Diploma
Botswana	26-30	Female	Temporary	Aged care worker and Disability support worker	4 years	Diploma
Zimbabwe	56-60	Female	Citizen	Nurse	20 years	Diploma
Zimbabwe	36-40	Male	Temporary	Medical Doctor	2 years	Bachelor's degree
Mozambique	46-50	Male	Permanent resident	Engineer	8 years	Diploma
Malawi	36-40	Male	Permanent	Tradesman	6 years	Bachelor's degree
Malawi	46-50	Male	Permanent resident	Truck driver	10 years	Bachelor's degree
Zimbabwe	56-60	Male	Citizen	Medical Doctor	25 years	Bachelor's degree
Zimbabwe	21-25	Female	Temporary	Aged care worker and Disability support worker	3 years	Studying for a bachelor's degree
Zimbabwe	26-30	Female	Temporary	Aged care worker	3 years	Bachelor's degree
South Africa	31-35	Female	Temporary	Aged care worker	4 years	Studying for a bachelor's degree
Zambia	36-40	Female	Temporary	Aged care worker	3 years	Bachelor's degree
Botswana	46-50	Female	Permanent resident	Nurse	18 years	Diploma

South African	26-30	Male	Permanent resident	Auto technician	8 years	Diploma
Zimbabwe	36-40	Male	Temporary	Pastor	4 years	Bachelor's degree

Among the participants, the number of temporary residents (international students and skills visa holders), and the number of permanent residents (citizens and permanent residents) were even. Similar to the temporary residents, prior to attaining their indefinite stay, those who were permanent residents and Australian citizens originally came to Australia on temporary visas, either as international students or temporary skilled workers. The number of male participants was slightly higher, 15, compared to that of female participants, 13. The youngest participant was aged 23 years while the oldest participant's age was 60 years. Since some interviewees worked in the healthcare sectors in various roles such as nurses and doctors, both community leaders and migrants also gave insights on their experiences as healthcare givers and how they saw some of the challenges their communities faced. All the participants were professionals. Five Southern African countries were represented, and half of the participants were originally from Zimbabwe (14). South Africa was the second contributor with five participants. Three participants were from Botswana while Mozambique, Zambia and Malawi had two each. All the participants identified themselves as first-generation migrants.

The research targeted people who used, or who at some point attempted to use the healthcare system in Melbourne. A purposive sampling was employed (Creswell 2013; Polit 2006). Recruitment was done via social media advertisements, personal contacts, notice boards at hospitals in Western and Northern suburbs of Melbourne and social gatherings such as community events and church meetings. Four participants were recruited via self-selected sampling (Khazaal et al. 2014) after hearing about the project from their social networks and they approached me to be included in the research. Three of them participated in the pilot data collection and one of them is part of the 28 participants who took part in the actual research. All the interviews were conducted in English, the official language in Australia. While I assumed that most of the community members have competent English skills (which is the official language in many southern African countries and the fact that most went through English language competency tests when they first arrived in addition to living and working in a society that largely uses English language), recruiting

participants with competent English skills may have potentially overlooked those with limited English skills and skewed to proficient English speakers and the highly educated and thus caused bias to the sample.

Accessing the field was a relatively easy process. Apart from following strategies spelt out in methodology resources for professional and appropriate interactions with the participants, being an insider researcher was an equally important resource (Greene 2014). Belonging to the community I studied crucially assisted in navigating the cultural space and creating strategic networks; for example, approaching and building a relationship with community leaders, especially church pastors, facilitated in the recruitment of other participants. The issues to be explored seemed relatable to them and their community. Before the data collection began, questions such as, "Where were you all along?' and "How soon can we start' were thrown to me, which appeared to indicate that the community had finally got an opportunity to share their experiences. Perhaps because the issues to be explored resonated with them, two Zimbabwean community leaders showed great zeal by marketing the project at the events they coordinated. A few prospective participants contacted me later and explained that they had heard about the project from their community leaders. Following an agreement to participate and after proper debriefing, participant documents, the consent form, the participant information statement, and the withdrawal of consent document were shared.

Data collection, methods and process

Among the several tools available to a qualitative researcher I initially considered focus group discussions, semi structured interviews, and participant observation as methods suitable for data collection. Specifically, I had initially planned to use focus groups for discussions with community leaders and healthcare professionals. I considered focus groups a viable and advantageous approach for getting detailed stories and in-depth suggestions in relation to the identified issues from experts and strategic individuals (Nyumba et al. 2018). However, despite posting several fliers at the hospital notice boards and sending emails to various key persons working in the health sector I still could not find healthcare staff who specifically worked with people from Southern Africa to convene a group discussion. One community leader working as a nurse reminded me of the difficulties of recruiting such people because Southern Africans seem to be evenly scattered

across the entire city. Indeed, it proved to be an extremely difficult task. Community leaders were targeted as key resource persons who could provide deeper responses to the structural issues affecting their communities with regards to health access. Due to logistical issues, they also ended up taking part through one-to-one interviews. Although they registered their willingness to participate through focus group discussions, their availability at different times and being located across the entire Melbourne city made it difficult to convene focus groups. For the ordinary participants, in seeking to answer the questions around their personalised health beliefs and experiences in health access, it seemed obvious to collect data through directly posing the questions through interviews. The multiple identities of several participants of being both migrants and healthcare workers in some instances was also crucial in sharing their insights as healthcare givers. While the pilot study was useful for assessing the interview guide's conciseness and cultural appropriateness of the questions, one of the four pilot study interviews was included in the findings because of its richness. The participant agreed to this arrangement. After the pilot study which lasted four weeks, I collected data between February 2018 to December 2018.

Harklau and Norwood (2005) among others describe the field as an arena normally characterised by different cultural beliefs and practices which require ongoing flexibility. Apart from various commitments such as baby sitting and being available for the interview late at night, not only were most interviews conducted in the participants' homes, also a few of these were conducted in the presence of their spouses, especially for the female participants. This arrangement came with a few challenges. After two spouses of my interviewees asked me just to be present during the interviews and in both instances, I agreed not only for transparency reasons, but also for the cultural and symbolic meanings it could have carried, interestingly, one of the spouses "hijacked" the interview as I put across the questions to the interviewee. She seemed to be annoyed with the conduct of her spouse. Admittedly, it was also frustrating for me, but I feigned interest in his contributions in order to downplay his behaviour and maintain harmony. The spouse's behaviour thus undermined the very conducive environment I sought to create for the participants when we agreed to conduct the interviews in their homes. At the same time, some of the contributions thrown in by the spouses and family members in some instances were very pertinent to the issues discussed, and sometimes helped the participants to clarify or expand on their thoughts. However, on all the occasions I did not include their conversations as they were not part my interviews. The

relevant and interesting issues that they raised were followed up in other subsequent interviews. My overall verdict is that having the participants' spouses and family members present during the interviews was not disruptive as I earlier assumed. Rather, it boosted the confidence of the participants through verbal and non-verbal authentication with their "gate keepers" and provided vignettes.

As previously highlighted, focus group discussions were initially earmarked as one of the data collection tools but later abandoned because of the difficulties faced in recruiting participants working in the health sector and for logistical purposes in the case of community leaders. Consequently, the data was collected using one to one interviews and participant observation. The following section discusses how the data was collected using these two methods. While participant observation was an auxiliary and an ancillary tool to the one-to-one interview it will be discussed first as the interview section is closely intertwined with the section that succeeds it.

Participant observation

Anthropology and Sociology researchers among other social scientists have used observations to collect data within qualitative research for centuries (Agar 1986; Jorgensen 1989). It is a method that entails a procedure which collects data through participating in the routine activities and experiences of a group of people for a prolonged period to understand their implicit and explicit culture (Dewalt & Dewalt 2011). As part of exploring health issues with a socio-cultural component, it was imperative to examine the cultural and religious interpretations and initiatives of and in relation to illness in people's social milieu. Acitelli (1997) stresses the necessity of participant observation in order to have a fuller and a clearer interpretation of the group practices. Over a period of 11 months, I attended 24 social events to collect both tacit and explicit observational data through field notes. Church gatherings, community meetings, social events and national and continental day's commemorations such as the Mandela Day, Africa Day and various Southern African countries' Independence Days commemorations were attended. While independence days commemorations were of limited direct value since the research questions were not necessarily connected to the broader purpose of those gatherings, they became platforms for further forging relationships and trust with the potential interview participants. Overall, the church gatherings were vital in providing broader understanding of the health beliefs and the initiatives

that participants engaged in to restore and enhance their health. The findings' chapters, especially Chapter five on Mental health, and Chapter six on Religion, spirituality and health, elaborated why church gatherings were particularly important for observing health beliefs and practices. Other community gatherings were also useful in discussing health issues, initiatives and the cultural services participants utilised.

Being a member of the Southern African community helped in settling and inserting myself in the social gatherings and community events with few constraints. My "insiderness" as a fellow Southern African migrant on many occasions allowed the participants to be "themselves" and be free to naturally express at most of the events I attended. My familiarity with the various settings prior to data collection assisted me for further trust from the community members which allowed me to access richer data, including asking the questions where necessary. Furthermore, the power dynamics that often imbue the research settings (Chung 2015), between the researcher and the participants was less visible given the fact that I was a migrant researching fellow migrants which helped them to view me as an equal. I also felt that in some instances acknowledging my limited knowledge (or pretending to know very little) about the issues being discussed or rituals taking place made me a "student" willing to learn from them. This was meant to encourage participants not to gloss some critical issues based on the assumptions that as an insider I already know many issues thus missing out on some important data. The strategy appeared empowering to some of the participants as they exhaustively elaborated answers to posed questions, but, equally, it might have constrained a cohort of the participants that is more comfortable in divulging sensitive information to outsiders who they consider less judgemental, hence possibly missing out on important data as well.

Despite my positionality (which helped me to easily insert myself in social gatherings), gaining consent for participant observation was not a straightforward process. It was impractical —or would have been laborious to brief every member present at an event about the research. Rather, the informed consent was a continual process, at every gathering, where consent was sought through gatekeepers such as pastors and community leaders. I explained the project objectives and the data collection methods being used and assured those I sat next to that all the ethical procedures had been followed when some became concerned about my taking down of notes (even though it

was minimal). It may have appeared odd and journalistic to take some notes during the healing rituals in church services. As noted, taking out a pocket notebook and writing notes can be journalistic and invasive to people thus altering their normal behaviour including withdrawal (Gillham 2005). Therefore, while significant note taking is recommended as an important component in observational research that qualitative researchers should follow (Dewalt & Dewalt 2011), this procedure was minimised to avoid drawing attention and thereby distorting the naturalness of participants' behaviour, especially in the highly ritualised research spaces. As I navigated the field, I also dropped the idea of directly asking questions to the participants which was initially motivated by the desire to get nuanced and personalised experiences because using that approach was likely to further alter the natural processes. Nevertheless, withdrawal and behaviour changing was inevitable because some of the gatekeepers approached as part of ethical procedure, especially religious leaders, were at the centre of delivering spiritual healing and other religious rituals. The presence of a researcher may have had an impact on how they performed their duties.

Lincoln (1985) reminds us about the impossibility of separating qualitative researchers from events, values and participants because as subjective human beings, researchers also have religious, traditional and ideological loyalties which all have a bearing in the way they navigate the research space. As an insider researcher this was more apparent. My emotionality and experiential attachment to some of the events and the practices at places of data collection spaces meant an inadvertent failure to capture important events worth recording. At some occasions I ecstatically participated in events which made it impossible to maintain the position of a cautious and neutral research persona recommended in observational work (Dewalt & Dewalt 2011). My spontaneity in the events meant becoming 'too consumed' and distracted with the activities which further compromise objectivity (Adler & Adler 1987; Gillham 2005). As much as I attempted to follow the methodology textbooks, as a subjective human being it was not always possible to maintain the position of a cautious and neutral research persona potentially missing out on important events worth recording. I particularly attempted to keep distance in order not to be immersed into the events as it has been known to distract the process of gathering data (Adler & Adler 1987; Gillham 2005), it was not always the case. Adler and Adler (1987) stress the

impracticality of the complete removal of the researcher from the participants, activities and events, this was also the case during my data collection process.

Dialogical interviews

One indisputable lesson I learnt from the fieldwork is the unpredictability of the fieldwork processes. It revealed a significant gap which can exist between theory and practice. In this study my fieldwork experiences brought about some unforeseeable changes that required pragmatic adjustments. While I found methodology resources helpful on guiding how to conduct a qualitative study, they were also inadequate in fully preparing me as a qualitative researcher. Despite enjoying a generally smooth access to the field due to my familiarity and networks with the Southern African community, what Chavez (2008, p. 481) referred to as the "expediency of access", I encountered several unexpected complexities that led to a rethink of the strategy to be used. Dealing with social beings often comes with several complex scenarios that require flexibility in the field (Frankenberg 1993), similarly I had to be adaptable and responsive to my challenges. Much of the data for the project was gathered through dialogical interviews, a method which was a product of the actual fieldwork process adopted after the traditional semi structured interviews failed to deliver the much-needed data.

On paper, interviews deceivingly appear as a simple method that any neophyte investigator can easily manage (see Chung 2015), yet it turned out that the rigidity of the interviewing process undermined the quality of the gathered data. When I started the data collection the majority of the responses that came from the participants were less elaborate and brief, in some cases the interviewing process lasted for less than 10 minutes against my projection of between 45 to 60 minutes. But more importantly the basic semi structured interviews did not solicit the much-anticipated rich data (Geertz 1974). Perhaps this was also because I was a novice researcher, and my approaches were somewhat too theoretical. I entered the field fully equipped with the fieldwork manuals, and since my positionality was that of an insider researcher (Greene 2014), I was fixated on strategies of ensuring objectivity. For example, I constantly reminded myself to not get too close to the participants and to entirely stick to the interview process throughout. Furthermore, some of the participants stated that it was their first academic study and that they had very little knowledge about the research process. To some the prospect of being interviewed for up to one

hour could have appeared a daunting and exhaustive task. A few participants clearly exhibited signs of being panicky, uneasy, vulnerable and anxious about how to conduct themselves and the fear of being judged through their answers. This was more apparent on questions around culturally sensitive topics such as mental illness and traditional health practices and beliefs. They might have felt that they were being interviewed by an expert, an authoritative figure around the issues they were being asked even though I considered them informed on the issues I investigated. I had lost the friendly image of a student, colleague, and friend I enjoyed a few weeks before the interviews and the resulting intimidating environment brought about "sheepish", reserved, and fearful personalities. A cohort of people who were keen to be interviewed a few months prior to the fieldwork had gone, and I was left with a mainly obliged group. The social participants were gone, and I was only left with "data vessels" (Chavez 2008; Kemmis et al. 2005; Ozanne & Saatcioglu 2008) yet the interview process and people involved cannot be separated (Frankenberg 1993). My conclusion was that creating trust and rapport and remaining a "neutral persona" was more theoretical than practical, and it was undermining the very data I sought to collect. I therefore had to make a choice between prioritising remaining an ideal researcher— a "neutral persona" —but without getting the much-needed data, or to be flexible and get thick data (Yin 2003). Logically, I chose the latter.

My next step was therefore to fight this traditionally distant, "clearly objective" and highly emphasised blank-faced research persona (Chung 2015). After dealing with the professional researcher or the neutral persona obsessed with adhering to the minute details spelt out in field manuals, I positioned myself to be as explicitly involved in the questions as possible. In her insightful discussion of how researchers should position themselves in social research, Ann Cunliffe (2003, p. 984) stresses the need for self-reflexivity in order to "capture the complex, interactional and emergent nature of our social experience". At times I shared with interviewees about my own life or elements of my own experiences (both positives and negatives) with the healthcare system. This self- reflexivity crucially reduced the powerful picture of the researcher, thereafter, and through the mutual effects of shared social experience, a familiarised safer environment was created for the participants to narrate their stories conversationally. Through this self- reflexivity (Cunliffe 2003), the "hovering, intimidating and powerful" picture of an expert researcher that may have been created by the research setting seemingly disappeared. Methodically

this meant a transition from semi structured interviews to dialogical interviews. In fieldwork, dialogical interview takes a flexible and egalitarian approach through exploring issues that both participants and researchers crucially regard in affecting the interests of the researcher and the researched (Knight & Saunders 1999). It is a departure from a unidirectional fieldwork interaction where the researcher asks questions and the interviewee only responds, it positions both players as equal (Farias et al. 2019; Freire 2018) thus the interviewer who usually holds the power (in terms of the issues to be explored and format used), work towards empowering and creating a balance in the dialogue. From this point therefore, any description of "interviews" in this study refers to one-to-one dialogical interviews. However, the interview guide was largely retained for consistency, guidance and thoughts organisation, and to ensure that the broadened responses remained within the scope of the research (Creswell 2013).

As the interviews increasingly became dialogical, the participants further settled in as the environment switched from being "formal" to "informal". Further, starting the interviews with general discussion about social, political and economic issues in their home countries and in Australia before introducing the actual interview questions further helped with the participants' comfort. As participants relaxed, the conversations started getting longer; some participants even tried to actively include me in their narratives through making me part of their thought process as they worked on an idea. I can easily recall one instant when a participant said to me; "I'm sure you have also come across this?; You know what I mean?; "Does that make sense?" Apart from trying to validate their opinions with me as the case with the above example, participants also sought to take cues from my bodily gestures. When they felt that I also related to the point they were making, or I clearly understood the point being made, they became more comfortable and expansive. Equally, when they felt that I was lost, or I did not relate to what they had said, they tried to include me in their stories and to help me navigate issues from their perspective. One participant said; "Imagine what happens when you visit a clinic, and everyone just looks at you". As this was not a familiar description with me, and as I reacted — probably through an expression of shock and confusion nonverbally, she changed her tone and put a disclaimer; "I guess that's just my personal unique experience". In instances where I thought interviewees struggled to express themselves, I would try to help by suggesting terms they may be looking for, or bring a teaser thus helping them to navigate themes (see Chung, 2015). While it is from such interactions that dialogical interviews

may be criticised for bringing in the interviewer's bias, this method was necessary for this study to generate the sought data. Also, although offering clues to the interviewees might be argued to have altered the meaning or completely missed the actual point the participant put across, the benefits of such interactions outweigh the criticism and risks emanating thereof (Greene 2014). As Fontana and Frey (2000) stress, there is much to gain from openly acknowledging the "contextual, societal and interpersonal elements" of the interview rather than trying to downplay their potential influence. Providing clues and sharing my own health accessing experiences is likely to have created a feeling of shared experiences and "struggles" with the researcher thus further providing a safe space for participants to share their stories. I did not find the dialogical interviews undermining the truthfulness of the quality of data gathered, rather it produced the very rich data that Yin (2003) implores qualitative researchers to access. Further, the dialogical approach of interviewing was beneficial to the participants and the interview space through smooth power transfer (Gillham 2005) from the researcher to the interviewees and facilitated a mutual flow of information rather than the objectification of participants as data vessels only meant to churn out answers. Clearly the participants had power over the interviewing process through their responses, determining the areas of emphasis and how they wanted to elaborate their stories without being too confined in their responses, thus making them active interviewees.

Reflecting on my insider researcher positionality

Dewalt and Dewalt (2011) identify several membership roles of insider researchers including those that occupy peripheral space or who keep a distance from the core group activities; active community members who remain outsiders to the group's values and goals; and those who already possess group membership or fully become part of the group during their projects. For example, DeLyser volunteered to clean toilets during her study in a mining ghost town to remain accepted by those she researched, and Gerrish offered to make coffee and do the dishes at a district hospital to be accepted in that setting (see Greene 2007). However, unlike DeLyser and Gerrish who strengthened their memberships at certain points of their research, my insider positionality — strongly sharing values, goals, ethnicity, culture, language, background, religion, and migration experience and aspirations with members — started before the research project and fieldwork process. My positionality is best described by what anthropologists would call "native" (Taylor 2011). Sharing ethnicity, background and culture among other important characteristics with

members of the group I studied, not only did I consider myself as an insider, but also my existing closer knowledge of the cohort was of a greater advantage in getting critical insights from the participants. To further contextualise my fieldwork experiences and the challenges that were to be navigated it is useful to briefly discuss how I integrated and becoming member of the Southern African community in Melbourne.

Despite having no social ties in Australia at the time of arrival, and when I was still setting up my project, I met some people from Zimbabwe and these initial contacts became important for my eventual research sample of participants. My contacts in the community quickly grew to more than 50 individuals within my first three weeks of arrival. One of the community leaders who welcomed me, quickly introduced me to the broader community through various social gatherings. During these formative weeks, community members would ask me (out of good intentions) the nature of my project and the issues to be explored. While my ideas were quite rough at the time, I believe that I provided them with decent responses on the scope and nature of the project which sought to explore health access issues from a socio-cultural perspective. It seemed to me that overall, the research objectives closely resonated with the community experiences and struggles. Many of those I spoke to showed great enthusiasm about the research, and a few community leaders the importance of such a project. There was no doubt about the acceptance of the project, and also that it resonated with the community; the eagerness to share their stories across the target population was apparent. The trust and openness were evident from the beginning, and there was a sense that being one of them as a researcher meant that I was privileged to understand issues specific to them, particularly on culturally specific areas.

Because of my nativity I smoothly blended into the participants' setting without upsetting the social surroundings or experiencing the culture shock suffered by some qualitative researchers (Greene 2014). In many of the field encounters, the interactions were "natural", participants showed interests in discussing their experiences (particularly sensitive themes) and views with "one of their own" (Taylor 2011). Through context familiarity based on my pre-existing knowledge of the participants I was well-equipped to interact with the participants respectfully and able to read the culturally specific non-verbal cues. Understanding the nonverbal was important in providing cues on whether a topic or a question should be probed further thus allowing me to go

deeper and be able to give an informed interpretation about the respondents' stories (Berg 2007). Nonverbal communication is culturally located; thus, its meanings differ across cultures. For example, in Zimbabwe looking at an adult right in the eye when engaging in a conversation is discouraged and may be a punishable offence because it can be viewed as a form of disrespect. The same act of eye contact avoidance in western culture might be interpreted as a sign of "shiftiness". Being an insider researcher was therefore useful to identify discrepancies between verbal and the non-verbal expressions during the interviews. Where I picked possible inconsistencies between the two, the response was cautiously taken and later probed further from another angle or validated with other participants. For example, after asking a 26-year-old male from Zimbabwe about his beliefs and usage of traditional medicine, he said, "No". At the same time, he adjusted his sitting position and looked a bit unsettled. I also picked an awkward excitement on his face. It was clear that while it was a topic of interest to him, he was not yet comfortable to discuss it, possibly because of the stigma around it. After discussing other issues and as we further dialogically immersed ourselves in the conversation, I then brought up the same issue from another angle, including sharing my own beliefs about the matter. Thereafter, he opened up, which points out that he may have initially been uncomfortable to discuss his traditional beliefs because of the backward and dirty labels associated with them (see Neba 2011). It is from this standpoint that I consider my insider-ness —in terms of beliefs, values and experiences and proximity — an advantage to get deeper interrogation of the issues. The importance of providing a full picture, stating my positionality as a researcher is important nonetheless as it helps the audience to potentially locate possible biases and personal values that interfered with the findings.

It has been well argued that insider researchers have significant advantage over outsider researchers in terms of accessing the field, rapport creation, and soliciting rich data (implicitly and explicitly) (Bonner & Tolhurst 2002; Delyser 2001; Harklau & Norwood 2005; Kanuha 2000). The binary identity of being the researcher and the researched also confronts the researcher with complex research that outsiders might not face (Greene 2014). I discussed how my indwelling in the Southern African community created close and casual relationships with some of the potential participants prior to the actual data collection. Notwithstanding the benefits of this relationship, it also became problematic as I struggled to demarcate a professional relationship between a researcher and an interviewee. In many situations the interactions with the participants started

before going into the fieldwork and they continued to exist after the fieldwork exercise. By association, friendship and belongingness to the broader community, some participants mainly from Zimbabwe knew about my project, including the issues to be interrogated well before the actual data collection. There is also a strong possibility that belonging to the participants' community could have subtly exerted some pressure on the participants such as feeling socially obligated to help a friend, a community member, a fellow student, or a fellow congregant. Although it is difficult to tell how many people participated in the study based on that social obligation, the way the respondents "beat about the bush" constantly checking my responses seemed as if they were ascertaining if they were being helpful. Responses such as, "Are you interested in getting information related to ancestral beliefs…"; "Does it make sense to you if I use my friend's experience …."; "Would it be helpful to you if I share this story…"; "I hope I'm sharing information that is helpful to your project" appeared to be coming from people who were socially obligated individuals. It was further telling when one of the participants asked me detailed questions about the nature of the study, what literature says, and my objectives, which I concluded was meant to figure out ways of providing helpful information. Another participant constantly left her sentences incomplete — perhaps because of our shared social life she assumed I already knew most of the issues she raised despite my signalling to her to elaborate. Interestingly, as participants narrated their issues, it became trickier and difficult to measure the total effect of our emotional attachment and connection from our shared life outside the research project. During the interviews, I was very familiar with some of the responses given, some of which were vivid to me; I was no longer sure if I conflated their responses with what I had heard at other forums or what we might have discussed outside the research setting. Nevertheless, care was taken to ensure ethical research. Participants freely volunteered their stories for this study.

I am not sure if my own experience with the healthcare system and health beliefs may have partly influenced my conclusions on the issues raised, thus affecting data interpretation. Watson in Dwyer and Buckle (2009, p. 59) also had similar experiences, as she writes, "I still remain unclear whether this is my interpretation of an actual phenomenon, or if I am projecting my own need … onto my participants." Even post fieldwork, when one expects the "official relationship" to wind up or scale down at least, my relationship with other participants continued normally, there was little room for the analytic distance from the participants. While Greene (2014) stresses the importance of self-

critiquing and reflexivity to insider researchers in order to maintain independence and distance, for me this was a mammoth task because the community and the field of study synonymously represented places and spaces of belonging and indwelling. In other words, I was "permanently immersed" in my research. I am not sure if my own experience with the healthcare system and beliefs may have partly influenced my conclusions during data analysis. Voloder (2009), a migrant to Australia who explored citizenship and belonging also reported being confronted with the issues she posed to her participants. Such experiences complicate one's ability to measure the total effect of the emotionality, attachment and connection of the shared life outside the research project which might leave little room for analytic distance and objectivity (Taylor 2011).

When discussing the insider researcher's proximity to their participants, Van Heugten (2004, p. 208) suggests using techniques that bring a clear separation between the researcher from the researched during the study period, such as the deconstruction of the familiar world through speaking to others outside the researched community, stream of "consciousness" writing, and interviewing oneself. Through continuous interaction with participants in regular life I might have been exposed to the so-called non-researcher lens in the analysis of data (Asselin 2003). It was difficult to distinguish between "normal interaction" and "too much interaction" when one is an insider researcher. Community members showed great enthusiasm and interest, whenever we bumped into each other at various social gatherings they asked about the progress of the project. Some would even call just to check on me, and in those conversations, it was normal for them to ask a research student how the project was going, what issues were emerging, how much fieldwork ground had been covered, and if I needed to be linked with other potential participants and so forth. Thus, while Greene (2014) among others stresses the importance of self-critiquing and reflexivity to insider researchers in order to maintain independence and distance, this was bound to be more theoretical than practical because of my permanent immersion and indwelling in research. On the contrary, the relationship with community post fieldwork seemed beneficial; we remained connected post-fieldwork, it meant walking with them thus becoming part of my data analysis which I considered an important ethical aspect of the research. Drew (2006) uses the phrase "seagull researchers" to describe the tendency by some researchers (especially outsiders) to simply come into the community for their "career-related selfish agendas" to collect data and abandon their participants. Walking with the participants and having a closer post-field relationship avoided

this “exploitative” relationship. At the same time, Dwyer and Buckle (2009) note that as researchers work on their transcripts, they carry the voices and experiences of the interviewees, therefore making it impossible to retreat and be “independent” and create “distance” from their participants. I tried as much as possible to have a clear mind and interact with the data impartially, nevertheless.

Sanjari et al. (2014) stress that because of the nature of their projects, and their tendency to use methods that usually produce text rather than numerical outputs, all qualitative researchers, both insider and outsider, are confronted with bias and credibility issues in their projects. As such, commentators warn that while researchers must in particular safeguard against maleficence (protecting their participants from all forms of harm), insider researchers must also not risk their own wellbeing by being overly self-critical about bias and fear, and problematic methodological issues that also confront other qualitative researchers across the board (Van Heugten 2004). From the start, it is the researcher who determines the research objectives, topic selection, the methods used, participants (group), the phenomenon to be studied, wording of the interview questions, the recruitment strategies, data analysis, and, more generally, that what is considered important and interesting in the findings depend on one’s subjective orientation (Greene 2014; Guba, Lincoln & Denzin 1994; Van Heugten 2004). which can all be argued as some form of a researcher’s “bias”. Complete removal of the researcher’s perceptions, preconceptions and values influences at certain stages of the research process is near impossible. Reiterating Fontana and Frey’s (2000) stance, there is much to gain from openly acknowledging the “contextual, societal and interpersonal elements” of the research processes rather than trying to downplay their potential influence to provide a full research picture for those who may be interested in evaluating the research processes and the generated findings. The acknowledgement of my positionality allows as much as possible to provide this picture to the audience and to inform the extent to which the processes aimed at ensuring objectivity and believability of the findings have been implemented. I discuss how these requirements were fulfilled in the following section.

Ensuring credibility

As just discussed above, and noted in literature, qualitative projects are susceptible to the researcher’s perceptions, preconceptions and values’ influences at certain stages (Guba, Lincoln

& Denzin 1994). Lincoln and Guba (1985) among others therefore implores researchers to be transparent by detailing their positionalities so as to provide a full picture of the research process. They suggest that qualitative researchers follow a set of procedures to ensure credibility of the findings; they described these as objectivity mounts. Accordingly, I adopted this strategy to ensure the credibility, objectivity, and believability of the findings.

Lincoln and Guba (1985) had proposed credibility, transferability, dependability and confirmability, as equals of the quantitative concepts such as validity and reliability. Conforming to the principle and the concept of credibility which is concerned with an accurate representation of a social phenomenon (Koch 1994), before analysis the electronic recording (where applicable) and its transcript were sent to the respective interviewees to confirm and verify if their stories had been accurately and fully captured. Overall, the participants were satisfied, and only a few participants noted cosmetic issues which did not affect the data. In addition, the data was also accessible to my supervisors as stated in the participant information statement. It means that they could check if my data analysis was consistent with the raw data when necessary. These processes critically helped with research integrity through picking issues in data analysis that could have been unduly influenced by my own subjectivist construction of reality (Greene 2014; Van Heugten 2004).

External validity involves the extent of the application of one's results to other contexts (Merriam 1998). But unlike in quantitative research which is more interested in applying the results to the wider population (Shenton 2004), qualitative researches are often context specific according to Lincoln and Guba (1985). Thus, the generalisability of the findings and its inference to other populations would therefore be limited given the study specificity and the used methods (Neuman 2000). Nevertheless, the intention of the research was not to develop universally generalisable explanations of phenomena. Rather, the research focused on gaining a contextually situated knowledge of Southern African migrants' lived experiences in terms of their health beliefs and health access. What this study provides is a vivid and clear picture of the research setting through a thick description including the period of the study to provide other researchers with a proper context for them to gauge the transferability of the findings to their own settings (Koch 1994; Polit 2006). The demographic characteristics of the participants and the period in which the research

was carried out have been provided at the beginning of this chapter and a detailed picture of the study environment is covered in the introduction chapter, as well as the third section of this chapter.

Lincoln and Guba (1985) argue that "work auditing" is necessary to guarantee that the research is dependable and confirmable. This is meant to create a platform for the future researchers concerned with the same phenomenon to "repeat the study" as Lincoln and Guba (1985) stress. Emphasis is on replicating the same process used rather than necessarily obtaining the same results. While Greene (2014) recommends for on-site team interactions as part of work auditing, this was not possible for my project as I was the sole investigator during the fieldwork. Instead, the measures I used were more general in the sense such as keeping the field notes, day to day log of activities and a personal reflection diary.

Data analysis and interpretation

For qualitative research projects, data analysis refers to the procedure of methodically and systematically looking and organising the transcribed interview data, observational notes and other non-textual materials that the researchers accumulate for an enhanced understanding of the phenomenon (Bogdan 1982; Taylor 1998). In this study data from the interview transcripts and field notes was organised according to themes and sub-themes. The data Chapters (i.e., Chapters four-six) are organised to discuss the findings as themes, and each chapter/ theme is further broken into subthemes.

Geertz (1988) expounds that the rich descriptions are crucially important in qualitative ethnographic work. I sought to access in-depth data through observations at social gatherings and ritualised religious spaces and in-depth interviews. However, for the in-depth data to be useful to the body of knowledge, it requires a clear organisation and thoroughness (Taylor-Powell & Renner 2003). A typical ethnographic technique of listening to the interviews was followed in addition to reading transcripts and fieldnotes. The services of professional transcribers were used to transcribe most of the audio data (however, few individuals opted not to be audio-recorded) and the generated text data alongside the fieldnotes were combined. In this analysis procedure, I used a hermeneutic approach to analyse the text and constructed the "reality" (Roberge 2011) of the participants' experiences, realities and beliefs from interpreting their texts. The hermeneutic approach is

rigorous, involving theory and practice of data interpretation which requires reflexivity and decision-making on the part of the researcher in accordance with the specific needs of the research (Allen, 2017). I followed Bogdan's (1982) steps. These steps include "working with data, organising it, breaking it into manageable units, synthesising it, searching for patterns, discovering what is important and what is to be learned and deciding what you will tell others" (Bogdan & Bikle 1982, p. 145). There was constant posing to reflect what the participants' stories meant and the symbolical meaning of their health practices as I transformed the raw data into meaning and significance. In analysing the data, the aim was to bear the participants' voice through confronting myself on what can be learnt and taken from their transcripts and texts (fieldnotes). As part of self-positioning in the study, and to avoid reductionist interpretations of the stories of the participants (Koch 1996), the transcribed data were shared with the participants. The interview guide also had some questions for the participants to suggest ways of dealing with the issues raised, thus their responses to those questions informed some of the recommendations.

The large volumes of data were reduced and categorised according to coherent themes and subthemes. While the themes were initially predetermined using the research objectives, as an interpretive research approach, several other themes were informed by the participants' experiences and initiatives in response to health problems in their Australian context thus the findings reflected the specific reality to the participants. To ensure that the stories were well captured and that as a researcher I was as accurate as possible in explaining the participants' stories, the data was also accessible to the participants. As previously stated, during the data collection, I also incorporated some issues raised by the participants (that were not in the original interview guide). For example, if an interesting issue was raised by one participant, the issue was raised in subsequent interviews, and some themes were developed/expanded from there. Though the data analysis was a continuous process, it intensified and became more nuanced post fieldwork. During the fieldwork, the observed data was reviewed to establish what was worthy, feeding into the themes. After combining the two sets of data, I started making sense about the data and the nature of themes that emerged such as spirituality and health, healthcare experiences, health beliefs and practices. These were ranked according to the research objectives and the themes were then interpreted through the searching of the meaning of participants' actions, stories, practices and views as reflected in their transcripts and fieldnotes. After identifying these themes, an outline to

present the participants' stories was developed using constructs or analysable themes to organise data as a means for presenting the generated interpretations. The participants confirmed with me their Australian experiences, the challenges they face in accessing healthcare services how they produce and reach to the culturally appropriate health services which will be detailed in the next three chapters.

Ethics and the Protection of participants

Ethical approval for the research was granted by the Human Research Ethics Committee (low risk) at La Trobe University, Australia. The ethics application covered all the key elements from the research objective, design, methods, interview guide questions, data use, data collection and analysis procedures and the targeted participants. Before each interview, participants were asked to provide an official, signed informed consent. As part of the briefing before participating in the studies, key issues for example, the purpose of the study, its the voluntary nature, the themes to be asked, confidentiality, the participants' rights such as the refusal to answer some questions or even a complete withdrawal from the study were explained. Although there was an explicit mention that there were no individual benefits for taking part in this project, the likely macro gains to the community were mentioned if the study suggestions are adopted in policy making. The participants were also asked if they consented to an "extended informed consent" through the information participant statement. This meant that although there were no specific plans to use their responses from this project in any other future project, there might be a need in future. A possible scenario could be another study building from the findings of this research. However, it was reiterated that all the future studies will still have to thoroughly undergo all the ethical processes including keeping identities anonymous. Non-identifiable demographic variables were used, any potentially identifying information provided by the participants was not passed to anyone outside the project. While some of the responses are directly quoted in this thesis, and may be used in future academic work, chances of linking the excerpts in the findings with the specific individuals are minimal. The audio files and the transcripts (electronic data) were securely kept, only myself I had access to. The audio files were deleted from the recorder after they were downloaded to a secure computer, the files were deleted from the recorder. Printed transcripts, participants' documents and field notes were locked away, separating the identifiable details from the transcripts and fieldnotes. The

participants and their data were matched through codes. The participants also had an opportunity to compare their audio files and the transcribed data to authenticate if their voices were correctly captured. Participants had up to four weeks from the day of the interviews to withdraw their interviews if they wished to do so. Not a single request was made, nonetheless.

Reasonable and adequate steps were taken to avoid harm, such as structuring the interview questions in a way that assuages chances of causing emotional discomfort and including testing the appropriateness of the questions through the pilot study. This was part of the project's compliance with the "non-maleficence principle" (Beauchamp & Childress 2001) which basically means "do not harm". However, it was not entirely practical to completely eliminate the possibility of causing mental distress. Discussing migration and health related issues invoked sensitive, emotionally discomforting issues and feelings in some of the participants. At least three participants showed signs of emotional discomfort, and even though they insisted that they were okay and were happy to proceed their bodily language communicated otherwise. It could be that some of the questions might have invoked some stressful previous experiences. For example, a participant working as a nurse almost broke down as she described how she was racially abused by a patient. I responded by pausing the interview, but she insisted that she was fine and wanted to discuss the encounter. When I also tried to manage these scenarios by sidestepping the sensitive issues, participants kept bringing them back in the discussion. As I concluded, despite the emotional risks the issues were of paramount importance to the participants, so I cautiously proceeded, since not discussing them would have been a denial of the opportunity to share their stories, the very essence of the project. Information about 24-hour counselling services was also provided to the participants to use in the event of a distress.

Conclusion

The chapter explained the processes by which this qualitative research was conducted; data collection, its analysis and interpretation, and the instruments used during these steps. Particularly I demonstrated that the fieldwork and the data collection methods needed to be adapted, as the research progressed. There are several factors involved that shaped the fieldwork processes including the inexperience of the participants to take part in an academic interview and the identity of the researcher. Being the researcher and the researched meant that one could not be divorced

from the culture and the practices investigated, which may blur the line between the research process and ordinary life. Also, what is theorised and assumed prior to conducting research is not necessarily how the data can be collected. Rather, the actual fieldwork experience informs what can work and what cannot. As Sanjari et al. (2014) stress, a lot is learnt as the research unfolds which makes trial and error a key part of the study, and through the actual fieldwork process solutions to the identified challenges can then be implemented. However, having a cultural connection with the participants can be a strategic resource to access rich data, navigate themes and probe issues deeply without upsetting the social settings. Qualitative research critics have particularly criticised insider positionality conflating it with bias, but as this study shows, there are several procedures that can be adopted to ensure the credibility of the research regardless of one's positionality. Adhering to all the ethical considerations for the protection of participants is an important aspect of the research process. Nevertheless, when researching delicate topics, notably health and resettlement experiences, the reasonable steps one can take are not always adequate to avoid the emotional distress. The following three Chapters (Chapter four-six) present the study's findings and their discussions.

CHAPTER FOUR: FINANCIAL OBLIGATIONS, SOCIO-CULTURAL CHANGES AND THE EFFECTS OF RACISM AND DISCRIMINATION ON WELLBEING

Introduction

The project was mainly concerned with the examination of health issues and practices of Southern African migrants in Melbourne, exploring what shapes these from a socio-cultural perspective. This included examining the health beliefs, practices and experiences of utilising the health services. As part of context setting, the first research objective looked at the issues and the experiences that might affect health and wellbeing as people resettle in a complex, socially and culturally diverse country. This chapter discusses these issues in the context of Southern Africans migrants in Melbourne. It discusses the socio-cultural and economic factors affecting the Southern Africans' wellbeing thus making them more susceptible to health problems. As the chapter addresses some of these issues, it also lays a foundation for the next two findings chapters that specifically examine the health beliefs, health experiences, and Southern African migrants' behaviours to deal with the health issues. The chapter is broadly organised into two sections which are further broken into subthemes. The first part focuses on the issues connected to the participants' own cultural values and expectations, particularly the financial hardships associated with fulfilling their obligations. That is, the financial burden of supporting their loved ones back home, as well as the higher financial needs necessitated by being isolated from relatives and friends. In discussing the financial and cultural responsibilities, the discussion particularly draws on Ubuntu to illuminate these obligations and cultural loyalties to the extended families back home, and how the desire to be ongoingly legitimated as a human being drives individuals to overlook their wellbeing for the sake of their relatives. The second section explores the experiences and the possible effects of racism, discrimination and exclusion also in contributing to the waning away of the healthy migrant effect, especially in terms of mental wellbeing. In stressing the effects of discrimination to the wellbeing of people, mainly the indirect effects emanating thereof such as the failure to access services for fear of being judged, negative self-evaluation, an ensuing sense of exclusion and unbelonging are also of particular interest to the discussion. The section borrows from some of the critical race theory ideas (Chandra 2012) in making sense of the Southern Africans'

experiences. These issues were mainly cited not only as elevating the risk of the participants experiencing mental health difficulties and undermining their physical wellbeing, but also as creating barriers to access the services in a timely manner. It is important to highlight that while the issues discussed in this chapter seriously impact mental health (discussed in the next chapter), these have been presented as separate chapters for clear work organisation and to draw richer insights from the data.

Financial responsibilities and social obligations

Moving to a new country, either planned (pulled) or forced (pushed) (Lee 1966), imbues certain inevitable cultural changes which invoke psychological and socio-cultural stresses associated with a new environment (Li 2013). Of course, the experiences are not the same among different individuals and groups of people due to cultural coping mechanisms, economic opportunities, individual and family expectations, feelings of belonging, and the presence of support networks in the host country. For the study participants, Australia provided not only an opportunity to improve their own lives through better economic and life opportunities, but it also improved the lives of their families left behind as they remitted some money to support their family members back home. At the same time, the Australian society differs from their home countries socially and culturally in many ways, particularly the lack of social networks protective of various acculturative stresses. In the home countries of the participants, friends and relatives substantially help with duties such as baby minding. Domestic workers who also help with such duties in home countries are unaffordable according to many of the participants. Therefore, relocating to Australia as single parents or as a nuclear family unit meant being separated and alienated from those social support networks. As a result of this isolation, participants' only option was to utilise the formal services such as childcare centres or professional babysitters. In order to meet the associated costs among other responsibilities, migrating to Australia essentially meant higher financial burden. Working longer hours and in multiple jobs was a common practice for coping financially. In stressing their difficulties in Australia, one of the participants said:

> … People are very busy here because they are isolated, they need money for day care, they have to go up and down with school run whereas in Africa the social network is big, there is always someone to help you, to walk your kids to school, to send to the

> shops if you aren't well, your neighbour will give you a ride to work and you will help with fuel but only if you can, if you go away your neighbours can take care of your kids. (Female, 35 years old, Community leader, Zimbabwean)

Participants glowingly spoke about the importance of their families back home in mitigating and addressing mental health difficulties. Because of these networks, the intervention to various stressors is early and the problems are unlikely to develop into serious and severe mental disorders. In expanding on the role of the family in this regard, one of the participants had this to say:

> Even if you are troubled you share your issues with your grandparents, aunties, your cousins, you're just not there by yourself to think about your problem like from morning to night. You could just go to your neighbour's house because the life isn't very busy, people have got plenty of time. That's why people in Africa look happy even if they're wearing rags. (Female, 36 years old, Nurse, Zimbabwean)

Functionalist theorists such as Murdock (1959), Talcott (1977) and Smyth (2021) stress that the family has an important role for the stabilisation of adult personalities through providing the emotional support especially to those going through difficult times. In other words, the family is crucial for mitigating against mental illness through providing the cultural, material and emotional resources that enhance wellbeing. These scholars also contend that the family provides a social integration role through fermenting a sense of connectedness to a society and the primary socialisation of the children including teaching them the norms and values consistent with their families and/or community. Mngomezulu (2008) specifically sees the African families as resilient comparable to other family structures, especially the nuclear family structure, because the African family "secures" its members collectively and interdependently from various shocks through its humanistic values and its expansive nature. The social fabric, cohesion and functionality of each family member is underpinned and strengthened in the definitional issues of what a family is and the roles of each family member. A typical African family has no Western lexis such as cousins, aunts, nieces and uncles to describe relationships, but one that apportions children having multiple parents, and parents also have multiple children because one treats children from their siblings or "cousins" as theirs (Nzegwu 2006). Writing about the African communities in South Africa, Tlou

(2013) interprets such relationships as evidence of the Ubuntu values, especially communalism and interdependence. Metz and Gaie (2010) also use the "solidarity" dimension of Ubuntu to explain the ethos and principles shaping the interpersonal relationships and expectations through a collective and collaborative responsibility for survival along communal and kinship lines. This relationship becomes a cultural resource for both material and emotional support, and thus a mitigation against hardships and the associated stresses. Postmigration this changes, therefore an elevated susceptibility to various mental stressors which are discussed in the following chapter.

Most of the participants indicated that in some instances they rely on phones and social media platforms to remain connected with their families back home for emotional support among other reasons. Time differences and work commitments, however, negatively affected the participants' reliance on their family members, especially those with families residing in the rural areas where connectivity is generally poor. More crucially, sustaining a close relationship with the folks back home was undermined by the "cultural gap" created, according to one of the community leaders. Culture gap has been defined as a systematic difference that may exist between two cultures which will undermine mutual relationship and understanding (Marx & Moss 2011). This concept is further engaged later in this chapter.

Migrating to Australia ushered, or rather further oriented, participants into internalising western values such as materialism and consumerism as benchmarks of success which not only were a departure from their collectivistic values, but also carried a massive financial cost. While praising the economic benefits of migrating, one of the community leaders was also critical of the role of the cultures and practices they were ushered into following migration to Australia. In his own words:

> …when we come here it's all competition, cars, houses, fancy life and stuff like that…we are always competing; we're failing to live within our means and within our income and we end up doing lots and lots of shifts to try and maintain the kind of lifestyle which we have created for ourselves. So, we work too hard, doing too many shifts… We must continue with our simplistic and basic lives we lived back home. (Male, 40 years old, Community leader, Zimbabwean)

Being a community member was an opportunity to witness some of the issues raised by the community leader in the above excerpt. Some of the community members I had casual encounters with mentioned being burdened with huge projects such as building bigger houses back home while also being attracted expensive cars. Sending children to private schools was a norm in their communities which the community leader and another participant interpreted these initiatives as indirect ways of affirming their social status. Foucault's "mentality of governance" or simply governmentality, is useful to understand the government and thought which most explains participants' experiences. Foucault broadly sees "government" as strategies and ways of directing human behaviour (Foucault 1991). The government has mostly previously been discussed as a more pronounced authority such as school or prison settings where authorities control students and prisoners respectively (McDonald et al. 2017). The same governmentality also permeates many sectors of life; thus, the shared beliefs, perceptions and life expectations of a community can assume a similar role. In contemporary western societies, predominant neoliberal values of individualism and materialism underpinning the consumption culture (Eckersley 2011) seem to shape and mould the thoughts, conduct, and ways of being for achievement and happiness. As participants pursue this newfound happiness and self-fulfilment they latently subscribe to the governance of the economic and social structures which allow self-managed actions through one's seeming liberty, and the ability to make an individual decision and pursuit in a so called free market society (McDonald et al. 2017). Embracing these values, following the lead of other citizens of a post-modern neoliberal society, and thus acquiring a consumerist kind of subjectivity (Cabanas 2017), they pattern, template and organise their lives around costly and unsustainable pursuits. The overall message given in such societies is that there is no place for failure which the society judges from being left out in what many are doing that has been imposed by the society non-conversantly (Abel, Buff & Burr 2016; Dogan 2019). To belong one has to conform to this consumeristic behaviour even if it means that health and wellbeing are sacrificed. Notwithstanding the competition discussed by the community leader and the mental burden it generates, it is also crucial to point out the dilemma and the pressures participants might face if they decide not to participate in the popular culture.

Heightened vulnerability to mental illness increases when previously collectivistically-oriented individuals are exposed to the cultural shocks of complex western societies (Caldwell-Harris &

Ayçiçegi 2006). Indeed, the stressful experiences and emotional struggles among African diaspora have been reported as resulting from their ambivalence and shock at being situated in a new cultural system; a system underpinned by ideologies that negate cultural harmony, communitarianism, interdependence and cultural obligation that previously defined their identity as a people (Renzaho & Vignjevic 2011). Africans' communitarianism is expressed in Ubuntu maxims as, "It takes a village to raise a child"; and "Work the clay while it is still wet" which participants in this study mentioned several times during data collection and other informal intercations. As noted earlier, the social networks and those they share cultural commonalities with are left behind in their home countries when one migrates. Similarly, participants evoked these collective and African values to explain their difficulties:

> Back home you have your grandmother, your aunt, your neighbour, your nephews. So, if you start work early there is no need to stress the kids by dropping them off very early at school because someone is always there to help you with that. But here in Australia, oh my goodness! Kids are like your horns, you don't leave them, everywhere you go, whether it is shopping or hospital they are like your handbag… it's very strenuous on them and myself but I have no other option; I don't have money for the childcare, neither can I leave them at home alone unattended. Also, if I am not well, I need peace to recover, but I can't get it, kids are everywhere and there is always noise. (Female, 32 years-old, Student, Zimbabwean)

Corroboratively, another participant associated her children's overweight and obesity for spending too much time watching television, using iPads and less of physical activity. This was very concerning and stressful because of the related medical conditions that had affected some of her family members. But there was much she could do about it. She explained that if she were in her home country (Zimbabwe) this would likely not have been the case because their lifestyles and the common games children play use a lot of energy. When asked why she does not take advantage of many play centres and parks in her local community, she explained that a very busy schedule does not grant her time to supervise them outside. She elaborated:

> …Australia is very different to Africa, back home people don't care what their kids are doing, you just know that wherever they are, they are safe, they don't need any supervision. But here, we can't do that to our kids, we're expected by the laws to supervise kids when

> they play. I don't have time for that because I need to clean the house, cook and do other chores and make sure that everything is in place before I head off for work. (Female, 33 years old, Student, Zimbabwean)

If the participants speaking in the above excerpts lived in a community where Ubuntu, which is concerned with interdependence on others for day to day living (Tutu 1999), largely shapes the community attitudes, the cited issues would have been addressed as they are mitigatable through social networks, thus enhancing the participants' sense of wellbeing. Literature shows that individuals who are socially connected have higher mental and physical wellbeing than those who are isolated. For example, Durkheim ties mental health issues and suicide as being aggravated by social isolation among other factors (Condorelli 2016). Durkheim further links living in complex societies with exacerbating role tensions as the separation of the family roles is compressed (Condorelli 2016). Similarly, for the participants living in a complex Australian context, being away from their families and communities, meant resetting of family and gender roles, and elevated exposure to mental health challenges.

The resetting of gender roles and their possible effects on the mental wellbeing are well exemplified by the experiences of male participants. Several reported performing duties they considered feminine such as cooking, changing baby nappies, caring of the children and the cleaning the house. While the redistribution of the household work was mainly linked to shift work and working odd hours by their partners, for most male participants it symbolised a power shift and redistribution of the power they enjoyed back home when they were the main breadwinners. It was also symbolic of the loss of Ubuntu (respect) by their spouses through redefining the gender role according to the western systems that are sometimes conflictual with their norms and values. These experiences prompted a male 40-year-old community leader from Zimbabwe to position Western cultures and the associated freedoms as promoting marriage disharmony by "encouraging" wives to challenge their spouses' gender roles, and thus, contributing to the rising divorce rates in his community, a phenomenon he described as uncommon in his home country. Another male participant reported feeling disempowered and disrespected by his wife since she became the main household contributor upon migrating to Australia. He feared that it was only a matter of time before his wife expelled him from their marriage, something that was a taboo back

home. At the same time, discussing these issues with his family back home not only undermined his "manhood" because culturally it was interpreted to say he had lost his position as a man, but was also stressful to their families. When asked to elaborate, the participant said:

> …my old man is also stressed big time, because what his daughter in law is doing is culturally unacceptable…she doesn't cook for me anymore… maybe it's because she makes more money. (Male, 45 years old, Driver, Malawian)

In her work on gender order (the patterned system of ideological and material practices through which power relations are made and remade between men and women), Raewyn Connell discusses hegemonic masculinity as a key feature in patriarchal societies where social structures are strategically modelled to position men in dominant social roles over women (Connell 2012; Fox et al. 2002). While the global gender roles have gone through some transformation in the last several decades (are no longer as rigidly fixed, and women are increasingly becoming important contributors in the public sphere) (Rabinovitch 2001), many Southern African societies still have traditional patriarchal ideologies compared to Australia. Therefore, the more fluid gender roles and the general cultural freedoms of Australian society seemed more confronting and discomforting to male migrants. On the contrary, a 55-year-old female participant from Zimbabwe working as a nurse had a lot of praise of the Australian societies in this regard. She explained that unlike in her country where women, as daughters or wives have little control of resources including the incomes they earn, Australian society empowers them to determine when and how they should use their incomes. Other studies with migrants who come from other regions of the African continent show similar trends of African men as being uncomfortable with the way Australia and other western societies have challenged and eroded their power over their families (see Omar, 2015). Thus, although the material benefits of migration are particularly important to the participants, clearly the impact of changing gender roles is experienced differently between genders, in this case the negative impact to the mental wellbeing was felt by male participants while female participants' mental wellbeing in this regard improved.

Furthermore, the mental health difficulties reported by some of the participants are somehow related to the ways in which the societies differ, especially on the roles of formal and informal institutions. Some behaviours participants regarded as normal behaviours in their home cultures

were not only against local norms and values but also illegal and prosecutable offences. Some of these clashes are exemplified in the following excerpt:

> …this was an African guy who was on a Mental Health Act Forced Treatment. When he saw me, he thought, I've seen a fellow African, and he was now explaining to me; "Look here, they are detaining me against my will, and they are saying I'm mad." And then I said, "No, I have seen this a lot of time." I said, "Let me do my research and find out what exactly is happening." … I realised that this guy was from Congo (Democratic Republic of Congo) and had left his three children aged four, six and eight alone at home... Then the neighbours reported him, when the police and everybody came to investigate, he became aggressive, he was saying, "So what? This is what we do in Africa, in Africa, you can leave children, and nobody is called... he tried to do that, he ended up in a mental health institution. (Male, 47 years old, Mental Nurse, Zimbabwean)

The maxim of Ubuntu is the recognition of one's insufficiency to meet their needs therefore individuals necessarily rely on the goodwill, assistance and the relationships with others to satisfy their most basic needs (Gade 2012; Wilson & Williams 2013). The allegiances and relationships created by this communitarian humanist ideology create interdependence and communal responsibility to take care of the children hence Ubuntu sayings such as "It takes a village to raise a child". For the participant, leaving children at home is a normal and acceptable practice in his home country because every community member is expected to care for them. Whereas a similar act of leaving minors alone at home is a prosecutable offence, apart from the dangers of harming themselves at home, the social context is also different which makes the neighbourhoods of Melbourne less safe in this regard.

Acculturative stress in many instances is connected to personal circumstances such as financial support, family commitments and employment opportunities (Skromanis et al. 2018). This study findings reveal similar trends. One of the participants, a mental health nurse, had counselled several clients of African background with mental health issues that were all connected to relocation difficulties ranging from unemployment, financial obligations, balancing school and work and balancing work and family needs. To further underscore the point of the economic and emotional effects of social isolation he made, a community leader also mentioned being

approached by one of the community members to see if some form of assistance could be provided to a stranded community member:

> ... You just don't know how you are going to deal with that situation… so she was told that she was having an anxiety and foreboding, she has a lot of issues to deal with, she just started going to school, she has got a young child and she was having financial troubles. She told me it was her first time to hear such illnesses…she had no clue what they were talking about, but it's not like she didn't have personal problems back home, she had but the difference was that back home there were just too many people to help her though. (Female, 35 years old, Nurse and Community leader, Zimbabwean)

The individual referred to by the community leader arrived on a student visa and had been in Australia for around two years. Her institution of learning was in Frankston which is about one-hour drive from Melbourne central business district, and she was attempting to transfer to a Melbourne campus in order to live near a few Zimbabwean families who may assist with babysitting. The desire to move from Frankston to Mernda is motivated by the importance to recreate and recover social networks migrants lose when they move to a new country. Not only will doing so come with material support, the student mentioned to the community member, residing within the vicinity of her friends and compatriots also comes with food and language preservation (Ley & Germain 2000). Indeed, migrant networks, that often come in the form of interpersonal ties connecting newer and older migrants through shared backgrounds and communities of origin, are part of social capital those that come later can draw on to lower the migration costs and risks and maximise their migration investment (Massey et al. 1993). However, the resilience of migrants to recover the lost social networks through using cultural strategies to address the disruption and reorganise through reviving nationality-based or ethnic communities, can manifest as "visible minority neighbourhoods" (Murdie 2003; Walks & Bourne 2006) thus creating ethnic enclaves which have been places for poor service delivery, neglect and racial discrimination historically (see Assari 2018). For instance, Horyniak et al. (2017) discuss the elevated targeting and enforcing of the law in areas where there is a larger cohort of Africans in Melbourne.

Other student participants described their mental health difficulties because of being on "wrong visas", referring to the tough visa conditions students must abide with. Apart from study and traditional learnership issues that affect students across the board, international students needed to work to raise the exorbitant tuition fees (Forbes-Mewett & Sawyer 2016), and to meet their daily needs (food, transport costs, accommodation, bills). They also remitted some money back home to support their families as Ubuntu dictates. However, meeting all these obligations and expectations within their visa conditions, particularly the 20-hour per week work restriction, was an impossibility. As Giddens (1984) points out in his argument of the structure not only as constraining, but also enabling, imposing a limitation on the number of hours international students could work compels them to come up with other unorthodox arrangements. The majority of the participants who were students reported working in cash-in-hand jobs as they attempt to avoid officially violating their visa conditions which can attract legal sanctioning from the Department of Home Affairs such as visa cancellations or jeopardising future visa applications. A "cash-in-hand job" generally refers to jobs that are paid in cash as opposed to the normal payment through banks or other financial institutions. This unorthodox set-up seems a "win-win" arrangement for both the employer and the student. The employer may get away with not paying taxes and other employee related obligations while the student can work more hours, but officially meet their visa working conditions. Similar to many other western economies, Australia has a 20-hour per week work cap on international students as these students usually enrol full time. Yet, what one can earn for working 20 hours in low paying jobs (as already shown) is inadequate to support the students' financial needs. In most cases working in cash in hand jobs was driven by necessity However, employers "further took advantage" of this loophole to exploit the students through underpayment and making them work in riskier environments with little or no protective clothing. Most of these complaints came from participants who worked in the retail and hospitality industries. The negative health effects of this abuse are likely to be both mental and physical. One of the participants, who often helps international students from Africa at the university where he teaches, further explained the challenges they face:

> They are only supported to pay for the initial semester prior to getting a visa, after they get an air ticket they are on their own. Some are even expected to send money back home to help with the fees for their siblings, so they work in cash jobs where there is a lot of abuse. They come straight from work to school, mentally and physically exhausted, no time to

> shower and freshen up, they are dozing off, some even miss class which will affect their performance at school. If they fail it means their visas are going to be affected, if their visas are affected, they have to renew them and pay extra money to the universities... (Male, 60 years old, Lecturer, Zimbabwean)

If it is generally accepted that students who are workers have higher risks to injury and exploitation (Nyland et al. 2009), it is logical to also presume that as a result of limited knowledge to navigate the job market, relative language skills deficiency, isolation from kin support, inadequate non-wage income support and cultural knowledge, international students are more exploitable. Furthermore, their vulnerability is also more pronounced as they lack the bargaining capacity that underpins the position of domestic workers such as social security benefits, cultural awareness of their rights and the appropriate behaviours of their employers (Haley-Lock & Shah 2007). Poyrazli et al. (2004) stress that these factors can result in adversely affecting the social, mental and physical well-being of the students. However, as rational actors, when individuals migrate, they assess the cost of migration and the possible returns (usually monetary) of that decision (Massey et al. 1993). For these participants, moving to Australia on a student visa is some form of investment, thus the hardships they face have a lesser weight than the monetary benefits to be derived thereof. Interestingly, in most cases student-participants indicated that in the event of feeling unwell, they would prioritise going to work unless the pain has become unbearable. Being casual workers, they were only paid when they actually work. Thus, while the Australian workplace environment in some instances is characterised with some form of abuse which can affect the participants' physical and mental wellbeing, it is worth enduring as the long-term benefits are seen as outweighing the associated hardships.

Through family and friends, students were aware that to some extent living in a foreign country would come with some difficulties. However, some of the challenges, participants encountered were far greater than what they had anticipated. For example, one of the participants who worked in real estate in Zimbabwe thought she would get part-time work in the same sector while she studies for her postgraduate degree. Apart from failing to secure employment (because of her temporary residence and lack of local experience) she separated from her partner a few months after arriving in Australia which also meant additional financial burden. She, however,

demonstrated strong agency and resilience by simultaneously enrolling in her master's degree and six-month course for certification to work in the aged care sector. Nevertheless, taking care of two children as a single parent (albeit with casual help from friends), studying two courses and working part-time was overwhelming to her. She was diagnosed with depression, and in order to remain functional in that space she relied on taking antidepressants. She stressed:

> …I worry a lot about my studies, my kids and many other stuff…I have been diagnosed with depression and anxiety… I'm one of those people who don't usually take drugs because they affect your body, but I must take some because I have a lot on my plate, placement, kids, I need to eat, you feel like this is not time to follow your principles and just do what you have to do. (Female, 33 years old, Student, Zimbabwean)

The participant's problem might be more structural yet being defined, experienced and addressed in a way that is normal in the society where she now lives. As a student and temporary resident with several obligations the participant internalises the outer demands expected of her such as achievement and being independent as the case with her peers despite her own personal circumstances. Working, studying and being able to take care of herself are part of those expectations and obligations, therefore medicating becomes a resource she turns to for achieving even though her excerpt shows that she loathes using drugs. However, regarding her situation or condition only medically, without giving attention to the underlying structural issues of the problem is tantamount to decoupling her life and experiences from the social and market expectations that force her to perform all those roles and redefine it entirely as an individual problem. To this end, sociologists such as Sandell and Bornäs (2015) are critical of the deficiencies of most interventions as they wean individuals away from their social, political and economic world; the very forces that have a significant role in the mental and physical health to the wellbeing of people.

Various migration perspectives such as Lee's "push and pull" (Lee 1966), Piore's "segmented labour market" (Piore 1979), "neoclassical theory" by Todaro and Maruszko (1987) and "social capital theory" by Massey et al. (1999) are some of the commonly available resources that broaden our understanding on human beings' decision to migrate. Logically, people migrate when the

expected return (financial, economic, political, and emotional) for such a decision is higher relative to their current situations. While the participants thought highly of Australia and considered it a place where their economic and financial fortunes will be realised, there was a significant discrepancy between their lived experiences and their expectations prior to migration. Skill mismatch (as the case with some students, for example the preceding excerpt) was a common occurrence which frustrated many professionals. In explaining their frustration, one of the participants mentioned that after having lived in countries where he felt not valued because they were not of the same background and where discrimination and xenophobia were very normalised, he thought they chose a multicultural country where their skills would prove to be more productive and bring higher rewards, a country that prides itself for giving everyone a 'fair go' (Bolton 2003). Yet qualified accountants, engineers and physiotherapists worked as Uber and taxi drivers, cleaners and carers after they failed to get opportunities in their fields, a similar trend to what is happening in other countries (Cote et al. 2019). This not only meant little and lower return on their educational and migration investments, but also affected their self-esteem and confidence and resulted in negative self-assessment, as well as lower job satisfaction. Participants also mentioned that they were aware of the challenges of finding commensurate jobs in Australia since they lacked local experience and social connections to access unadvertised vacancies. They expected to start in other low-paying and semi-skilled jobs. However, they had been trapped in these jobs for far too long. Active searching for jobs in their fields had not yet paid off for an engineer and an accountant who worked as semi-skilled workers for more than six years. They had projected that they would need less than a year to secure jobs in their fields. Generally, participants felt it was harder to convince their prospective employers of the value of their overseas experiences to the local environment especially in an environment they lacked social resources (those resources established through networks) (Huang et al. 2019). Similarly, literature reports that lack of knowledge about the recruitment processes, knowledge on how specific industries work, and resume discrimination as some of the militating factors against the participants' efforts to secure jobs in their fields (Booth, Leigh & Varganova 2012; Oreopoulos 2009). However, the mental health difficulties for the participants may be influenced by the lack of recognition of a "fair go" (a lack of fairness) for overseas trained professionals by the accreditation methods used by the Curriculum Council, Overseas Qualifications Unit and Trade Recognition. Particularly the

sections carried out by professional registration boards have been described as unfair (see Colic-Peisker & Tilbury 2007).

Sending money home

Remitting money back home was a regular and common practice across all the participants. This was out of necessity, as the economic situations in home countries were generally described as dire, and, culturally, those who are relatively better had an obligation to look after their families. When asked about her motive of sending money home, one of the participants said:

> I have a family back home that needs my help... My parents are already retired, all their savings were eaten away (eroded) by inflation, and I am now looking after them. So, I'm looking after my family here, and I'm also looking after my parents back home. Even my siblings, they call me and share their problems, it's not like they want to but there are no jobs for them to work so it breaks my heart, I have no option than to help them. I am feeding my family and helping my extended family simultaneously… I work in three jobs, about seventy-eighty hours a week to make ends meet... (Female, 36 years old, Nurse, Zimbabwean)

Fatigue, lack of concentration, higher cholesterol, hypertension, heart problems and poor sleep are some of the common effects of overworking identified in literature (Artazcoz et al. 2009; Bannai & Tamakoshi 2014; Fukuoka et al. 2005; Messenger, Lee & McCann 2007; Sparks et al. 1997). Participants mentioned physical and mental draining as effects of working many hours and in multiple jobs. They mentioned the importance of earning extra money in order to remit some back home to support their families (extended) which was, to some degree, compensation for the painful separation. The practice ingrained positive emotionality; it fostered social relations and a form of atonement for their absence and was a symbolic badge of honour which participants willingly wore. At the same time, it is a practice informed by the Ubuntu philosophy which in this sense is more concerned with striving for legitimation through a greater good (Poovan, Du Toit & Engelbrecht 2006). Ubuntu also authenticates one's personhood through others (a person cannot be a human through himself/herself), and sending money home can be a form of exhibiting one's humanisation (Meiring 2015). As Menkiti (1984) observe, one earns their

personhood as an ongoing process as they participate in communal life and play socially and culturally accepted roles.

Nevertheless, in seeking to ensure that one is ongoingly legitimated (through Ubuntu standpoint) as a human being through performing and fulfilling specific cultural roles at different life stages, participants admitted that the desire to ensure that the benefits of their migration trickle down to their family meant that less importance is placed on one's mental and physical wellbeing. In elaborating this, one of the community leaders noted the communitarianism values inculcated in them prior to migration as having shaped their cultural and family loyalties. He mentioned that for many of the participants moving abroad meant pulling resources together by several family members to meet the relocation costs for their son, uncle, daughter, or grandchild who will be the face of the family. It becomes an obligation or a reciprocal act to contribute to the uplifting of their siblings through for instance, paying for their school fees or meeting other financial obligations. Also, through remittances, participants not only showed that they did possess socio-cultural values/valued goods (Kankonde 2010) or their loyalties to Ubuntu, it was also a confirmatory gesture of their new affluent diasporic social class as their successes were judged through family contributions.

The cultural obligation and/ or expectation created meant migrants living "dual lives", which meant excessive working to sustain this. Apart from sending money to support their families, three participants explained that they were building houses as self-insurance in case of unforeseen circumstances in the host country. One of the participants in this group further mentioned that building a house in his home country (South Africa) which he intended to use as an investment property would also help him to support his family. All three participants nevertheless complained that their families had an impression that their relatives were dishonest and "predatory" with the way they handled and used some of their finances because they assumed that they were rich. For these participants they found themselves in a contradictory and ambivalent space; not to send money affected their attachment and relationship with family, but to send money came with many stresses and frustrations which both affected their mental wellbeing. Some of these experiences and clashes when dealing with their families' back home, nevertheless, exposed the often romanticised relationship between the transnational networks in literature (see Baldassar 2007).

The section that follows further discuss the factors participants reported to undermine their wellbeing under the racism and discrimination banner.

Racism, discrimination and a sense of not belonging

The work of critical black thinkers such as Yancy (2008) highlights the ways in which the dark-skinned individuals are generally perceived in white societies. Mapedzahama and Kwansah-Aidoo (2017) specifically discuss how the dark-skinned people in western societies have been, for centuries, problematically constructed as differential and oppositional to whiteness. Thus, the difference permeates beyond the mere skin colour. Rather, as an identity socially and persistently constructed and juxtaposed to what is considered as white, and also that which whiteness sees as inferior (Mapedzahama & Kwansah-Aidoo 2017). In Australia, racism and discrimination are well acknowledged in various research (Dunn, Atie & Mapedzahama 2016; Horyniak et al. 2017; Mapedzahama & Kwansah-Aidoo 2017). Among other issues, these reports and findings have noted the ways in which racism, intolerance and discrimination are produced and reproduced through the media and those who invoke nationalism for political point scoring. As these utterances are relayed to the public, they shape the attitudes, views and behaviours consciously and unconsciously thus affecting the sense of belonging, integration and enjoyment of public goods of those targeted. What this section discusses is yet further evidence of racism and discrimination incidences and how these affect the wellbeing and health through elevating vulnerability to mental health difficulties and reduced socio-economic opportunities that would otherwise enhance wellbeing and health access. While some of the stories, as will be seen, might not be unequivocally described as racist, what is more important to illuminate is how the participants interpreted these encounters and the possible associated health consequences.

Structural and subtle racism/discrimination

There are popular narratives that migrants, particularly refugees (whom participants were conflated with), do not want to work taking advantage of the country's generous social policies (Colic-Peisker 2009; Fozdar 2011a, b; Fozdar & Hartley 2013; Rizvi 1986). Consistent evidence from literature (see Fozdar & Hartley 2013; Colic-Peisker 2009; Rizvi 1986), nonetheless demonstrate that migrants work very hard which exposes the hidden and political motives of such claims. Findings from the study, including working in multiple jobs and deskilling to meet

financial obligations also disproves the laziness and parasitic claims levelled against migrants. Rather, some of the challenges they face are a result of being discriminated. The following excerpt elaborates this:

> Discrimination in the health sector is big. I remember when I gave birth to my child, I went to a private hospital… one of the best hospitals... I delivered through a caesarean surgery, on the second day after my surgery I felt neglected… the nurse was checking on other patients except me maybe because I was the only African woman... But when you start your shift, you go around, you introduce yourself to the patients and you do hourly checks on them. But instead, I ended up calling to her and said, " Even though I have just given birth I am just like you, I work in a hospital, I know we have to do hourly checks, and you have not come here to check on me, you have not introduced yourself, you've not seen me for three hours…What if I'd fallen down with the drugs I'm taking? What if the baby has fallen down and I can't reach for the baby?" (Female, 36 years old, Nurse, Zimbabwean)

While some elements of the discrimination described were glaring such as attending to other patients but ignoring the participant, the excerpt also importantly evidences the subtlety of (structural) racism. The key implication is that victims may take their experiences uncritically and associate their mistreatment as the way things are, say in a hospital, school or at workplace. Nevertheless, prior to coming to Australia the participant lived in England which gave her an opportunity to compare two countries that are socially, culturally and politically almost similar. For her England was “not yet there” but had made significant progress in terms of addressing racial discrimination. On the other hand, Australia is a place she thought racism is commonly tolerated. In her words:

> …even at my own workplace discrimination is very real, there’s still a long way to overcome it. I have worked in different nursing units, and even if they know you're good, they cannot just give you that credit because you're African. I have also lived in the UK, the British are better, generally they now appreciate other people, if you are good at something, they give you credit for it… (Female, 36 years old, Nurse, Zimbabwean)

Another participant, a 43-year-old male engineer from Zimbabwe corroborated this story through his own experiences. He worked for a construction company for sixteen years, yet he was still occupying the entry grade of a junior engineer. He described the promotional system as tactically

designed by considering individuals who are experienced in particular departments. And he was never seconded to work in those, effectively making him ineligible. Despite numerous requests to work in those departments in order to gain the relevant experiences, he felt his manager patronisingly rejected his requests. When asked about some of the responses he was given, he mentioned that the manager would stress that he is "too important" to leave the department unless they get someone who is equally competent to temporarily stand for him. Another participant with a related experience had this to say:

> Promotion is allergic to this black skin, it doesn't matter how long you have been employed… it's not about your competence, my supervisors trust me, they often assign me complex task and they know I can deliver under pressure, but I'm not sure anymore if it's about trust or punishment, I believe trust comes with appreciation... (Female, 47 years old, Nurse, Zimbabwean)

Norman Long's "actor-oriented approach" (Long 2001) positions everyday spaces including workplace and public areas as places of interaction, as spaces and arenas where various actors with different and conflicting values encounter each other. Actors use their various types of knowledge, including ideas about oneself and those perceived to be outsiders to shape the interfacing along their binary imaginations of "us" and "them" (Long 2001). The difference and sameness become important proxies and criteria for recognition and rewarding and not rewarding. In racialised societies, social categories such as skin colour and race are important aspects for the inclusion - exclusion dichotomy (Forrest & Dunn 2006). However, as a result of equity, equality, inclusivity and successive legislative and policy reforms over the years, discrimination in formal spaces such as workplaces has shifted from open to a more latent one. Instead, to appear conforming to legislation and create a picture of functioning within expected ethical standards, skin colour, gender, physical abilities, age, religion discrimination shift from being observable to become more subtle and nuanced not only to avoid social and legal sanctioning, but to also emphasise that egalitarian norms and expectations are met. But policy change or legal enactment do not automatically transform deeply entrenched prejudicial attitudes in some individuals to become progressive entities (Forrest & Dunn 2006; Fozdar & Hartley 2013). Through their subtlety (Amin & Thrift 2002; Dunn & Nelson 2011), racism and discrimination may also legitimately blur the discriminatory behaviours of managers and co-workers who may hold racist views perpetuating

them justifiably but perceiving themselves as not racist. Descriptions such as aversive racism (Dovidio & Gaertner 2008); ambivalent racism (Katz & Hass 1988) and modern racism (McConahay 1983); among others articulate the fluidity of racism as it becomes more latent and defendable. Yet, publicly, anti-racism is discussed as something that is confined and limited that can be easily erased through macro policies such as multiculturalism (Dunn et al. 2009). Credit to its fluidity and ingeniousness, modern racism, continues to render bold and ambitious multicultural and anti-racism initiatives for example, "Let's Kick Racism Out of Football" and United Nation's "International Convention on the Elimination of All Forms of Racial Discrimination (CERD)" elusive (Dunn et al. 2009). In its varied form, old fashioned (racial slurs and other forms of blatant racism) or covert (subtle, hazy, fluid, low toned), nevertheless, it will undermine the wellbeing of the victims (Begg et al. 2008). For Paradies (2006), racism produces individuals susceptible to low self-esteem and other mental health difficulties, through internalisation of racism experiences, passive responses, and unfavourable self-evaluations.

A 40-year-old male engineer from Mozambique was tapped on the shoulder by his work colleague (an apprentice) as the colleague comments that he "had worked out a white man's magic" after he fixed a complex technical problem that many had struggled to. The participant thought that despite it being a little offensive, the comment was not consciously meant to demean him. To him it rather showed that his colleague lacked the understanding of the ways in which racism and discrimination are expressed and manifest. However, Forrest and Dunn (2010) note, racism is not only consciously expressed, they stress that a society can legitimise certain behaviours, questions and comments which can be prejudicial to others but normalised by the majority or those who use them. Therefore, the general sentiments and perceptions in a society including casual racism are part of the discourse formulation and narrative that cannot be separated from people of influence such as politicians, media commentators and other public figures. In Australia some of these people have used images of the minorities in the mainstream media and speeches that can be argued to be racist for political purposes among other motives to deflect attention from the challenges of the day through blaming the vulnerable who lack the means to fight back (see Majavu 2020). Indeed, the work by Schaffner and Gadson (2004) disprove the allegations often raised against the minorities. These researchers investigated news coverage in the United States and saw a form of media biases against minorities by both the journalistic process and content which were aimed at

creating a cognitive activation of certain perception among the mainstream audience which is then extrapolated across the community. Thus, even though the media almost always vehemently argue that they do not outwardly support racism (Entman 1990), some of their journalistic practices have a legacy of yielding a stereotyping society that generate mental illnesses in those targeted.

Overt racism/discrimination

Although subtle, minute, fluid and elusive racism was dominant in most of the participants' stories, explicit racism was also reported. The following excerpt exemplifies this old-fashioned racism:

> Someone who you are helping, they look at you and they tell you in your face, "African blood, whether from animals or humans is infectious, I don't want it near me." And you are there trying to help them, they are very sick, you are doing everything for them, and they tell you that… but I just thought, "It's just a patient, I will not take it to heart." But it's something that you constantly think of, "How can someone not appreciate like that?" (Nurse, Zimbabwean, Female, 52 years)

The participant did not raise the complaint but only shared with a few friends from her country, and they assured her that she was not alone as they too, had similar and related experiences. Based on her quote above, the participant was sympathetic to the patient, to some extent she felt the racism she suffered may have been contributed to by the sickness of a hospitalised client, notwithstanding her clear message on how such discrimination affected her own mental wellbeing. Nonetheless, considering that her friends (who were not participants in this study), and a few other participants shared similar experiences, this suggested that it was not an isolated incidence and that it was not a product of one's illness. Indeed, there is an array of evidence ranging from academic work to anecdotal evidence demonstrating strong embeddedness and continued racial discrimination in Australian society. Some of the available literature (Fozdar 2011a; Hage 2012; Mapedzahama & Kwansah-Aidoo 2017; Shoemaker 2004) and the participants' experiences indicate that Australia still has a considerable way to go to redeem itself in response to its long-troubled history when dealing with people coded black due to their darker skin. Using skin colour or blackness and whiteness, where black translates as an othered and undesirable tag (Gatwiri & Anderson 2020), was a culturally and politically constructed racial ideology developed to create a sense of worthlessness, inferiority and incapability for the racially marginalised to

"stomach" their disadvantaged position as natural and inevitable according to Thomas (2010). Therefore, blackness as a social category in white-dominated societies in many ways creates self-surveillance and self-questioning (which whites are not compelled to engage in) because they have not been structured for those coded as black (Yancy 2008). In addition to the blatant and subtle discriminations they face, working in the nursing and caring fields (as the case with the majority of the participants), dominated by team conflicts, experiencing first hand human suffering and death, increased scrutiny of medical and care errors, long hours of work, near misses, omissions of care, rigid policies that prevent them from doing what they feel is right further elevate the participants' vulnerability to mental health issues (Cohen & Erickson 2006; Davidson, Agan & Chakedis 2016; Thomsen et al. 1999; Ulrich 2020). Also, the nature of work participants engages in, especially shift work and often working odd hours, further heightens risks for mental difficulties and physical illness, as they have no clear circadian rhythm, not mentioning working in fields where exploitation is also rife.

"We don't belong, multiculturalism is just a token"

At the time of the interviews, most participants felt they did not belong to the broader Australian society as they felt ostracised and alienated due to their skin colour. Apart from accessing cultural benefits, organising community groups in line with their nationalities created home and identity for most of the participants as a response to the feelings of exclusion in Australia. Taking part in this study appeared to be a long-awaited opportunity to share the hostilities they encountered, and in discussing these confronting and damaging issues, they showed some eagerness and apparent comfort; perhaps they were more comfortable sharing their stories with me because of my positionality as a researcher. While the participants had different residence status ranging from unstable (students and skilled workers on temporary visas) to stable (permanent residents and citizens), they felt they were all overall arbitrarily perceived and treated as outsiders. Importantly, this sense of "outsiderness" had an effect for societal cohesion and creating a sense of inclusion. For example, a 34-year-old male student from Zimbabwe had withdrawn from using community services. He reported that he felt unwanted and unwelcome at a local pub, resulting in him resorting to drinking at home. Interestingly, the participant associated his weight gain to this. Drinking at the pub was regulatory because he would ensure that he does not have too much alcohol in his blood as he would have to drive home afterwards. Also, the higher price of alcohol

at the pub had an effect on how much he can drink, while on the other hand, drinking at home promoted bulk-buying which is obviously cheaper, and there was no need to be mindful about the driving duties immediately after drinking. Another participant who also felt unbelonging said:

> It's very hard and it makes me sad, my kids were born here but they are not accepted very well, they are usually asked a very difficult question about where they came from. It's hard for them because they don't know any other country except Australia…They ask me why they often get such questions, but I have never been able to give them a satisfactory answer. I can't even tell them that we are Africans because when we visit Africa we are only there for few weeks and they don't feel like they belong there because their culture is now different, they are just treated as visitors. (Female, 52 years old, Nurse, Zimbabwean,)

From Maslow's (1954) inclusion of belonging (in his basic needs hierarchy) to a more recent examination of the importance of belonging to wellbeing (Choenarom, Williams & Hagerty 2005), human beings have longed to belong (Barut et al. 2016). While literature identifies the importance of belonging to wellbeing (Choenarom, Williams & Hagerty 2005; Hagerty et al. 1992), societies and their institutions can produce mental health disorders through exerting pressures on the individuals to question their belongingness. Schools among other places are arenas where people spend significant amount of time interacting with others. Also considering that schools are crucial for establishing and developing the construction of identity (Giroux, Freire & McLaren 1988), for the participants' children to be asked such questions in these places meant that not only have such places became symbolic for hostilities and intolerance, but also places where adverse emotional processes and associated mental disorders are produced.

Similar concern was also expressed by one of the participants who often gets asked where she came from at her higher tertiary education. To her this was a question with many racial undertones:

> I don't really like that question, why do you have to ask me where are you from? … it's very telling that even when you were born here, Europe or anywhere else, but as long you have a black skin, you're always an African and you don't belong here. (Female, 27 years old, Student, Zimbabwean,)

Other questions that were a source of discomfort to participants included; "Do you like it here; did you run away from warlords?"; "Would you consider going back and work in your country when you finish your business here?" Clearly some of these questions have prejudicial tone, however, some including the one in the excerpt could have been genuine and motivated by curiosities to learn about other people's cultures, traditions and their histories. Van Leeuwen (2008) reminds us that human beings' longing for a sense of meaning is characterised by the desire to know what eludes their immediate understanding. In a multicultural society question might be asked to those who have their lives or historical experiences not readily available in the public sphere in the quest of knowing. Feelings of being insulted or demeaned can therefore be an unwanted consequence in cross cultural interaction. Regardless of the intention of such interactions, minorities' wellbeing is affected as these questions carry a powerfully subtle message and a constant reminder of their "foreign-ness".

Goffman's pioneering work on stigma is useful in understanding the political, economic, social and cultural power that deeply discredits and creates a new image of a tainted and discounted person (Goffman 1968). Yet, these power issues are often ignored because the power differences are usually taken for granted and/or usually seen as unproblematic (Dunn & Hopkins 2016; Dunn & Nelson 2011; Hage 2012). The discrimination and prejudice participants reported was because their being "black" was conflated with primarily coming to Australia for asylum and refugee seeking. Although the participants had no negative feelings about being refugees or asylum seekers, they saw this as prejudicial labelling because being an African humanitarian arrival is generally synonymised with "being lazy", ungratefulness, criminality, inability to speak in English, reliance on government support, draining of public services and unwillingness to integrate. A 60-year-old academic from Zimbabwe perceives this construction of Africans not as random or isolated but one inculcated even by those who champion equality and humanity. To buttress his argument, he gave examples of humanitarian organisations such as World Vision, Care International, Salvation Army and Plan International that have a certain depiction and use images of Africa and Africans as they seek to convince people to partner with their cause. The international students seemed affected most by the humanitarian arrivals classification, especially considering the tens of thousands of dollars they pay as tuition fees, as well as the costs they meet for their daily needs in Australia. Partly because of those encounters, a 34-year-old male student from

Zimbabwe said he no longer actively participates in social activities such as going out to watch football or having a drink at a local bistro. If, indeed, the participants' suspicions are correct, the stigmatisation is largely unfounded. There is overwhelming and consistent evidence showing that immigrants are hard workers, and even those that originally arrive on humanitarian visas have strong desire to gain employment rather than being on welfare, and are willing to work in the jobs locals are not prepared to take (Colic-Peisker 2009; Fozdar & Hartley 2013; Rizvi 1986).

Furthermore, the participants' experiences relate to what earlier studies have revealed especially a strong entrenchment of views highly critical of migrants in Australia (Dunn, Atie & Mapedzahama 2016; Hage 2012; Majavu 2020; Mapedzahama & Kwansah-Aidoo 2017). Anti-migrant views invoke Hage's (2003) notion of "paranoid Australian nationalism", a remnant of the White Australia Policy according to Ndhlovu (2011). The discriminatory policies, especially the White Australia Policy, over the years have created a sense of entitlement among some white population and created images that racialise Australia as white, fostering an environment in which non-white migrants are excluded (Fozdar 2011a). Over many decades the now abolished policies created an environment of othering and negative construction of black bodies in white spaces, and being black became a symbol of not belonging, outsiderness, and that which whiteness opposes (Mapedzahama & Kwansah-Aidoo 2017). Several studies show that while blacks in the so called white spaces (western societies) continue to report objectification over the years, the sense of entitlement among white folks not only tolerates racism, but also perpetuates it through the creation of an uneven dispensation of citizenship and belongingness which obfuscates efforts to challenge or question it (Fanon 1970; Gee, Kobayashi & Prus 2004; Yancy 2008). The normalisation of racism is further insidiously promoted through a new form of "political correctness" that criticises those who try to draw public attention to it as "using the race card" (Dunn et al. 2001). Yet the race card demonisation of migrants happens in a space where they lack the economic, social, cultural and political power (Forrest & Dunn 2010; Hage 2012; Mapedzahama & Kwansah-Aidoo 2017). Through such a clever and discursive turning of the opprobrium, the racism discussion is shifted towards those who are opposed to it, thus its enablers evade and downplay it and its reproduction (Fanon 1970), and therefore it remains socially pervasive. For this reason among others, critical race theorists in recent decades have also emphasised racist phenomena including those who experience harassment such as "driving while black", or having their conversations with friends

and family interrupted by strangers reminding them to speak in English to spearhead the racism conversation without being accused of the race card or labelled "cry-babies" (Yancy 2008). Considering that the literature is replete with evidence showing that racism manifests also as xenophobia (Viruell-Fuentes 2007; Yoo, Gee & Takeuchi 2009), this suggests that anti-immigrant sentiment could also affect how the public goods, including healthcare, are given to those constructed as unbelonging in addition to the general hardships of living in a society where one feels discriminated against.

As a country built by migrants, Australia was more attuned to accept other migrants as prospective co-citizens as it declared itself multicultural in recognition of the differences of its citizens post White Australia policy (Modood 2013). Through this declaration, it sets an agenda for a somewhat successful multiculturalism. Aptly, noting its social and cultural benefits, Moran (2011, p. 2156) expresses, "Australia's national identity has shifted from a racially-based white, British Australia, to a diverse, multiethnic, and officially multicultural Australia since the 1970s". Without necessarily dismissing some of these gains of multiculturalism as a policy agenda, especially the desire to create an inclusive, and socially integrated Australia, however, through his own experiences, one of the participants felt multicultural policies were overall tokenistic. In his words:

> Australian multiculturalism is just theoretical and rhetoric for us blacks, we are only used on inclusivity ads (advertisements), we feel unwanted and unwelcome, the right wingers and anti-migrants are marching, racism is on the rise, racist media and politicians are getting involved in the national discourse. (Male, 34 years old, Student, Zimbabwean)

As noted above, notwithstanding the gains of multiculturalism in Australia (Forrest & Dunn 2010; Modood 2013; Moran 2011; Paradies 2006), indeed, as a policy and discourse, it has also come under sustained challenge for its shortfalls. For example, multiculturalism has a frame and reference point; it derives from certain kinds of practices and understanding of a particular society thus favours certain values and philosophies (Kymlicka & Norman 2000). In Australia or "Australianness" (participants' context), national ethnocentrism borrows heavily from the British culture (Dixson 1999) which becomes the centric point and a benchmark to measure the compatibility of others, and those values that are perceived to have at most a minimal negative effect on the main culture are embraced as multiculturalism while overlooking more tangible

issues. Multiculturalism critics therefore argue that it is not a neutral concept, but one that sustains ethnic/racial hierarchy through putting whiteness as the core culture, and other cultures at the periphery which are signified by minoritised racial features that assumedly demark a more differentiated and creates uncertainties in relation to the national norms and values (Collins 1999; Nolan et al. 2011). It therefore sustains perpetuation of culturally, ethnically or racially based hierarchies of belongingness and citizenship that have been known to create a sense of ambivalence, discrimination, social exclusion and the not-belongingness it claims to have overcome (Hage 2003; Nolan et al. 2011). Similar to its predecessors, notably assimilationist and integrationist policies (Modood 2013), multiculturalism mirrors these earlier conservative models of integration that aimed to manage differences through emphasis of a national culture and core cultural tradition that charges migrants to conform to the core national values (Forrest & Dunn 2006; Modood 2013). Not until when the minorities can sustain their culture (food, dressing, music) in the public sphere (politics, policies, workplaces) rather than only at home or other structuring spaces (Modood 2013) will multiculturalism and belongingness of minorities be a regular occurrence. Living in a society where they cannot freely express themselves culturally, and where multicultural policies can be argued to be tokenistic, participants will feel excluded and have their sense of being undermined, as well as likely to abstain from utilising and other social services freely if they suspect that they will be negatively evaluated. On health matters, Mishler (1984) uses the phrase the "voice of medicine" when discussing the power disparity between patients and doctors. He stresses that it is the physician who frames the questions, and interprets and records the responses given and captures the responses deemed relevant biomedically, while Dew, Kirkman and Scott (2016) contend that clinical questioning in some instances is just a procedural formality rather than providing the appropriate services. How health services are seen as "multiculturally tokenistic" by the participants is covered in the next two chapters.

Indeed, being negatively evaluated socially undermines psychological and physical well-being (Williams et al. 2007). The ways in which the mainstream society react to the presence of the migrants can exert and impact on their thoughts, emotions, motives, and shape and program their behaviour consistent with their rejected experiences. Participants' sense of exclusion and not belonging also emanated from their cultural practices which were seen as archaic in modern Australia. For example, a 33-year-old female student from Zimbabwe explained how she was

confronted by two women for wrapping her two-year-old son while walking on the streets and was "reminded" that she was not in Africa, and she needed to use a stroller. Hence, instead of viewing and considering themselves as Australians, home countries remained their principal frames of references despite the lengthy of the period of living in Australia. Notwithstanding that I also used nationalities as part of purposive sampling and a descriptor, participant themselves put emphasis on their home countries in their stories which I also interpret as how they constructed their identities. The following excerpt elaborates this:

> I have been with the (the employer) for more than 10 years, I'm the only person from South Africa, Africa rather. But all the Aussies guys I joined with in 2009 either left or secured higher positions. My juniors too. I know for sure that I'm not overlooked because of incompetence because I've been teaching new staff for seven years my review is very good…but after training them they get considered for further training and promotion leaving me at the same position. Everything is secretly done, and you only get to hear through grapevine that so and so went for training and the next thing they are promoted. It pains me that at the end of the day I report to a junior person. (Male, 38 years, Accountant, South African)

This participant had been in Australia for more than 10 years and had attained his Australian citizenship in 2013. He had been an Australian citizen for around five years when he participated in the study. But interestingly, he did not see himself as an Australian or an "Aussie", the way he had described his work colleagues. It was remarkable that he also saw the need to clarify his identity from a South African to an African. This might have been a result of the general understanding that South Africans mainly refers to whites who moved to Australia from South Africa. Describing himself as an African might have seemed more resonating with his African descent. This was also the case with most of the participant who had attained the Australian citizenship. Tellingly, they used home countries not only as a descriptor, but also places of belonging and cultural identity. Thus, maintaining home countries' identity might have been a pointer to their marginalised experiences which undoubtedly undermines a sense of belonging in a supposed multicultural Australia. These experiences are not unique in light of what some scholars have of late noted. Hage (2003) among others stress that integrationist policies including multiculturalism are also being developed and shaped and reshaped, or even being hijacked by

certain institutions with a malicious agenda, including to often remind of the "unbelongingness" of certain minorities. For example, as an institution, the media create a crucial space and an important tool that can be used to challenge and resist interests of minorities and the imposed multicultural identities through policies, by reproducing the cultural powers that reinforce social relations and social hierarchies and the forms of discrimination associated with them (Cottle 2008).

Also, in conservative societies such as Australia (Bessant 2011) where multiculturalism as a policy came as a correction of assimilation and integration policies (Vertovec 2007), particularly its commitment to "plurality of self-contained cultures" (Parekh 2006), it is unusual for it to face resistance. While the minority may view it as tokenistic (as the case with one of the participants with an earlier excerpt), it also receives intense criticism from the mainstream because it is seen as a symbol of that which undermines the core culture of a society (Grillo 2018). Alibhai-Brown (2002) stresses that some of the mainstream cohort might not view it as a policy to ensure equity and equality but a transacting space between the government and minorities, a space that exludes the participation of the mainstream. Vertovec (2010) discusses this in the context of what he sees as a "post-multiculturalism" society in western countries in response to increased backlash against multiculturalism. This perhaps partly explain the hostile reception of various groups of migrants' experiences in Australia (Forrest & Dunn 2006; Fozdar & Torezani 2008; Moran 2005; Ndhlovu 2011). Conservative commentators and politicians have accused multiculturalism of being a policy that is oppositional to the mainstream values. Fuelling ethnic tensions, increasing terrorism, promoting class-based inequalities through lowering of wages, jobs competition and increased costs of housing, and to the demise of the welfare state through overwhelming public services have also been politically explained as the failure of multiculturalism (Vertovec 2010) which clearly create a hostile environment for the participants alongside other migrant communities.

While some scholars (Grillo 2018; Vertovec 2010) conceptualise government as a multiculturality voice especially in countries such as Canada and Australia that were some of the first to embrace multiculturalism in their national discourses (Modood 2013), in more recent years this has not been the case. Anecdotal and populist talk from media especially the emphasis on "our Australian way of life" commonly deployed to "rebuke" the so-called non-conforming migrants sets multiculturalism for brutal criticism by scholars and minority groups as only useful as a public

relations policy because it retains the Anglo-Celtic culture as a desirable image of an Australian culture (Ommundsen 2000). Nagra and Peng (2013) argue that this is because in Western societies, cultural values and religious practices of the minority groups are seen as undermining citizenship, integration and social cohesion. However, Modood (2013) thus contends that multiculturalism to some extent duplicates its outdated predecessors that had an assimilationist nature.

It is not surprising that the political discourse on Australia's migration shows that power can be used as a tool to punish and have authorities over those that have been framed as foreign, deviant, different, and unassimilable (Gatwiri & Anderson 2020). For example, in 2007 an 18-year-old Australian of Sudanese background was assaulted by two men who were of non-African background (Nunn 2010). The victim later died in hospital. Yet, the then Immigration Minister Kevin Andrews, and the subsequent media attention, focused on the violence committed by the African refugees (Gatwiri & Anderson 2020). As a result, the minister announced significant reduction in the number of the African refugees settling in Australia (Nunn 2010). While the decrease had actually been announced two months earlier because of changing global priorities for the Australian humanitarian programme, the message was reframed in the aftermath of the violence (Nunn 2010). Participants among other African migrants therefore, find themselves in an anomalous position of overrepresentation in negative media stories through their high visibility (because of their skin colour) (Majavu 2020) yet almost invisible in coverage of Australian everyday life such as sports, game shows and soap operas. As the media and views by politicians' cascade in society, not only do they activate a certain perception in the way in which ordinary people on the street should treat Africans, they also stimulate feelings and senses of disconnection and ambivalence and of being "unAustralian" once the mainstream community start treating them with the attached label (Majavu 2020). Thus, while the continuous reference to Africa as a place and symbol of their identity (by some participants), it could have been shaped by their national identities, historical experiences and cultural attachments, equally it is an imposed and a reinforced identity that depicts Africans or "Africanness" negatively; a repository for Australians' social pathological fears inculcated through certain representation by society's important institutions (Majavu 2020; Mapedzahama & Kwansah-Aidoo 2017).

Unsurprisingly, a number of participants questioned the worthiness of attempts to integrate and embracing the so-called "Australian norms and values" when they have a black skin that is arbitrarily used as a key variable for the outsider labelling and subjection to racist and discriminatory incivilities. To further contextualise racism in Australia, a 43-year-old male engineer from Zimbabwe hypothesised that even if he had been born in Melbourne and being an active economic contributor, his chances of being seen as a model Australian citizen are not anywhere near that of a white person born in Africa or Asia, and who might be undermining the very Australian values through criminality and other deviant behaviours. According to this participant, Australia is imagined as white. Therefore, living in a society where participants have feelings of exclusion and being stereotyped as criminals and undermining the core values, this could result in the deterioration of their physical and mental well-being (Mann et al. 2004).

Intercultural racism

This research also found that even though most discrimination and racism complaints were raised against the mainstream population (white Australians), intercultural racism also affected the wellbeing of the participants. Relatively larger and well-established migrant groups, for example, Lebanese Australians, Indian Australians and Chinese Australians were accused of reproducing the "white racist mantle" (Waldron 2002) through subjecting participants to similar discriminatory experiences. Participants mentioned latent ways in which intercultural racism takes place. The following excerpt from another participant further demonstrates intercultural discrimination participants endured:

> The most recent one is when an African colleague was confronted by another nurse from Asia about why she got a higher position at the workplace…, "How come you got a higher position, you haven't trained here and how come they accepted your qualifications?" Before she even responded she said, "anyway I am not surprised because I went to university with a lot of people with an accent like yours, I wouldn't have thought they would pass, but they passed, I don't think they were doing their own assignments… I think someone have been doing it for them, maybe they paid someone." (Female, 52 years old, Nurse, Zimbabwean)

These experiences were not only confined to the health and care sectors. Egyptian Australians, Lebanese Australians and Iraqi Australians in the automotive sector were also described as

exhibiting some racism and xenophobia. An auto mechanic explained his struggles in getting hired by companies owned by people originally from Egypt, Lebanon and Iraq. When he eventually secured employment at an automotive garage owned by a Lebanese person, his wages were comparatively lower to his colleagues, and he thought that he was always set to fail by being expected to complete complex tasks and duties which his Arab Australian colleagues would have refused to undertake. He quit the job after four months, and he was still looking for his next job as a mechanic while he worked as a cleaner when he participated in this study. How this affects one's mental wellbeing has thoroughly been covered already in this chapter.

The ideas about racial superiority over Africans by Asians and Arabs are rooted in their cultures and literature that picture, reproduce and reinforce this supposed racial inferiority of Africans through depicting them as of lower intellect (Esseissah 2015). Certain Western media particularly from America also instilled an image of Africans in other ethnic groups through efficiently defining and reinforcing the roles of blacks, white males and women (Esseissah 2015). While the media images were originally intended for the American society, as the American culture spreads, the message had a greater impact in the Middle East and Asia where it was uncritically taken due to a lack of countervailing voices (see Esseissah 2015). Thus, as the American media and American culture spread through the American-led global economy, its cultural principles (diet, clothing, artistic forms and expressions), racialisation and "inferiorisation" of blacks were consumed and embraced. In his discussion of racism where non-whites have been implicated as perpetrators, Sambaraju (2021) argues that while being "White" (with all the efforts that have been put to expose racism), provides a platform for one to easily realise that they belong to the majority group, this is not often the case for those with membership in other racial categories as they still struggle to understand themselves as oppressors as well. Sambaraju lengthily focuses on Indians' racism against Africans. Sociologist Bonilla-Silva (2006) also observes that in addition to whites being perpetrators of racism, some non-whites who see themselves as closer to the whites (structurally) are also complicit in perpetuating racism to the most vulnerable. As a result of the perceived intercultural racism especially by the Asian and the Arabic diaspora, one of the participants, a 46-year-old pastor from Zimbabwe warned that while all the attention is on discrimination and racism perpetuated by the whites (which he actually believes is on the decline or reshaping), the marginalisation of blacks is on the rise because intercultural racism continued to be overlooked.

Conclusion

There is a common narrative in Australia that the continent is a land of opportunities. Indeed, for the participants, it is an outstanding place to upskill themselves, earn an income not only for them to live a decent life, but also to be able to materially take care of those left in their home countries, a way of expressing of Ubuntu when one moves abroad. However, in order to raise the financial resources associated with these obligations and needs, Southern Africans resort to excessive working. The financial needs are also worsened by living in Australia, a place where they are isolated from the extended families and other social networks, they normally rely upon for their daily living such as babysitting. Formal services particularly day care services/centres were used which many described as expensive especially for those participants on temporary visas who are not eligible for some form of government subsidies. Although ICTs to some extent helped in contracting the geographical separation as participants sought emotional support back home, there was a cultural gap (the existing gap between two cultures that might undermine mutual relationship and understanding) hindering their ability to draw from those support networks. In most cases the advice given by their cultural streams back home was patriarchally embedded and overlooked the realities of the Australian context such as the importance of dual incomes and overnight shift work. This meant that men were expected to perform duties traditionally regarded as feminine. These experiences suggest that the participants are likely to have elevated risks to health problems. The chapter also discussed how exclusion, racism and discrimination on the wellbeing of the participants. While most of the stories reveal a latent form of racism, there was also evidence of overt racism taking place at workplaces and intercultural racism from other larger migrant communities, yet it largely evades public scrutiny, and thus is not addressed. Many participants highlighted unpleasant experiences of being racially discriminated against and being labelled as incompetent and parasitic to the government's welfare services. For these reasons, among others, they felt that multiculturalism is largely tokenistic, and their experiences fostered a sense of unbelonging, hopelessness, exclusion and a sense of ambivalence. The reported racism, in its varied form (intercultural, overt or covert) further meant that participants have limited social and economic opportunities protective of their physical and mental health (Gee & Ford 2011; McKenzie 2003). In discussing the factors negatively impacting the wellbeing of Southern Africans in Australia, this chapter lays a foundation for the following chapter, "Mental Health", that closely builds on the issues covered in this chapter.

CHAPTER FIVE: MENTAL HEALTH

Introduction

The previous chapter discussed the social and economic difficulties participants encountered following their migration to Australia, a society which is significantly different from their home countries socially and culturally. We have seen that Southern Africans are socially isolated from the cultural support streams for material and emotional support, and have considerable financial responsibilities for tuition fees, childcare and taking care of their loved ones who are left behind back home among other needs. Also, as part of the context for thinking about mental health and its direct impact on health, the previous chapter examined the effects of racism and discrimination. Building on the issues discussed in the previous chapter, this chapter analyses the participants' indigenous knowledges, beliefs, traditions and ideologies as these not only shaped how they interpreted mental health difficulties, but also the services utilised and how they attempted to address these problems. This chapter demonstrates the particular importance and overarching role of supernatural forces (demons, evil spirits, avenging spirits) in the interpretation of mental difficulties, and their implications on the use of readily available "evidence-based" mainstream services that draw on western biomedicine, cognitive-behavioural, and psychotherapy models. What will be shown is that while the various hardships participants faced have a significant bearing on their mental wellbeing, their understanding of mental illness means that they essentially regard most of the available services as ineffective. At the same time, acculturation and familiarity with the Western services to some extent bridge the gap between their Indigenous beliefs and the available services especially for those participants employed in the health and care sectors. However, as Southern Africans respond to the lack of the culturally appropriate services, they demonstrate their resilience and resourcefulness through creating their own ethnocultural spaces to access health services compatible with their beliefs and knowledges. Belonging to Pentecostal churches with African roots and utilising the community leadership in their localities were some such common initiatives. Nevertheless, often these initiatives were of limited utility in fostering adequate interventions. The sentient and sacred resources (trees, animals, inanimate objects), and the places (shrines, sacred forests, ritual places) ritualised for the healing, along with most of the spiritually gifted healers, are in their home countries. However, in order to continue drawing the health benefits in home countries through relying on friends and relatives, as well as drawing on

the culturally appropriate services such as spiritual healing locally, we see a particular drawing on Ubuntu networks and relationships.

Mental health difficulties from the view of the participants

Three frames, which are, African Traditional Religion, African Pentecostalism and Biomedical, were used by Southern Africans to explain mental health difficulties. Unpacking their differences is important in making sense of and deriving richer meaning from the participants' stories and practices. Within the African Traditional Religion context, the cause of illness is seen as a supernatural attack from bad or evil spirits and spells cast by evil individuals (White 2015). It is also associated with the ancestral punishment if the living do not treat them "well" or if they do not accord them the respect consistent with their superior positionality (Magesa 2014; Westerlund 2006). Thus, in the event of an illness, spiritually gifted individuals such as herbalists and diviners have a role to restore one's health through exorcism, spiritual cleansing and appeasing the gods and ancestors (White 2015). African Pentecostalism also sees mental illness as caused by demons and evil spirits (Kpobi & Swartz 2018). While this is somewhat similar to the African Traditional Religion, in Christianity the healing usually involves the sprinkling of holy water, laying of hands, praying to God, fasting to invoke divine intervention and exorcism of the evil spirit causing illness (Kpobi & Swartz 2018). On the other hand, the biomedical approach proposes that an illness in an individual is a result of a specific cause that affects human bodies in a specific and predictable manner (Germov 2014). Mental disorders are also seen as the neurobiological and genetic imbalances within the body (Lebowitz & Appelbaum 2019). The biomedical theorisation thus facilitates a universalistic approach in curing and restoring the normal functionality of the human body (Germov 2014). While the biomedical model sees illness as caused by the malfunctioning of an individual's body, and involves an internalised approach to illness, the African Traditional Religion and African Christian Pentecostalism put the supernatural powers and processes at the core of the illness and healing. However, as a medically pluralistic cohort, all the three models are used to explain the mental health difficulties although the biomedical model had a lesser significance among the participants. It is important to note, as this chapter shows, that medical pluralism was less in evidence when participants discussed mental health difficulties and healing practices, than when they discussed physical illness and related healing practices.

As part of contextualising the chapter, it is necessary to briefly discuss mental health literacy of the participants. According to Jorm et al. (1997) 'mental health literacy' covers the knowledge and beliefs regarding mental illnesses which are useful in our understanding, prevention, recognition and management of the disorders. However, Bourget and Chenier (2007) argue that this definition is not specific on whose beliefs or models demonstrate good mental health literacy. Thus, what could be interpreted as poor mental health literacy by biomedical mental health practitioners could be different from the conceptualisations of African people who traditionally have constructions that are based in their worldview (Nwoye 2006), especially the view of mental illness as a manifestation of a disharmony between complex supernatural, physical and social relationships (Ross & Deverell 2010) among other explanations. The failure to acknowledge these differences may mean that African people are seen as having poor mental health literacy, which overlooks the reality that clinical phenomena are socially constituted and the fact that different societies' knowledges are drawn from different worldviews, which in turn shapes their understanding and explanatory models of the mental disorders (see Mokgobi 2014).

Traditional beliefs

The African Traditional Religion and African Pentecostalism largely shaped most of the participants' mental health beliefs, ideologies and practices. Both religions conceptualised mental health difficulties as problems caused by and a manifestation of a disruption of the relationship between human beings and the supernatural powers, although there were some ideological differences which are discussed later in the chapter.

The African Traditional Religion

Most participants conflated mental illnesses with being totally "derailed", "having loose connections in the brain", "madness", "craziness", walking on the street naked, being extremely violent and other extreme behaviours. They contended that mental difficulties are a result of evil spirits notably avenging spirits, witchcraft, demons and the devil that have the power to disrupt one's life supernaturally. For example, one participant had this to say:

> … What it tells us is that one has been bewitched, a magic spell has been cast on them, so they need to be exorcised to get back to their original state of mind or good state. In many cases a ritual should be performed at the homestead of the sick person by a traditional

> healer, and the ritual normally requires that the family slaughter a cow or a goat and the blood of the animal is used during the exorcism process. (Male, 48 years old, Engineer and Community leader, Zimbabwean)

The participant's response shows a unique traditional and religious conceptualisation of mental difficulties. Viewing mental health difficulties as conditions ethno-culturally and religiously mediated, generally dissimilar to the conditions Australia's predominant Western cognitive therapies and psychopharmacology seek to manage, means that those services are of marginal relevance to the participants. Hence, using a biomedical approach to deal with these health problems (which is largely the case in Australia) in different groups of people might not only lead to withdrawal from utilising the services. Although Southern African countries have embraced, to some extent, the biomedical approach to health, it is important to stress that this largely applies to the physiological aspects of health. Several factors including resource constraint, beliefs and values and the elusiveness of mental illness compared to the physical illness contribute to this. For context, in 2006 Zimbabwe had 11 psychiatrists for its 15 million people population compared to Netherlands which had 4000 psychiatrists for almost a similar population size (Cavanaugh 2017). In 2020 the Zimbabwe's psychiatrists had increased to just 17 (Mangezi 2020). Government reports show that Australia had 3,441 psychiatrists in 2018 for its 25 million citizens. However, the key point here is that the severe stresses, depressions and anxieties that could have been generated by the hardships participants face (discussed in the previous chapter) do not easily meet the threshold for intervention.

From the above excerpt from a participant interview, mental difficulties stem from a spiritual curse, being jinxed among other socially and culturally constructed deviances. An outside entity (external to person) has caused the mental problem (cast a spell) — and that a particular ritual is needed to bring the person back to "normality". This differs significantly from the way similar problems are contextualised and how help is sought in western societies. Therefore, what constitutes a mental problem or disorder is socially and culturally relative which also determines the appropriate intervention within a community's specific rules. Durkheim's functionalist work, particularly on the mutual constitution of the society, stresses the rules and standards of setting the parameters of what is pathological and how these rules reinforce the values in a specific society

(Durkheim 1964). There is a mutual constitution of normality and what is pathologised, as people come up with the pathological in order to produce, sustain and strengthen the normal (Busfield 2000). However, the pathologising of certain behaviours is interpreted differently from one society to another. As shown, for Southern Africans it is primarily spiritually caused which thus invalidates the usefulness of the available biomedical services in Australia. The failure to seek help in this context should therefore be seen as a consequence of the unavailability of services yet there are many mental health services available.

Also, in the previous except, especially the emphasis on "exorcism" and restoration of one's original state of mind, mental health difficulties are synonymised with the loss of normality or the "executive function" since a person is no longer in control of themselves due to the external forces that have overtaken. The loss of the executive function refers to one's lack of capacity to meaningfully and purposefully regulate their mind for a focused, and goal-oriented decision making process (Jones 2004). This was also the case with the other participants. For example, to his shock, one of the participants, a 40-year-old community leader from Zimbabwe was asked by his Anglo neighbour to pick up his children from school as he had an appointment with his psychologist. When the participant asked his neighbour if he had called an Uber or had arranged with someone to come and pick him up, he was further confused to learn that his neighbour was to drive himself. Armed with his own knowledge of the gravity of the problem, the participant offered to drive his neighbour, insisting that his wife was not working on that day so she can pick the children up from school. The offer was declined, with the neighbour insisting that he can drive himself with no difficulty. The participant concluded that the neighbour was pulling a stunt; that visiting a psychologist was an excuse for doing other sinister errands, or that he saw a problem where there was none. The different meanings, definitions and misconstruing of mental health difficulties exhibited here further highlight the extremeness of the symptoms for one to be classified as mentally ill in Southern African communities. It shows that these problems are equated with the more severe problems of what Western psychiatry would see as psychosis. Nevertheless, this narrowed view of mental health problems was also held to more recently in the West; mental health conceptualisation of what constitutes mental health problems has only expanded to include the "common" disorders of depression and anxiety since the 1950s (Horwitz 2010). Thus, for Southern Africans, the likelihood of seeking help is lower if a person feels that

their problems are still manageable, and besides the nature of help sought would be different. Through this framing of mental illness, the likelihood of early intervention and its benefits is likely to be missed in these communities.

The different meanings accorded to mental health difficulties are also exemplified in the following excerpt from another participant. While the participant mentioned regular use of health services such as Masseurs, Podiatrists and Dentists as she was always conscious of her health, she did not see the need to use the services of counsellors and psychologists. As some of her life experiences might have warranted the utilisation of such services, when asked to elaborate her reasons for not using mental health services, she said:

> Why? No, I don't think that's relevant to me, I never tore my clothes, I never lost my mind, I didn't walk naked on the street, my family didn't see the need as well... (Female, 32 years old, Student, South African)

For the participant the mental health difficulty is determined by what can be observed by others, becoming "crazy" or losing control of one's executive function, as Jones (2004) explains as an indicator of mental illness. Nonetheless, the participant highlights an important dimension in her understanding of the problem as she mentioned the role of the family and others. Her excerpt implies mental illness as not just a severe condition, but also something that a victim cannot comprehend as they lack the capacity to process their world.

While the participants were concerned with the extremeness of symptoms in defining mental illness, this was not something only shaped by their religious beliefs and a conceptualisation not only confined to Southern African participants. Rather, what constitutes mental wellbeing and mental disorders has evolved over time. The 19th and 20th centuries' definitions of mental illness in western societies also had similar idea, for example in Britain (Busfield 2014; Scull 1979), in Australia (Cade 1979) and Rosenhan (1973) in the United States. Also, Goffman's seminal work on the psychiatric institutions in the United States (Goffman 1968) on early psychiatry further demonstrates how the earlier conceptualisations of mental illness were characterised by severe symptoms and custodial care during the asylums or institutionalisation period to house those the society could not manage. However, over the last decades several changes have taken place

including the new editions of the Diagnostic Statistical Manual (DSM); the rise of self-help literature; public policy (deinstitutionalisation and the rise of community care and public conversations about mental health); focus on self-management in models of healthcare (responsibilisation/ neoliberal imperatives) and more increased formal help-seeking (Busfield 2012) have contributed to the ways in which mental health issues are perceived. Similar to many other western societies, mental health policies have positively changed particularly the focusing on the social inclusion of people with mental disorders, their active participation to enhance their rights (see Sawyer 2011). More so, the scientific investigations have led to rigorous refinement of mental illness and psychiatry definitions through peer reviewing and new methods and professional scrutinising, resulting in contemporary definitions of mental health problems including less severe difficulties such as stresses, depression and anxiety which was not the case in the earlier conceptualisations (Busfield 2012). So far this has not been the same trajectory for other peoples and cultures in other places, where religion and traditions among other explanatory factors still have greater credence in the interpretation of similar and related issues. Seeing mental illness only in its severest forms, and regarding other issues not as mental illness, results in less use of services. Driving a car for an appointment with their counsellor (as the case with one of the participants' neighbours) and the ability to logically talk to a counsellor thus falls outside the participants' purview of a mental health difficulty that warrants help-seeking.

Conceptualising mental health difficulty as a condition that originates from the supernatural world brings into question the efficacy of western treatments and services such as psychologists and psychiatrists. Attempting to seek help for these problems was considered scandalous because it would undermine and trivialise a problem instigated by the supernatural forces. In explaining this health belief, one of the participants said:

> Well generally Africans don't believe in psychiatrists but if you're going to a psychiatrist, it's almost accepting that the problem is with you, it's internal and individualised yet dealing with a cultural or religious matter… So instead of going to a psychiatrist or a psychologist, we consult spirit mediums or traditional healers because they deal with the actual cause of the illness. (Male, 40 years, Community leader, Zimbabwean)

The "actual cause" in the excerpt above indicates what could be diagnosed is not the root of the illness. What is regarded as a starting point of mental illness notably neurotransmission issues as the case with depression (see Sandell & Bornas 2015), or genetic factors for schizophrenia (see Lieberman 1999 and Laing 1964) are not regarded as the real cause of the illness in the participants' cultural or religious context but a misnomer. While western scholars such as Sandell and Bornäs (2015) also recognise the role of external forces outside the individual such as the impact of neoliberal-induced expectations and the emphasis on self-responsibility in exacerbating mental disorders in an individual, for the participants it is mainly a result of mystical and supernatural forces. The genetic or neurotransmission problems diagnosable as depression, anxiety or schizophrenia in biomedical conceptualisations are either not classified as a mental illness or they are theorised and named differently. Where biomedicine views the illness as a problem in the individual's body, participants largely externalise this and associate the disorder, that biomedicine views as schizophrenia in western terms, as a manifestation of the disequilibrium in the supernatural world. Thus, to address the so-called actual cause of the illness, experts that share similar beliefs, notably traditional healers and spirit mediums, are consulted instead of psychotherapists to affect the healing. Yet, these expects are rarely available in Australia. What this also entails is that while Australia among other western countries prioritise early intervention to address mental health problems since the early 2000s (Forbes-Mewett & Sawyer 2016), because of the ideological differences these initiatives are of very limited utility in certain cohorts.

African Pentecostalism understanding of mental health

For participants of African Pentecostal faith, ancestral spirits, demons and witches were the actual cause of the mental health difficulties:

> It is an extreme and spiritual condition linked to ancestral, witchcraft and other evil spirits, it should be dealt with by consulting divinely gifted people such as prophets and apostles. But I prefer consulting people of African background because we speak the same language, we pray and worship the same way and we have a common understanding about the source of our mental illness unlike Australian Pentecostals. Unfortunately, it is difficult to get African Pentecostal churches in Australia. (Male, 46 years old, Uber driver, Zimbabwean)

This excerpt is not only insightful about the traditional beliefs and ideologies around mental health difficulties, but also the reality that there are not many of these services. More importantly, this

explanation (without dismissing its philosophical basis) does not focus on the resettlement hardships (racism, financial difficulties, overworking) and their implications for mental wellbeing. The nature of interventions therefore is oriented towards addressing the supernatural cause rather than the everyday socio-economic struggles. Nevertheless, the participant's understanding is limited and creates a somewhat false picture of people from Africa as a homogenous and a culturally static cohort. Notwithstanding some similarities, Africans have different religious beliefs. For example, when he talks about the importance of Christian prophets and apostles to fight ancestral spirits causing the illness, those of the Traditional African Religion do not see ancestral spirits as problematic but as a solution to mental health difficulties. Scholars such as Okeke, Ibenwa and Okeke (2017), Gifford (2008), Kalu (2008) and Asamoah-Gyadu (2004) also describe the African indigenous beliefs differently. However, in expanding the religious-situatedness of mental health difficulties, another Christian participant saw it as a condition caused by witchcraft, ancestral spirits, demons and other evil forces, therefore, Holy Spirit is required to address the anomaly. She also cited the bible to explain the spiritual genesis of the problem and justify their beliefs:

> It is a manifestation of a demon, there are many examples if you read in the Bible, where people were exorcised of demons, which were causing them to have signs of mental illnesses including living in the graveyard, being violent and destructive. If everything is working perfectly well spiritually, one shouldn't be having mental illness. (Female, 39 years old, Student, Zimbabwean)

Apportioning blame on ancestral spirits among other causes by the Christian participants not only shows the multiplicity (though related) of the African belief system, but also highlights a tense relationship existing between these. As discussed earlier in chapter two (page 28), Hirst (2005) draws parallels between the African Traditional Religion and the African Pentecostalism, both as systems of thought and practice, especially the association and similarities between evil spirits and witches in the African Traditional Religion and Satan in Christian Pentecostalism. The politics involved, especially the "Godliness" and "purity" of Christianity and the alleged darkness associated with the African Traditional Religion, resulted in African Christians advocating for the rejection of the indigenous sociocultural and religious practices for incivility reasons, yet

embedding their healing practices in African traditional healing was also seen in the narratives of the Christian participants.

Nonetheless, applying supernatural explanations to their suffering, participants position spiritual forces as superior to individuals and having the power to alter their lives because they have either created human beings (God) or have a superior say in the affairs of the living (God and ancestors). In this sense, similar to how religion is viewed in Durkheimian sociology, a religious force is a glue for the social order by regulating behaviours through socially binding values in everyday life, and straying from these is punishable through mental difficulties. Stanford (2007) discusses the attribution of the causes of mental difficulties as spiritual in nature including sinful acts, demon possession and the absence of faith. Religion had a functionality of organising and lending coherence to the participants by providing a common symbol and understanding of mental difficulties through their shared identity and worldview.

At the same time, the two excerpts above from Christian participants locate mental health difficulties, and the required interventions, biblically. In the bible, there are more than 70 examples of mental illness healing in the New Testament (including duplications) which was apportioned to demons (Favazza 1982) which demonstrate how religious and spiritual interpretations are attached to mental health difficulties. Indeed, literature also shows how mental problems among those who sought help for demonic possessions attributed it to the devil (Ward & Beaubrun 1981). Therefore, as the Western oriented approaches mainly utilise scientific methods to address the problem, we see the science-religion clash somewhat manifested as Christian participants not only see scientific explanations as misplaced, but also of negligible utility in addressing the supernaturally caused illnesses. The science-religion duel has been around for many years. For example, psychoanalyst Sigmund Freud perceived religious beliefs as infantile life outlooks, obsessive neurosis, and/or narcissistic delusions that were dangerous to use to treat individuals in society because of their determinative approach which reflected unhealthy psychological status (Kronemyer 2011). With this religious understanding of the mental health difficulties, the likelihood of seeking help from the available biomedical services would still have been limited even if the participant were to recognise their everyday stresses, depression and anxiety as mental disorders.

Predictably nearly all Christian participants inserted themselves in African Pentecostal churches established in their communities. These participants were not only critical of western and formal mental health service providers such as counsellors and psychologists for their failure to understand and respond to the ethno-cultural and religious beliefs of their communities, but also the mainstream churches in Australia for their lack of recognition of their indigenous values. Membership in these churches was mainly drawn across Melbourne and nearby towns but almost always consisted of people from the same country. The worshipping styles, the observance of the religious calendar and other rituals were modelled along the mother churches back home. Resident pastors were sourced from home countries as well. On special religious gatherings such as the Easter commemorations or annual conferences, guest speakers mostly came from their home countries. Clearly these practices demonstrate how culture and religion continue to shape the spiritual identity and its role on health matters postmigration (Adelowo 2012; Madu 1996). Further, the excerpt below highlights how participants continued to sustain their religious beliefs, and by extension how they perceive mental illness:

> I was at a church conference last year and our guest preacher was a powerful preacher from Zimbabwe…He said a lot of spiritual things to the church, but on mental illness he said that the craziness you see in your children here is because there are evil spiritual forces being commissioned by both the ancestors and the living back home to disrupt your lives, they can bewitch you regardless of the distance and you start seeing your child becoming mad (insane) from nowhere, but here they will just say it's because of drug use. (Male, 55 years old, Teacher, Zimbabwean)

The participant felt that the people at the church gathering were very much in agreement with the preacher. He himself was also of the similar view as he went on to say that in their culture if something happens in terms of mental illness, it is not because there is something wrong with the individual, but it is because witchcraft and witches have caused it. Among the many researchers who have examined the complex but important role of religion on mental health problems (Bowlby 1982; Eshun & Gurung 2009; Pargament et al. 1990; Pargament, Koenig & Perez 2000; Pargament et al. 2013; Pargament et al. 2003; Webb, Stetz & Hedden 2008; Wesselmann et al. 2015), John Bowlby's "religion attachment theory" stands out in providing an

intriguing foundation for understanding participants' experiences. Bowlby (1982, 1998) uses the physical proximity in a child and parent relationship to seek solace when distressed, but the physical proximity between the attaching person and the attachment figure naturally becomes less important as the child grows and matures, and it transforms from a physical security to a "felt security". The African Pentecostal churches and their doctrine as shown in the above except thus becomes a symbol and creates a sense of "felt proximity" and a "felt security". They are places to address their health problems spiritually and create and fostering a sense of wellbeing through a feeling of connection to God. Participants' religiosity which crucially shapes their understanding of mental health issues by extension largely shape their attitudes towards services rooted in ideologies that are critical and opposed to their beliefs. As will be shown later in the chapter, however, these religious places were places of solving some health difficulties thus a culturally appropriate substitution to the biomedical services which the participants felt were largely useless in terms of helping with their mental wellbeing.

While both African Pentecostalism and African Traditional Religion participants described mental illness issues as a sign of negative spiritual forces, one of the participants (a senior pastor at a local church) distinguished the ideological differences between the African Traditional Religion and Christianity, and related complexities. Such differences further account for the dissimilarities in the conceptualisation of causation and remedies. For him, as a Christian, mental illness signals persecution by the demons and ancestral spirits merely for one's decision to become a believer in Jesus Christ. He described mental illness in the African Traditional Religion as evidencing bewitchment caused by jealousy, hatred and the avenging spirits known as *ngozi* (Zimbabwe) for the sins committed by an individual or their family member. To further explain *ngozi*, the pastor further equated it to a more familiar Hindu concept of *karma,* in order to show that something (especially a bad thing) happens to a person because they deserve it, and they caused it through their actions. In his words during the interview:

> … the avenging spirits come to haunt those who have done something bad, suffering from mental illness symptoms confirm that one is being tormented for a deviant behaviour committed. The notable difference between *ngozi* and *karma* however is that while karma is often viewed as having individualised consequences, in the African culture *ngozi* can be collectively felt, the punishment is felt by many people, and it can be transferred to the

> other person. For instance, if a transgressor dies before paying for his misdeed, the punishment is transferred to a close family member, of the same blood. (Male, 46 years old, Pastor, Zimbabwean)

An important dimension to highlight, however, from this religiously embedded diagnostic model is the imbued labelling power. From the excerpt the labelling connotates mental health difficulties with being jinxed due to their moral weakness or for the transgressions of others who prematurely died, thus one is being punished by ancestors and God. The blood relationship one has with the transgressor creates a connection for them to be punished on behalf of their loved ones according to one of the community leaders. Similarly, White et al (2003) discuss the conflation of mental illness with not being prayerful and diligent in their Christian life among other African diaspora communities, which might encourage them not to acknowledge the problem and avoid seeking help. This is to preserve their dignity. Goffman's sociological treatise on stigma sought to illuminate the effects of human societies' categorisations and the linkages with a stereotyped belief. Goffman (1963) argues that the label is socially produced and enacted through how people interact and their relationships. It is enacted in the rules that define acceptable, customary, "normal", or expected norms imposed by a social group which shapes their actions at different points, times and places. The participants' rules around mental difficulties and the cultural and religious stigma it carries shape their help seeking and healthcare system utilisation attitudes; in this case, because of the stigma associated with mental illness, even the non-Western health services are likely to be overlooked.

Following is also another example of how the labelling as a spiritual malady shapes help seeking:

> I remember last year it got to a point where she wanted to kill her child maybe because of post-natal depression. She is an international student, and it was not a planned pregnancy; the child came very early prematurely; the guy refused the responsibility and her entire life literally stopped. After telling her mother that she is considering killing the child and herself, she was told that it is because of *ngozi* in her family caused by a murder committed by her great grandfather. She encouraged her to look for a church and ask the pastor to pray for her… (Female, 34 years old, Nurse, Zimbabwean)

Although the participant, like many other participants, emphasised the religious and cultural explanations for mental health difficulties, she used Western descriptors (post-natal depression), perhaps because of her professional training and experience, to describe what her friend's family considered as *ngozi*. Clearly, there are two kinds of labelling in the nurse's comments —the medical label that she seems to adopt, which is post-natal depression, and the spiritual label that her mother uses. It seems the participant favoured the biomedical explanation as she went on to explain how the religious beliefs could be a barrier for utilising the services. Implicitly, she did not regard the suggestion of visiting a pastor from the mother of her friend as a service to the mental disorder associated with her friend's behaviour. The "cultural services" section that comes later in this chapter will argue that such people are a form of utilisable service.

However, the morality issue in her family associated with *ngozi* is tricky to remedy. Firstly, the Western healthcare approach, because of its philosophical foundation and theories of practice, is not equipped to address the problem. Secondly, being in Australia and using the local African Pentecostal churches for spiritual intervention, comes with moral condemnation of being part of, or coming from, a jinxed family. Apart from exposing family's sensitive information, seeking outside help can then be regarded as a sign of failure by the family to address their issues without involving the outside world (Araya 2001), altering their normal social roles and undermining their status in society. Therefore, despite some evidence showing efforts in western countries to overcome stigma through mental health literacy (Reavley & Jorm 2011), those initiatives in the minority communities with strong non-scientific beliefs are undermined due to self-stigma (internalisation of community prejudice) and the fear of perceived stigma — community attitudes towards a particular group (Martin, Pescosolido & Tuch 2000). Nevertheless, the stigma and labelling are not only confined to minority groups, such as the participants with their religion/spiritual based mental difficulties' belief systems, but are a feature also of a more widespread problem. In some specific Western communities, protecting themselves from public embarrassment and maintaining a good social image and standing in the society means that families isolate their mentally ill family members from the community (Harden 2005; Jones 2004; Karp 1996; Quah 2014; Richardson 2013; Young, Bailey & Rycroft 2004).

Embracing Western definitions of mental health

The previous section discussed the endurance of the participants' indigenous beliefs, especially the viewing of mental health difficulties as caused by external causes which was largely determinant of their lack of utilisation of the available mainstream services. While Western mental health services have spread to Southern Africa, their number is still small (Jack et al. 2014; Rathod et al. 2017). Among other reasons such as religious beliefs and limited awareness, as this section demonstrates, they are not as prevalent in Southern Africa and not dominant in the understanding of mental difficulties. Nevertheless, moving to Australia clearly oriented participants to bio-medical understandings and diagnoses. This was more apparent among the participants socialised and acculturated to these theories and practices such as those working in the health and care sectors. Concepts and terms previously unknown to them had become part of their mental health definitions and meanings of what it meant to be mentally well. For example, one of the participants said:

> … I thought depression and anxiety were just fancy names used by the whites. The way that I used to think and view mental illness before I came here is now different from the way I view it now. When I first came, mental illness only meant somebody who is a psycho, somebody who's totally out of the odds, an aggressive and violent person, and one who cannot understand anything in any way. But I have since realised that it includes a lot of things including depression, anxiety and severe stress. (Male, 43 years old, Disability Support Worker, Zimbabwean)

For another participant, she broadened her understanding of mental health issues when she moved to the United Kingdom where she witnessed three young African nurses losing their lives due to work related stresses. She was also worried that many Africans overwork themselves in Australia, therefore, she started a campaign to make them aware of the physical and mental dangers linked with it. This was corroborated by another participant:

> People now appreciate that anxiety, depression and so forth are part of the mental illness but we were brought up to be strong to face whatever comes your way, and we were made to think that mental health issues are something you can deal with it yourself, and it's not an issue, if you complain you are accused of making up stuff, you're just seeking attention or something. (Male, 52 years old, Pastor, South African)

This ideal of stoicism, that is keeping as private and exercising emotional control of painful emotions (Wagstaff & Rowledge 1995) shows different ideals of selfhood in Australia and Southern Africa. Murray et al. (2008) view stoic values as a non-uniform trait across social groups, but rather a behaviour that is socially and culturally learned and differing from one group to the other. Similarly, Sherman (2007) sees stoicism as a manifestation of a particular worldview people use to respond to their suffering and pain. At the same time, Moore et al. (2012) argue that the fear and embarrassment instilled by stoicism, as well as the sense of wanting to rise above one's situation and be in control (of one's health wellbeing) undoubtedly undermine help seeking which is similar to the participant with the above's excerpt explanation. This exacerbates problems into serious mental disorders through social stigma (Ahmedani 2011).

A 32-year-old male student participant from Zimbabwe also working in the health field, explained that for over a year he considered depression and anxiety and post-traumatic stress disorders as concepts designed by and therefore applicable to western cultures. However, after several months of unemployment, financial and marriage problems, he found himself in a place he described as "a dark world". He had withdrawn from his social circles as he felt that he no longer belonged among his financially stable colleagues while he survived on food banks as he struggled to make ends meet. When he eventually sought help after several people intervened, he was diagnosed with several mental disorders and had attended free counselling sessions. One of the community leaders, also a healthcare worker, acknowledged that people from Southern Africa are slowly recognising the importance of seeking help, but he also gave cultural insights in explaining why it is taking so long for them to develop broader views of mental health difficulties:

> Mental health from the people of Southern Africa and the Western world is very different. A Westerner can view depression as a mental health issue. I mean, I left Zimbabwe ages ago, or Southern Africa ages ago, but I can tell you that I never met anyone who was depressed. So, things like depression, things like anorexia nervosa, bulimia are illnesses that we never knew about in Africa… they may be coming up now because of mingling with the Western world, but the fact is, for you to be labelled mentally ill in Africa, you really would have to be extremely psychotic for anyone to recognise that you were ill. (Male, 46 years old, Mental Health Nurse and Pastor, Zimbabwean)

While this participant's view may be outdated as he concedes that he had left his home country decades ago, he also acknowledges the role of modernity and globalisation in mental health literacy and the subsequent widening of the healthcare services. Nevertheless, despite this broadening of their view among some of the participants, they were unsure and unconvinced about the nature of interventions used in Australia's healthcare system since they largely retained non-scientific explanations for mental health problems. At the same time, based on some of the explanations given, the general reluctance to seek help indicated a hierarchisation of illnesses. Because of their form and symptoms, mental health difficulties were accorded less importance than the physical ailments. For example, a 46-year-old female nurse from South Africa emphasised that mental illness is different to physical illness as it is not easily observed or tangible as the case with a broken rib, or through a blood test in a lab. The following chapter discussing physical health issues show a clear combining of indigenous and biomedical services for a holistic intervention, which was not so clear when dealing with mental illnesses. Indeed, Okasha (2002) observes that mental illness is accorded much lesser attention compared to physical illness in Southern Africa. Limited health funding and religious beliefs among factors contribute to this. Therefore, it is likely to take more time for the expanded understanding of mental illness to establish in Africa and command similar recognition to physical aspects of biomedical services, and for it to be fully part of a pluralistic health approach.

Even though the South African nurse and others mentioned hierarchisation of illnesses as a factor in lack of seeking help on mental health difficulties, what might require some clarification is the gap between what literature notes as help seeking vis a vis what the participants actually considered as "help seeking". To Rickwood et al. (2005) the process involves actively seeking help of those who are suffering from other people to obtain help such as advice, general support, information and treatment of a problem or distressing experience. Health seeking behaviour has also been defined as an action aimed at utilising the services of the trusted individuals in the community for interpreting their troubles, treatment, guidance and general support for their stressful circumstances or from the formal healthcare services (Umubyeyi et al. 2016). What this shows us is that while some of the participants reported that they never sought help for their mental health difficulties, they did so through family support, church and resourced community leaders in response to the various stressors discussed in the previous chapter. For example, when asked if he

ever utilised any services for mental health difficulties, one of the participants insisted he had not done so in his eight-year stint in Australia because he did not see any need. Nonetheless, he went on to say:

> I usually call my eldest sister, if I have any problem, she is more like the counsellor in our home. If it is a problem that require man, I usually discuss it with my uncle, my mother's brother. Then beyond those two I can also have other elderly people, not particularly related to the family but who can offer counselling. (Male, 42 years old, Tradesman, Zambian).

The participant draws on Ubuntu, through accessing the life experiences and wisdom of the elderly for coping with their mental health challenges hence utilising the appropriate services to him. These Ubuntu-embedded initiatives are already being utilised in the participants' home countries. As a panacea to the shortage of psychiatrists and other challenges and in the recognition of the importance of these cultural services, Dixon Chibanda, a psychiatric director in Zimbabwe, started an initiative called "grandmother/friendly benches" where mental health services are provided in public spaces to people through ordinary discussions and without necessarily labelling the issues they dealt with as disorders (Cavanaugh 2017). Although the initiative initially faced intense criticism at its inception, it turned out to be a huge success (WHO 2018). Another Zimbabwe-based psychiatrist, Walter Mangezi also uses an approach tailored for his clients in dealing with mental health difficulties. Because of the indigenous beliefs of his clients, most of which first approach traditional healers prior to utilise biomedical services, he underscores the importance of not prescribing his biomedical theories, but instead to create an environment for the clients to use their belief system prior to his implementation of biomedical approaches (Mangezi 2020). The model has so far been working in addition for it being a part solution to the clinical constraints in Zimbabwe (Mangezi 2020).

The preceding chapter covered how the participants worked excessively in order to take care of their loved ones who are left behind and also supporting themselves in the host country. One of the participants, a 46-year-old male pastor largely blamed his communities' mental difficulties on the adoption of lavish lifestyles. He also expressed that because of Southern Africans' background and culture, most of these struggles do not qualify to be classified as mental health issues due to

their conflation of it with severe symptoms. Here two fundamental issues might be deduced from the pastor's position. The first points to his embracing of new and expanded concepts that might not previously have been part of his context to explain and legitimise mental difficulties. The second issue, perhaps more crucial, highlights the complexities of moving to a new society and the associated health challenges. In the previous chapter I discussed the refashioning of their lives, involving some movement away from Ubuntu collectivist values and embracing neoliberal values of materialism and consumerism as they acculturate to the western values and also compete amongst themselves. Some of the popular culture in neoliberal societies is seen as being shaped by the Fear of Missing Out, and this can significantly shape certain lifestyles. Przybylski et al (2013, p. 1841) see "pervasive apprehension that others might be having rewarding experiences from which one is absent." This might have been the case with some of the individuals mentioned by the community leader. Other community leaders bemoaned that prior to migration people relied on Ubuntu, their values and social network to ensure their wellbeing through communalistic values and interdependence. This had changed as participants became acquainted with western values of the internalising factors and privatising inner emotions of wellbeing in a more individualistic society, hence losing their social and cultural networks protective of mental difficulties, as well as confronting a new value system/ set of norms to do with "overwork". The increase in mental health issues among Southern Africans in this context signals a departure from Ubuntu, a "humanistic and less materialistic" philosophy shaping people's lives.

Yet most of the interventions to mental health difficulties in recent decades have been oriented towards medical treatments rather than confronting the ideologies that are producing mental disorders. This has created what has been described as a "medicalised society" (Esposito & Perez 2014; Van Dijk et al. 2016). Criticising the medicalisation of society, Dregni, Horwitz and Wakefield (2007), draw on statistics showing a massive rise in the use of drugs such as Prozac, Paxil and Zoloft in the United States. Those drugs usage almost tripled between 1988 and 2000 and around the same time the spending on mental disorder drugs increased by 600%. Using the Swedish case study, also another Western society with many similar attributes to Australia, Sandell and Bornäs (2015) discuss neoliberal structures as generators of mental illness through their competition-orientation and the framing of success materially. The approaches employed to address this, especially medications, are therefore flawed because of their individualistic approach

when dealing with issues largely outside the control of an individual. Confronting racism, the harmful pursuit of unsustainable materialism and consumerism in contemporary neoliberal societies, as well as finding a balance between supporting loved ones back home and working sustainably, will have a greater impact on the issues producing participants' mental illness.

Furthermore, in contemporary societies, as Foucault (1980) notes, knowledge is produced and legitimated through particular frames and structures and through the power they possess. Certain societal institutions instil a sense of what is normal and acceptable. In the context of mental health wellbeing and difficulties in contemporary Western societies, concepts such as "disease mongering" through "diagnostic inflation" (Busfield 2012; Scull 1979) have been used to describe the pathologising of previously normal human behaviour, or the medicalisation of the society which have also been mostly associated with the activities of the pharmaceutical companies (Moynihan & Henry 2006). Critics of a medicalised society do not entirely dismiss the utility of pharmaceutical products or the significance of psychiatry to improve the quality of life, rather they argue that in as much as the contemporary environment is characterised by an array of complex factors which increases one's susceptibility to mental health difficulties, the interventions prescribed thereof are misplaced. Contemporary factors for some of the participants emanated from the social isolation, financial obligations to pay their tuition fees, work-study pressure, and support for their loved ones back home and racism and discrimination yet interventions were more oriented towards medicating (for example see excerpt on page 98). Again these issues largely require institutional interventions such as addressing structural inequalities and the inclusion of students with families to some form of subsidies rather than medicating. Sawyer et al. (2012) and Eckersley (2011) discuss the higher pressures ushered by the global economy's competitiveness manifestly through personal expectations and materialistic competition (which was also the case with some participants who were reportedly competing with folks back home and other more established migrant groups), drives them to "self-exploit" through overworking and lack of rest. Therefore, as participants refashion their identity from the shared cultural traditions and beliefs and intrinsic values of Ubuntu and existential certainty they lived prior to migration. To meet the expectations shaped by excess consumerism and other traps of a neoliberal society (Eckersley 2011), they fall victim to the associated disorders.

Experiences of using Western services

Of the five participants who sought mental illness help from psychologists and counsellors and other mainstream services for marriage problems, severe stresses, trauma, depression and anxiety, none viewed such services, and their experiences with them, positively. These participants blamed cultural oversight on the part of the service providers as the source of their dissatisfaction. The stories of the participants suggested that counsellors overlooked or ignored the importance of the role of their cultural values and beliefs. Yet these long-held traditions define them as people and differentiate them from others according to Waldron (2006) and Kirmayer (2004). A 45-year-old male teacher described his counsellor's techniques as "bookish" and "objectifying" while another participant, a 36-year-old-male student labelled their counsellor a "marriage destroyer". He explained that after he and his wife sought marriage counselling, they both expected words of encouragement and to be told to persevere in line with their cultural teachings. To their surprise, the counsellor advised the couple to divorce as she believed it was the best decision. Another participant with related experience added:

> I didn't see any value in continuing my counselling sessions, you're seated there, you're listening to him and you're literally saying that this guy has been reading something from a book, he is so divorced from me and my culture... But you don't care what someone says to you until you know that they actually care for you, and they understand your culture. For me to listen, I need to see your compassion, or something… I didn't feel that he understood me because I thought that all he was doing was trying to say, 'Yeah, you do it your way, do it in your way….' But he doesn't know my way. (Male, 34 years, Student, Zimbabwean)

Similar to the excerpt above, the following except is yet another example of how the cultural disparity and the lack of cultural understanding by healthcare workers not only produce unsatisfied clients, but are also likely to shape their future behaviour and responses in case of similar or related illness:

> …you just withdraw or stop using the services, so, after getting a referral to see a marriage counsellor about a possible post-natal depression, she tried to discuss our very personal issues which is a taboo in my culture, I can't bring strangers into my bedroom. In my culture we have family-based structures such as my aunt, family's friend, they are the

> pillars of the relationship…But here it's someone who does not understand the foundations of a Southern African marriage. So, already they're coming from a wrong viewpoint because the things that we call common practice to them they might view them as some sort of abuse that's the reason why she said we should divorce… so already even when you start saying that we have this problem that person has judged you. So even at work or at Uni (university) when they say, 'Oh, you've got this card, it's free counselling service or anything,' I'm like, 'I wish your counsellor knew me, or knew my culture.' I think that for someone to be able to help you he needs to understand what's happening, the foundations of your marriage unfortunately I don't think that's the case here. (Male, 38 years old, Support worker, Zimbabwean)

While the participant with the last excerpt participated in the study as an ordinary migrant, he demonstrates an in-depth knowledge about the complexity and the uniqueness of the Southern African setting which, if overlooked, undermines the applicability of the clinical suggestions and eventually the general use of those services. For example, he mentions being advised to divorce as part of dealing with his domestic issues, a proposal that is never taken lightly and highly abhorred in his culture. Many African countries view as a "lifelong contract" and divorce is usually not seen as one of the options in solving marital issues except for adultery even though the inclination was still towards convincing the couple to continue staying together (Arugu 2014). This is not (or no longer) the same ideology in western societies. Among others, two sociologists have given an outstanding assessment of marriage in contemporary western societies. Anthony Giddens, a British theorist argues that the western world is going through a "transformation of intimacy". In his book, *"*The Transformation of Intimacy*:* Sexuality, Love, and Eroticism in Modern Societies" (1992) argues that intimacy is undergoing radical change, the marriage vow of "till death do us part" is being displaced (Giddens 1992). Giddens refers to this as "confluent love", and it has as its model "pure relationship" — a relationship entered for its own sake and only lasts when both parties still have the satisfaction to stick around. An American family scholar, Andrew Cherlin is of the view that marriage is going through "deinstitutionalisation". Deinstitutionalisation of marriage in western societies focuses more on the present and future marriages. Cherlin (2010) argues that the social norms that have been the bedrock of the marriage institution are weakening, people today enjoy greater freedom regarding how and when to get married, or even not to marry at all. Marriage

has also reshaped in other ways, including the emergence of same-sex marriages, increase in cohabitation and one's choice to have children while unmarried (Cherlin 2010). The withdrawal from services could therefore demonstrate the different worlds of the healthcare user and the healthcare service provider.

The associated withdrawal from the service in the above scenario might also be examined through the concept of "power distance". That is, the acceptance and recognition by some participants that they have lesser power compared to the mainstream society that informs the culture of the service providers (Hofstede 2001). Social constructionist perspectives stress how different groups in terms of social class and categories maintain this different power distance in recognition of their advantageous and disadvantageous positionalities. Because of the different knowledges and the power dynamics involved, health services become points of trust or mistrust that shape people's behaviours, including their willingness to seek help in future depending on the previous encounters (Poston, Craine & Atkinson 1991). Those who lack satisfaction from using the services have a higher chance of withdrawing from the services especially when they lack the power to bargain with those holding the formal power. However, without recognising and acknowledging these cultural issues and their importance in shaping help-seeking among the health users, people are likely not to use the services.

Using cultural services

For most of the participants social networks were important resources for accessing interventions that are consistent with their mental health beliefs. Friends, people from their home countries in their local communities, African Pentecostal churches, as well as those back home (family members, prophets and other traditional healers also played a significant role. As shown earlier in this chapter, the importance of these people is derived from how the illness is perceived:

> … Where I come from, we associate it (mental health difficulty) with witchcraft, it is an indication that someone has bewitched you. I don't remember where mental illness is just being accepted in the family as something that just comes…, so it doesn't make sense to refer something caused by witchcraft to a psychologist and other western practitioners because it's a condition that requires an herbalist, or traditional healer. (Male, 43 years old, Engineer, Zimbabwean)

From such an understanding a decision on where to seek help is then made. This participant is an ardent believer of the African Traditional Religion, but the appropriate interventions for him such as traditional healers will not be available in Australia in the event of an illness. He predicted that if such a need arises, he was more likely to utilise pan African Pentecostal churches because they are religiously closer to his beliefs than the western services. In his words:

> But you can't easily get such people here in Australia, that's where the African churches may come in because they have a closer view to our traditional beliefs. Yes, there are differences, but we fundamentally agree on the external forces' role (Male, 41 years old, Engineer, Zimbabwean)

The participant hence highlights that while there are fundamental doctrinal differences between Christianity and the African Traditional Religion, there are some overlaps and ideological similarities. The belief that mental health difficulties are instigated by external forces. It is thus logical to approach another religious institution to deal with the problem rather than seeking help from biomedically-oriented services. Again, this is evidence that despite the ideological clashes between the two indigenous health initiatives, the shared similarities in mental illness theorisation present an opportunity for transcending and oscillating. Similarly, participants with Christian beliefs also expressed reluctance to engage western trained counsellors and psychologists for conditions they believed originated in the supernatural world, caused by demons and evil spirits. As a result, they relied on spiritual interventions which was done mainly through intercession meetings, approaching the church leaders for prayers, reading the bible and listening to testimonies from colleagues who had survived similar situations including giving up in response to life challenges and a sense of hopelessness. In justifying the religious initiatives instead of using western trained counsellors, one participant said:

> Mental illness is a sign that an individual is demon possessed, there are so many examples, if you read in the Bible, where people were exorcised of demons which caused them to have signs of mental illnesses. The illness is not something that is acceptable, and it's a sign that you've been bewitched, it is against God's will so it must be biblically addressed. At our church we pray and cast out demons to eradicate the mental illness and for you to

> get back to your original state of mind or good state of mental health. (Female, 35 years old, Pastor, Zimbabwean)

This was also corroborated by another pastor who cited several individuals he prayed for to exorcise demons which he thought were responsible for their stresses, sorrows, anxiety and financial hardships among other issues. When collecting data at the places of worship, I also witnessed congregants seeking intercessional prayers from fellow congregants and pastors for spiritual help to their personal problems, or on behalf of their loved ones going through difficult times. Through such initiatives, as the participants came together, grouping themselves as people with a shared culture, they created cohesive spaces for accessing culturally appropriate services. Interesting to note is the congregants' recognition of the need for help from the church and the pastors which is somewhat different to what some interviewees stressed earlier; that is, the failure by an individual to recognise the need for help as they would no longer have control of their mental faculties. For example, earlier in the chapter I discussed one participant saying she never saw the need to seek help because she was not "crazy" while one of the pastors felt his neighbour was lying when he was going to drive himself to visit his counsellor. This could therefore be a demonstration that there are different perceptions of mental illness among Southern Africans. Or perhaps the proactive seeking of help to mental health difficulties was a result of acculturation and socialisation.

Notwithstanding their importance, the religious places were also criticised on the basis that they produced and perpetuated cultural stigma (as mentioned earlier), because of the mental illness' association with a jinx. In elaborating this, one of the participants said:

> It is generally embarrassing, it's not something people usually want to be associated with. Sometimes you see that people have heavy issues on their hearts but when the pastor asks for people to be prayed for, they don't go, they are afraid to be judged by fellow congregants. (Female, 58 years old, Nurse, Zimbabwean)

A 50-year-old-male Zambian community leader also elaborated how the term mental illness in their community is equated to something "repellent" because of the negative connotations it carries. Several pastors therefore emphasised the importance of explaining the spiritual forces

behind mental illness in order to promote cohesion among congregants and enhance confidence of those seeking help. One of the pastors explained that associating mental illness with external or spiritual forces helpfully deindividualised one's stresses and worries. At the same time, he encouraged the church members to exhibit more of Ubuntu through interceding and fasting, as well as material support especially to the vulnerable students. While some scholars are critical of the importance of the religious rituals in treating and curing mental illness (Lewis-Fernández et al. 2011), Pargament et al. (2013) among others and the following chapter of the demonstrates how religious rituals and activities such as prayers and petitions directed to benevolent spiritual beings not only inculcate protective feelings and bring a sense of healing and "felt security", but also emotional and material connections and belongingness for wellbeing. Even for the healing, the emphasis is not on the "actual healing" (scientifically verifiable) to have taken place as Lewis-Fernandez and his colleagues might have argued for, rather it is on the positivity and a sense of hope that comes from the religious interventions, which not only fosters a feeling of being healed, but also inculcates a sense of belonging and identity. Helman (2014), Waldron (2010), Kirmayer (2004) and Patel (1995) among others stress that the understanding and the reaction to symptoms, patterns of coping, styles of emotional expressions, illness explanations and a sense of being healed are subjectively felt and vary from one culture to another.

In addition to religious gatherings in their communities, participants sought help from elders from their home countries living in their local communities. For example, after attending four counselling sessions following his mother's death, one of the participants turned to a fellow Zimbabwean, an elder at a local church:

> …then I found a friend of my father…he didn't know my mother but he is African, and he's Zimbabwean like me, just talking to an older man who understood me was incredible…I don't know what it was, I don't know what he gave me but after talking to him, I felt way better than the counselling sessions that were just trying to explain my loss, my grieving and my mourning etc as theoretical or a linear progression … (Male, 36 years old, Student, Zimbabwean)

In critiquing the linear stages of grief and, as he expresses, dissatisfaction with his help seeking experience, his experiences are very telling of the cultural situatedness of grieving and mental

health challenges. Indeed, assertions critical of the current models applied in Western psychotherapy and counselling have been made, especially their applicability to clients whose cultural orientation differs from the western culture where these theories originated (Sue & Sue 1999). The psychotherapeutic approaches applied on his grieving have been developed around grief stages such as numbing, anger, disorganisation, and behavioural and psychoanalytic theories (Bhugra & Becker 2005). Because of this, the interaction between Western workers and Southern Africans are less productive as the healthcare worker had a limited understanding of grieving and other mental difficulties of some cultures. This might also lead to negative evaluations of Southern African clients from Western healthcare workers, compared with evaluations of mainstream clients who are more relatable with the applied theories and forms of treatment (Sue & Sue 1990). For Pedersen (2003), the reported underutilisation of health services by minorities, discussed in the research literature, demonstrates the cultural biases of the models being used. They reflect and reinforce the social, political and cultural values of the Western models of psychological intervention which might be inherently and unwittingly expressed through the practitioner's own orientation to "normality" and "healing". Thus, the participants' agency to create (useful) cultural spaces to access appropriate and meaningful support reinforces Waldron's (2006) argument that most applied counselling interventions are developed in western culture and are less impactful when applied to clients of different cultural norms and values.

While the participant in the above excerpt eventually got help from his compatriot, this was not the case for other participants. As a result, they sought help from social networks in their home countries. Extended family members such as sisters, uncles and elderly community members among other Ubuntu networks perform the roles similar to that of marriage counsellors and other western allied health workers. The previous chapter discussed the importance of the African family institution, especially how its expansiveness provides material and emotional support to its members (Mngomezulu 2008; Nzegwu 2006; Scuglik & Alarcón 2005). Being isolated in Australia with social institutions that produce and reflect a culture significantly different from that of the participant, minimised their options hence their reliance on those back home. However, seeking advice in home countries to deal with environmental stressors in some instances failed to solve the mental difficulties because of the cultural gap. This highlights the limits of the Ubuntu philosophies especially its somewhat rigid understanding of the roles in the family institution when

applied in cosmopolitan and hybridised cultures. Relying on it evidently exacerbated the participants' problems, which further demonstrated the extent of cultural differences between homeland and host country. The help given to them was incompatible with the Australian experience and daily realities; for example, one of the participants said:

> It is now difficult to take issues to my uncle and aunt…They will simply say you have lost your position as a man, and they can call your wife without even seeking permission from you, they say whatever they want…They don't know shift work, baby-sitting, the need to have dual incomes, so I realised that if I keep involving them in my marital issues I'm going to destroy my family… but it's difficult because I also want some advice, clashes will always be there in marriage. (Male 48 years old, Accountant, Zimbabwean)

Several other male participants had similar marriage stories, and they mentioned being expected to perform domestic roles they traditionally considered "feminine". Yet, most of the gender roles adjustments and reorganisations were inevitable. The necessity of working in multiple jobs and the importance of having a dual income (supporting people back home, to raise tuition fees, meeting their cost of living) covered at length in the previous chapter contributed to this. What is crucial here is how this transition affects their emotional wellbeing as they still expected their spouses to take responsibility for domestic duties. The relatives back home had a limited appreciation of day-to-day life in Australia, therefore turning to home countries as a source of help further strained their relationships. The advice given was generally within the broader ideologies of home countries' values without considering the participants' new environment realities. A 52-year-old male community leader from South Africa traced some of these problems to the way in which couples marry in Southern Africa. He explained that the cultural authority of the African family institution is entrenched through lobola (bride price) which essentially gives the entire family some power over women in terms of ensuring that they play culturally accepted family roles. In elaborating this familial power, another participant, a 35-year-old female community leader from Zimbabwe, said that several family members are expected to contribute to the bride price, and that as a collective unit, parents and brothers have an obligation to play a part which brings some sense of "entitlement" over the daughter or sister- in law. However, it might be useful to highlight that historically the paying of bride price and marriage ceremonies in Southern African societies countries were for uniting and cementing a relationship between two families (Heeren et

al. 2011). These practices have also fallen victim to the neoliberal mentality as some see it as an opportunity for material benefit. For such reasons, Chiweshe (2016) argues that lobola in Africa has objectified and commodified the women's bodies and made them sites for complex interactions of patriarchy, hence a setback to attain equality among genders and the achieving of women's rights and wellbeing. Interestingly, as discussed in the previous chapter, female participants felt that the Australian environment was emancipatory to their rights.

As a result of this cultural gap, some participants resorted to the strategy of not discussing their personal troubles with their families back home. Notably, in order to protect his wife and marriage, a 42-year-old male participant from Malawi resorted to lying during phone conversations that it was his own choice to baby sit and do household chores when questions were asked about why he was undertaking feminine roles. Yet, during our interview he confessed that he needed their help on how to raise his family and deal with the domestic issues that might arise. This coping created its own stresses which was a tricky terrain as the participant engaged in an ongoing process of protecting his marriage while wanting to seek advice from his family back home on life issues including those that also call his masculinity/status into question as he and his family adapt to the demands of a different society (gender roles) linked to economic necessity.

The functionality of the family was more evident when one becomes ill. In the context of the participants, the unwellness of their relative abroad symbolises an illness of the entire family. In other words, even if one becomes ill, it is viewed as a spiritual attack on the entire family which requires a collective intervention. Family members back home play a part in identifying and consulting traditional healers who follow Ubuntu dictates in providing the service. Those in the diaspora will be expected to sponsor the traditional and symbolic ritual events thus creating symbiotic and mutual relationships between the diaspora and those back home and sustaining familyhood. This form of transnational health services including the ways in which healing is provided is well covered in the last section of the following chapter when physical health is discussed.

The explanations given by the participants of the African Traditional Religion for engaging transnational health seeking were quite straightforward; there were no interventions compatible

with their beliefs in Australia. African Pentecostal believers also sought spiritual services back home with some arguing that African Pentecostal churches no longer accommodated their indigenous health needs even though those churches were founded to fulfil their spiritual, material and health needs. Some of those African Pentecostal churches were accused of questioning the utility and symbolic power of the artefacts such as stones, oil and water in treating health conditions. Such churches to the participants they had become "too westernised" and no longer suitable to deal with health issues grounded in the African philosophies and traditions. While church leaders explained that there were doctrinal commonalities between Western Pentecostal churches in Australia such as Hillsong and Planet Shakers and the African churches, the former were to a larger extent considered incompatible with participants' Pentecostalism. Particularly, the role of demons and other evil forces in bringing mental illness to individuals. According to one of the participants, Western Pentecostal churches are "shallow" because they only generalise mental illness as the effects of demons but without further making distinctions based on the difficulties caused by magic, ancestral spirits, avenging spirits, spells and witchcraft unlike Pentecostal churches in his home country. For another participant, beliefs about demons and mental illness at his church back home were similar to a western Pentecostal church he initially attended when he first came into Australia, however, the cultural gap between him and the pastor was too wide to forge a closer relationship with the pastor. He considered that relationship crucial for disclosing issues and seeking mental help but could not do this with this pastor.

Lack of understanding of the community needs

Seeking help for the health problems back home evidenced the unavailability of the appropriate services in Australia. Participants were particularly critical of how service providers showed little awareness of their specific health needs. As one of the pioneers of their church, one of the participants had an experience of dealing with the Immigration Department during the visa application process for one of their pastors from the mother church in Zimbabwe. On four occasions the application was rejected, and he was not convinced with the reasons given by the Immigration Department. Rather, he suspected that the government doubted the genuineness of their application. He went on stress that:

> …the much-heralded religious freedom in Australia is just a political rhetoric, for the last three years as a church we have been trying to bring our pastor from Zimbabwe, but we

> always get unclear rejections. The department takes a simplistic approach, flimsy excuses are given I think they basically say if you are Pentecostal why can't you go to other Pentecostals around… (Male, 55 years old, Community leader, Zimbabwean)

This was supported by another community leader, a 50-year-old from Zambia who had a similar experience. Their application for a pastor's visa had been rejected multiple times. Visa rejection was interpreted as an indirect way of saying if they were indeed Christians, there are several Australian Christian churches Southern Africans could join, or recruit pastors locally. However, if the participants' assumptions were correct, it will be a myopic understanding of the roles of the pastors in other cultures and the extent to which African Christianity has been intertwined with traditions and indigenous knowledges in Australia. Notwithstanding the validity of the reasons the Immigration Department may have cited in the visa rejections; such stories portray a picture of a people who have little confidence and faith that government departments treat them fairly.

In also elaborating the challenges involved in trying to bring their pastors from their home countries, the participant stressed:

> …The bottom line is that the government would actually prefer to bring a social worker from Zimbabwe than a Pastor, but I tell you what, we use pastors not social workers or counsellor. (Male, 55 years old, Community leader, Zimbabwean)

Zimbabwe continues to lose social workers to western countries such as Britain (Willett & Hakak 2020), and is grappling with a shortage of social workers even comparably to its neighbours. In 2020 it had 121 social workers for its 15 million population, while Botswana had 420 social workers for its two million people. In South Africa there were 12 000 social workers for 47 million people, and Namibia had 400 social workers for its two million citizens (Wyatt, Mupedziswa and Rayment 2010 as cited in Kurevakwesu 2017). As literature earlier noted (see Shizha 2012), this shortage of health services promotes the utilisation of other services among other factors hence familiarity with faith leaders than social workers. The participant's response also stresses the expansive nature of the pastor's role showing the responsibilities go beyond routinised religious rituals and permeates into counselling and health matters of people.

It is important to stress that although the spiritual roles mentioned by the participant were also shared by many religious ministers in the western world (Furedi 2004), there has been an ascension of the therapeutic culture in western societies in recent decades which legitimised and professionalised the experience of suffering that was originally a feature of the private sphere and in the realm of religious leaders/priests (Wright 2008). As therapeutic culture ascended, pastoral counselling in some instances has increasingly been overlooked due to its lack of the disciplinary power and theoretical foundations (Woldemichael, Broesterhuizen & Liègeois 2013) which psychiatry and psychology possess. Since religious leaders importantly consider the multiplicity of factors including societal social standing, familial institutions and one's culture when intervening on mental health difficulties rather than relying on the psychological counselling which can undermine these fundamental institutions (Lasch 1980), the relegation of pastoral counselling undermines a holistic intervention to mental health. Rieff (1979) associates the undermining of the role and therapeutic power of religion and other traditional interventions in addressing mental difficulties as a political strategy to emphasise the capitalist political economy of neoliberalism and individualism through imaging professionalised healthcare workers as the pacesetters of change rather than efficacy. The rise of psychological knowledge and therapeutic practices is also related to Foucault's governmentality concept (discussed earlier) that comes as an insidious and regulatory form of social control which destabilises and disorganises the "private sphere" and its relationship with the public sphere (Furedi 2004). Illouz (2008, p. 243) contends that, "the therapeutic discourse establishes the self both as the problem and the solution for the ailments of modern life and offers psychological techniques to accomplish the task". Cabanas (2017) and Rakow (2013) among others discuss how various tools and self-help advice assist in the recognition and "appropriate" emotions, as well as how these emotions can be inculcated for an individual's stability. Lasch (1980) associates the rise of the therapeutic culture, birthing the narcissistic personality in the context of a complex capitalistic system. Brett et al. (2009) highlight some of the negative implications ushered through governments' adoption of neoliberal approaches in health services in contemporary western societies. Through therapeutic culture's ideals of psychic self-fulfilment (Illouz 2008), and the growing therapeutic sensibility (Lasch 1980), an anti-communitarian and anti-religion streak has to an extent weakened and reorganised the bonds between self and society in Western societies. Thus, critics of the contemporary complex and highly individualised society (and the therapeutic culture which has become a feature of it)

suggest the reinstatement of the role of the church and religion (in a different form) to partly help address mental disorders. They argue that the religious institution has the capacity to reverse, or rather reduce the "professionalisation of the private suffering" that gained popularity through the introducing of fashionable contemporary therapeutic psychiatric principles which has led to cultural decline, narcissistic concern with the self (Lasch 1980), and the rise of victimhood culture (Furedi 2004). In doing so, the mental health difficulties of the participants are likely to be addressed as the culturally appropriate services (including Ubuntu services such as the church and community leaders) would have been put in place. The participants' insistence on religious workers over biomedical services, and the literature's argument against the separation of an individual from a society present merit for further embracing these non-biomedical services and promote services usage.

Conclusion

This chapter discussed the participants' beliefs, knowledges and philosophies that shape participants' understanding and interpretations of mental health difficulties. Among Southern Africans, one must exhibit extreme symptoms including the loss of the executive function for one to be classified as mentally ill. The supernatural forces (demons, evil spirits, avenging spirits) functionally affect the health affairs of the human beings through protecting or permitting an illness to befall an individual as a punishment for the sins committed. Yet most of the services in Australia are biomedically modelled hence they are of limited utility in addressing the participants' ethno-cultural and religiously explainable mental difficulties. To utilise services such as psychologists, counsellors and psychiatrists is not only perceived as illogical, but also a trivialisation and undermining of the supernaturality of the problem. This is notwithstanding the fact that several community leaders and some participants have associated mental illnesses with the various socio-economic hardships participants faced postmigration. Participants therefore instead created spaces to access appropriate services that are meaningful in terms of their beliefs and knowledges such as forming the pan African churches and utilising the community leadership in their localities. On the other hand, through acculturation and familiarity, some participants, especially those employed in the health and care sector, embraced Western notions of mental health difficulties and attempted to utilise the available services. The biomedical services for this cohort were of little benefit, as they were considered as neglecting the role of culture. Its

importance in setting normality and deviant parameters, symptom reporting and what is considered important by the participants. Using a templated approach informed by other cultures also overlooked problem identification, norms of reporting including silence, conditions under which health is sought, responses and attitudes to interventions of a specific group of people among other factors. As Waldron (2010) observes, the issues discussed in this chapter reiterate that Western mental health services, as the case with many other social institutions, are structured, shaped and reflect Western values. At the same time, through acculturation and familiarity, participants expanded the utilisable services for their mental wellbeing as they embraced the biomedical services, though there were some cultural discrepancies to be addressed. The following chapter, Spirituality and Health expands the discussion but mainly focusing on physical health and the collaboration between biomedical and indigenous health systems.

CHAPTER SIX: RELIGION, SPIRITUALITY AND HEALTH

Introduction

For centuries religion has been an important part in human health across various groups of people. The first hospitals, for example, in Western Europe to care for the sick were established by churches and manned by religious leaders. In France from the Medieval Period up until the French Revolution the highest number of physicians were drawn from the clergy, and in the American colonies not only did the clergymen work as physicians to supplement their incomes, the church was also the regulatory and licensing body for the physicians to practice medicine (Koenig, King & Carson 2012). As science continues to increasingly inform the "best" practices in recent decades, there have been moves to separate healing systems from religion, especially in Western countries. However, in most developing societies there is little or no such separation (Koenig 2012). Thus, in order to further understand health issues among people from developing countries living in a highly industrialised complex society, it was instructive to have one of the objectives interrogating the role of religion/spirituality and health and the services and spaces participants utilised to restore their health. These issues are discussed in this chapter. The chapter is organised into three main sections. First, it examines the religious and other cultural spaces to interpret the health problems as well as accessing the services compatible with their beliefs. The ideological clashes between, yet a collaborative role of African Traditional Religion and the African Pentecostalism, is again discussed to illuminate the participants' agency to create and access health services as people respond to the unavailability of appropriate services. The section that follows explores the continuance and resilience of Southern Africans' health beliefs, especially a holistic approach to wellbeing. Unlike the previous chapter that showed very little collaboration between biomedical and indigenous health systems, this section emphasises the cooperation and substitution of different health systems as part of the participants' health ideologies, as well as for efficacy maximisation. Building from this medical pluralistic approach, the final section, transnational health seeking, examines the participants' utilisation of the transnational space as both response to the unavailability of the appropriate services, and as part of their health behaviour. This therefore entails that while the unavailability of appropriate health services in Australia promoted the need for medical pluralism and transnational health seeking, utilising health services abroad was part of the participants' identity, and this was still going to take place despite the state of the mainstream

services. However, in order to maximise health benefits from the health services in Australia and their home countries, we see a closer drawing on Ubuntu as a central resource to access various health services.

Spaces for spiritual intervention

The spiritual dimension of health and the utility of the spiritual sites for healing and ensuring people's wellbeing are addressed in this section. The spiritual therapeutic sites in this study involve various cultural spaces for healing to take place. Prior to engaging the central issues of the chapter, it is important to highlight that while there is a tendency among people in Western societies to separate an organised religion and a more individualised spirituality, the distinction makes little or no sense to Southern Africans as the two are interchangeably used. Thus, throughout this work there will be no attempt to separate the two.

The centrality of religion in the wellbeing of the Southern African people is well documented in the African literature, and it has also been discussed earlier in this thesis. For most of the participants health and ill health were associated with one's relationship with the supernatural/ spiritual powers. Their responses either explicitly acknowledged the importance of the spiritual powers for ensuring their wellbeing through supernatural protection or implicitly did so by engaging in spiritual interventions when they fell ill. Despite being experienced physically, ill-health to the participants heralded imbalances in the spiritual world that led one to become ill. When asked to elaborate the connection between an observable ailment with its origin that can be scientifically proven to a spiritual force that cannot be objectively proven one of the participants said:

> God is everything in my life, He grants me good health, He protects me, we are now living in a world full of infirmities, there is really nothing you can do on your own to stay fit, or not to be a cancer victim. Think of health-conscious individuals like athletes but had their careers cut short because they were diagnosed with conditions normally seen in unhealthy lifestyles. I can only thank God for looking after my health because if he doesn't look after me spiritually, I will be exposed to all forms of diseases physically. (Male, 43 years old, Support Worker, Zimbabwean)

Notwithstanding the importance of practices such as healthy eating, exercising and making regular health checks as part of one's health consciousness responsibilities, mystical forces such as witchcraft and ancestral punishments are seen as the actual cause of the illness. The broader argument participants sought to present was the overarching importance of the spiritual forces, especially their role to override the scientific understanding, but at the same time acknowledging the role of science in understanding our health conditions. How this delicate balance is struck is covered later in this chapter. An explanation from a 35-year-old female community leader from Zimbabwe in the meantime helps us to understand this broader point. She argues that if one is exposed spiritually, they are likely to become ill even if they eat and live healthily. By "spiritual exposure" the participant meant one's failure to honour the protective role of superior spiritual powers in their lives, thus losing the spiritual protection and creating an avenue for diseases to attack and disable them. Most of the religious activities such as praying, intercessions, singing and volunteering in church activities were importantly part of the spiritual initiatives to preserve and enhance good health because God was seen as the supernatural power that grants good health. While the participants spiritualised illness (health problems are associated and caused by the supernatural forces), they neither dismiss nor trivialise the physiological symptoms or the biomedical aspect of the illness, therefore illness is viewed as involving dual or multi dimensions. The first aspect, spiritual, was meant to explain the "why" part while the physiological discomfort and disablement experienced thereafter that can be diagnosed through observable tests is the "how" part of the illness. Similar to what Mbiti, Olupọna and Nyang (1993) show, the ways illness is perceived in Africa, that is, not as a coincidence or a natural occurrence that potentially affects all human beings, but one that is informative of a poor relationship between human beings and their protective supernatural forces, is still utilisable post migration. This "why" part is also indicative of the resilience of the participants' traditional ideologies and their utility in interpreting their illness. This will be later expanded upon in this chapter. It is important to point out that this theorisation of the illness was largely not the case when participants explained mental illness.

In engaging spiritual initiatives to manage health, participants regularly attended church services. Even though most of the churches that participants attended were open for any believer, conducting of sermons and other church programs in accordance with the norms and values of their home countries, including the use of their vernacular languages in some instances, essentially meant that

these gatherings largely attracted people from the same country. I visited four churches, each on multiple occasions during the ethnographic data collection. At these churches and in several instances, the pastors initiated the healing sessions by asking members who were feeling unwell to come to the front for prayers in what was popularly known as "altar calls" while in some instances congregants with health problems approached the pastors to be prayed for. Healing was ritually administered through laying of hands on the sick person's head, and the rest of the church members participated through singing and interceding for the ill. One of the pastors explained, that before each healing session he would reiterate the influence of evil spirits in making one ill. In doing so (participating and creating a healing of the congregant), the pastor and congregants role denoted and practiced African humanness (Ubuntu) that emphasises collectivistic spirit, to be concerned and obliged with the burden of their community members as that of theirs (Metz & Gaie 2010). The distinctive collective consciousness expressed by the participants for one's health also expresses "spiritual self fulfillment" of Ubuntu which stresses the universal brotherhood of being sensitive, sacrificial, caring and considerate of others (Gade 2012; Khoza 2012). Through shared culture and belief system, thus not only were churches places for doctrinal fulfilments, but they were also crucial places for meeting health needs.

On several occasions a striking rapport, positive energy, openness and commonness that brought feelings of communalism and belonging at the places of worship was witnessable. Usually, at one of the churches it officially finishes at 12 midday each Sunday, but it was not uncommon to see people still milling around outside the church venue several hours later. Interestingly many people addressed each other with their totems and tribal names reminiscent of how they relate back home. For example, as he greeted a new member after the church service asking him where exactly in Zimbabwe is he originally from, a fellow congregant interrupted him saying it does not matter as they were all somehow related. By that he meant that because of kinship ties, nationality, sharing tribal names, places of origin in home countries and shared totemic relationships they were all one people. The broader implication of these practices is the social connectedness; hence the church and other cultural gatherings became platforms for exercising and fulfilling Ubuntu roles in a communal sense, rehearsing and mirroring the nature of their relationships back home. This provided a place of belonging, identity and security for the members similar to their social networks back home. While security back home was mainly derived from relatives and neighbours,

this gap and the associated roles were fulfilled by fellow congregants in the diaspora. Therefore, through these cultural gatherings, the participants had a tangible force creating commonalities and offering social security and wellbeing for its members.

Despite my suspicion that through acculturation and the stereotyping of the African continent (Viriri & Mungwini 2010) and its cultures in Western countries, younger participants would be less attached to traditional health beliefs, participants in this cohort generally had similar beliefs to the older participants. My suspicion emanated from a generalised stereotypical label of African cultures as being problematic, backward, uncivilised, and the general disconnection attached to the African continent (Neba 2011). For the related reasons, young people from Africa often try to actively disconnect with those practices that have African identity and embrace local cultures for inclusion and acceptance (see Nunn 2010). While this could be the issue in other aspects of life, this was not the case on health matters. My conversation with one of the participants, a 23-year-old female originally from Zimbabwe studying for a bachelor's degree exemplifies her acculturation to the Australian norms for other aspects of life while at the same time retaining her indigenous values around health. She referred to me by my first name, yet we did not have a closer relationship. This was a bit odd at settings where people generally greeted each other with tribal names, formal titles and totems. However, I did not have any issues to be addressed with my first name, the interesting aspect here is that her behaviour typifies someone detached from Ubuntu values especially the emphasis on respect and formal addressing when talking to an older person. Yet, she still embraced spiritual and African health beliefs. She mentioned that while she has not asked the pastor to pray for her to effect healing, she attentively listens to her parents. Failure to do so, she felt, will attract a punishment from the spiritual powers which will manifest as an illness. She went on to quote one of the verses in the bible that talks about children honouring and respecting their parents.

Another participant, a 41-year-old female nurse from Zimbabwe, shared that she constantly reminds her children to be respectful to their parents lest they invoke the ancestors' anger who will punish them through removing the spiritual protection. If the protection is removed, according to the participant, an opening for illness to attack would have been created. While the participant emphasis was religiously embedded, it clearly echoes some of the key principles of Ubuntu

particularly the respect and maintaining of good relationships for well-functioning cultural institutions. Other participants reported informing their pastors in order to get prayers and prophetic words over the phone prior to going to a clinic when they become ill. The desire to have the problem addressed spiritually before being attended by healthcare workers further reinforces the mystical underpinnings of the illness. Similar to what research literature shows, this practice gives individuals who are regarded as spiritual, such as pastors and prophets, some form of authority and trust accorded to the biomedical experts when dealing with the health problems (Khoza 2012; Neba 2011). Pargament et al. (1990) also demonstrate the equal importance placed on spiritual solutions to manage life-stressing events among migrants who have been known to turn to a benevolent God in difficult times. At the same time, the participants' agency demonstrates the importance of spiritual, traditional and indigenous constructions of illness and treatment seeking regardless of where they are domiciled.

While these social initiatives helped the participants with appropriate and spiritual solutions to health problems, their utility was limited to participants from a Christian background. A smaller but significant number of the participants who belonged to the African Traditional Religion reported more challenges to access health services that were consistent with their beliefs. Where Christians emphasise Godly power for healing and protection, participants from African Traditional Religion emphasised the ancestral powers accessible through spirit mediums and traditional healers for the same cause. Four of the five participants who believed in African Traditional Religion healing were unable to access an appropriate traditional health intervention in Australia. Among these four, only one had heard about a South African traditional healer living and operating in the Dandenong area (Melbourne), though numerous attempts to contact the traditional healer had failed. The fifth participant mentioned knowing about a traditional healer from South Africa operating in regional Victoria and who had healed his friend with an erectile dysfunction after a witch cast a spell on him. My requests for his assistance to be introduced to the traditional healer were declined, citing the importance of their verbally entered but strict non-disclosure agreement. Attempts to interview the friend who had been healed were also unsuccessful. Even though traditional healers in Southern Africa have specific codes which they may get from their ancestors during the initiation period or by senior traditional healers that train them (Pinkoane, Greeff & Koen 2012), the traditional healer in question fails the Ubuntu test. As

someone who has been supernaturally gifted by the ancestors in order to help the community, he is expected to be within the reach of the members of the community who can be accessible or consulted by any person at any time (Mokgobi 2014). Operating in secrecy goes against these very communalistic norms and expectations of spiritual leaders.

Though traditional healing interventions were generally considered useful for illnesses linked to witchcraft such as erectile dysfunction, barrenness and prolonged and "unaccounted" pain, those that believe in the African Traditional Religion and community leaders were overall pessimistic about the availability of traditional healers in Australia. One of the community leaders argued that it was almost impossible for African traditional healers to operate in other countries. He was more sceptical on the availability of traditional healers intercontinentally since they lack access to the artefacts, sacred places, plants and trees, rocks and animal products used in the healing process because they are found in their home countries. In his words:

> … They are chancers, Australia doesn't give visas to traditional healers, so how did they come to Australia, what kind of visa do they hold and where will they get all the materials and artefacts for ritual performance. They are conmen who know very well about our need for genuine N'angas (traditional healers) to deal with our African problems like runyoka (erectile dysfunction) and other witchcraft related illnesses. (Male, 50 years old, Community leader, Zimbabwean)

The suspicion raised is reasonable because the African Traditional healing involve utilising "sacred" places and most of the healing procedures are framed within their indigenous contexts thus may be unavailable in Australia. Adu-Gyamfi and Anderson (2019) and Nelms and Gorski (2006) among others record African Traditional Healing as involving traditional healers using inanimate artefacts and animals such as goats and cows that are slaughtered and the blood sprinkled at the homestead of a sick person during the healing ritual processes. Notwithstanding this specific situatedness of the traditional healing, in their work on alternative health approaches with other African migrants in the United Kingdom, Grant and Young (2010) demonstrate the practicality of delivering African traditional healing in Western societies. They referred to the space these healers operate in as "an adjusted setting" which was a result of an agency to meet the growing demand of the indigenous services among the African diasporas. Practising traditional healing in an

adjusted setting (outside the usual symbolic and sacred physical environment) may also be the case with a traditional healer noted above through utilising many plants with medicinal properties in Australia (see Gaikwad, Wilson & Ranganathan 2011). Moreover, some similarities between indigenous healing ideologies and practices including the use of crafts, herbalism and sacredness of various places that are symbolical for healing potentially provide platforms for African traditional healers to learn and capitalise on some of the indigenous healing practices in Australia and forge an adjusted healing setting. At the same time, while the Zimbabwean community leader with the excerpt in the paragraph above questions the genuineness of African traditional healers in Australia based on the notion that there are no specific visas that enable traditional healers from Southern Africa to migrate and practice in Australia, in some instances African traditional healers have other professions which might have made them eligible for certain visas. The traditional healing practice can be done outside other professions. Mbiti (1990) describes part-time traditional healers as "ritual priests." For instance, anecdotal evidence shows that a Zimbabwean professor, the late Gordon Chavunduka, was a Vice Chancellor at the University of Zimbabwe, a medical sociologist, president of the Zimbabwe National Traditional Healers Association and a practising traditional healer at the same time.

Responding to the unavailability of their appropriate services, participants with health beliefs more aligned to the African Traditional Religion calculatedly capitalised on churches with African Indigenous roots because of the two religions' philosophical closeness, especially the positioning of God as the ultimate power over everything. Although these participants in most cases had no direct relationships or previous interactions with the churches' pastors, their connections in the community provided an avenue to access spiritual help. For example, one of these participants said:

> … I believe in prayers from the pastor at my wife's church…, it's not much of a difference, I think, above all, God is the supreme power, and, in my tradition, we acknowledge that he grants his power to our traditional healers. When we seek help traditionally, through ancestors and the spirit mediums the ultimate destination of the prayer is God. (Male, 60 years old, Lecturer, Zimbabwean)

The pragmatic transcending and tapping into spiritual Christian initiatives as an alternative for the unavailability of his preferred therapy, mentioned above, is facilitated by key fundamental ideological similarities between African Pentecostalism and the African Traditional Religion. The participant's acknowledgement of a hierarchical arrangement of the spiritual forces wherein the positionality of ancestors in the universe as spirits superior to the living beings but occupying a lower position to the supreme being (God), both having an important role in the wellbeing of human beings has been well covered in literature (Mbiti 1990; Turaki 2010). Turaki (2010) further argues that because of the "huge distance" between the Supreme Being (God) and Africans following the traditional healing, human beings turn to lesser deities for mediation to access God. Accessing Godly healing services directly via the church as opposed to going through the ancestors, the usual mediators, is one way of coping with the unavailability of his usual services. Participants' oscillating between traditional and Christian beliefs might further be understood using Mbiti's (1990) assertion that in worshipping God, some sacrifices and offerings are directed to spirits and ancestors for their superior position and influence in the affairs of the living. The cooperation between traditional religion and Christianity is also acknowledged within many African cultures, in terms of the role of and ways in which ancestral spirits protect their lineage members. In order to perform that role the ancestors look up to God for help (Mbiti, Olupọna & Nyang 1993). Hence, despite this well documented massive onslaught of the African Traditional Religion by the Abrahamic religions (Mbiti 1990), the search for health interventions by the participants ignores these ideological debates; rather they capitalise on the theoretical similarities of the healing process between African deities and the universal God in order to meet their health needs.

Medical pluralism

The previous section broadly discussed the diasporic networks participants utilise in creating spaces to access the appropriate services commensurate with their beliefs and ideologies. The church and other cultural networks were particularly important in the health initiatives as the participants not only view religious supernatural forces as a source of healing but also possessing the power to permit illness to befall an individual. These views were held by members of both Pentecostal African churches and the African Traditional Religion. While illness is principally associated with the spiritual forces, that is their ability to allow or block illness affecting the living,

the role of medications including biomedicines to address the observable illness was acknowledged by the participants. This section discusses the complementarity of the indigenous health system for a holistic approach and to maximise efficacy.

Some of the literature discussed earlier (Chapter two) shows that medical pluralism has been part of the Southern African societies for centuries. The intention of this section is not to repetitively reproduce what is already covered in the literature review, but to discuss the participants' initiatives in a new environment — a nuanced, oscillating, overlapping and sometimes contradictory set of actions in their efforts to recover or improve their health, necessitated by the specific Australian environment. The participants' access to health services through engaging friends and colleagues working in the western healthcare system informally, preferencing of African doctors, internet use, and collaborative use of western and traditional services, one substituting the other, and simultaneous use to maximise efficacy are covered. In order to maximise those health initiatives, participants particularly draw on the corporatism and the mutual support of the community leaders and the community members working in the health sectors who willingly participate in helping community members. Among other initiatives Ubuntu creates a sense of obligation in those knowledgeable and as communalistic individuals to fulfil their roles through helping their community.

Most of the participants generally had busy lifestyles, and as a result they faced time constraints to visit healthcare providers when they felt unwell. For most of these, engaging their friends and relatives working in the health sector assisted with getting access without necessarily visiting the hospitals or General Practitioners (GPs). From the advice given over the phone participants determined the seriousness of the illness which then informed the action required for health restoration. In most cases they were advised to visit a General Practitioner, use over the counter medication and/or other home remedies alongside prayers. For others, healthcare workers of African background were points for clarifying the information about their symptoms gathered from the internet. One of the participants said:

> I google, I ask Doctor Google, he knows every disease and also tells you the seriousness of your illness although sometimes I feel like I'm going to die based on the information I

> come across, from there I ring the nurses I know. (Male, 27 years old, Tradesman, Zimbabwean)

Although the information on the internet was useful to some, for others, its unclearness and seeming contradictions further created confusion and vulnerability in them. In such instances resourced community members stepped in:

> If I don't get clear information, I ask few guys working as nurses…, sometimes the response I get is not convincing, and in that case, I try to engage my pastor or this old man from my country. He knows a lot about the African stuff. (Male, 32 years old, Student, Zimbabwean)

The way the participants utilised services through their community members shows the importance of belongingness and the benefits of the networks established, shared by their cultural values of Ubuntu. Ubuntu facilitates the access to health services without visiting the health services, as well as minimising disruptions in other life and work commitments. Community leaders and participants working in the healthcare sector also explained that at some point they helped fellow community members including those they did not know personally. A pastor also working as a nurse explained that he can take calls and respond to messages anytime from the community members including those seeking clarifications as part of his community responsibility even for those he has no closer relationships with. He mentioned that several people got his number from the WhatsApp group with their issues which was somewhat demonstrative of Ubuntu. Through this, participants enact and revive norms and expectations of their home countries where community leaders as culturally resourced individuals are expected to be closely involved in the wellbeing of the entire community.

Even though Ubuntu was useful for quicker "triaging" and minimum disruption to their routine activities, attempts to redress their suffering through this "convenient" way may have equally undermined the capacity to address the illness, because of symptoms' misinterpretation. Without physical examination of an individual, there are dangers of wrong diagnosis which potentially lead to wrong medication, downplaying of the symptoms and procrastination delaying treatment (Crush & Tawodzera 2014). Nevertheless, advice from compatriots working in the formal health sector

and community leaders also covered interventions consistent with traditional and spiritual healing. As a holistic intervention to health, several participants mentioned combining two or more health interventions simultaneously for the same illness. For instance, apart from being advised on over-the-counter medication to buy and home remedies to use for the stomach pains, a 32-year-old female participant from Zimbabwe was advised by a community member (also working as a nurse) to engage in continuous praying accompanied with food fasting. Others were shuttling and oscillating between different interventions as an indication of their frustration of failing to get the appropriate, timely help. Through this "shopping and switching" (Moshabela et al. 2011; Nyamongo 2002) between various care modalities, the participants were agentic in taking care of their health.

Community leaders, as culturally resourced individuals (M'Jamtu-Sie 2003), facilitated the wellbeing of their communities through creating platforms and spaces to discuss and help members on social issues. I attended one of the gatherings for the Zimbabwean men, where several discussions covered health issues including mental illness (but without categorising it as such) and sexual health. Convenors of these gatherings (usually community leaders) asked every individual present to anonymously submit at least one question they wanted to be discussed. Most of the responses given reiterated the importance of both biomedical and traditional interventions on many aspects, dietary supplements and good lifestyles, and having a good relationship with God, ancestors, neighbours and their families back home which are all key principles of Ubuntu (see Mnyaka and Motlhabi 2005). One of the community leaders explained that despite having a busy schedule he always tries to attend such gatherings to provide a service to others. Similar to what Ubuntu advocates, the leader strives to become impactful in his society. Through that can he be ongoingly legitimised as a person – one who has Ubuntu values of humanness, compassion, empathy, selflessness and caring (Mnyaka & Motlhabi 2005).

These authors also stress the importance of restoring "broken relationships" with other forces as a holistic healing in the African setting. This broadened and somewhat outward oriented health approach was mentioned by one of the participants:

> I try to emphasise the spiritual connection of children's mischief because it is biblical, so I bring the influence of strained relationships with the extended families back home, or bad

> luck because the parents' parents, relatives or spiritual ancestors might not be happy. It is important to constantly remind them that nothing happens in isolation, they may be spiritual attacks or warnings. (Male, 42 years old, Pastor, Zimbabwean)

Another church leader added that before and after praying for a child or a family he often encourages the parents to also instil discipline and strive to have a good relationship with everyone. Interestingly, notwithstanding the clashes between African ideologies and Christianity (Craft 1992; Mbiti 1990; Mbiti, Olupọna & Nyang 1993; Osuji 2014), and based on the stories from the participants discussed in the previous chapter, both church leaders' advice echoes Christian doctrinal teaching on one hand, on the other hand reflects an African thought of a person (umuntu) from an African Traditional Religion. Umuntu is a product of a dialogical and cosmological image of all existence as having an animated, purposeful vibrancy in relation to all other beings and the environment (Mbiti 1990).

Ubuntu also facilitated mutuality among the community members. That is, the interdependences, expectations and commitments across the group to perpetuate values sustaining their communities (Metz & Gaie 2010). When the resourced persons such as pastors, healthcare and community leaders expectedly helped community members, those helped also had an obligation to be thankful and being ambassadors to the community by encouraging others in terms of what was needed to get the healing. Church gatherings were some of the places at which a healed individual performed their ambassadorial responsibilities through testifying about the goodness of God, the pastor and the church members involved in the healing process. When one of the congregants was asked to elaborate on the reasons for testifying, he said:

> Testimonies are meant to encourage other congregants in a similar situation to remain steadfast and faithful for divine solutions. If you are on the verge of giving up or questioning God's love because you are going through hardships a testimony from someone is glucose in your race. (Female, 35 years old, Community leader, Zimbabwean)

Although the above excerpt does not necessarily show medical pluralism, it provides a context of testifying among the participants in which traditional and biomedical interventions were infused. For instance, one of the participants was told by her doctor that her health was alarmingly

deteriorating, and she was recommended to consult a specialist surgeon. The specialist surgeon suggested an operation to fix the problem. After the participant shared the news with the pastor, the pastor and the intercession group fasted and prayed with her for several days. It is also from the church networks she was referred to another specialist doctor who was considered more reputable for her health problem. During an intercession meeting, one of the church members advised her to go and see a doctor the church previously consulted. Only after the Pastor advised her that he saw a vision of her having a successful operation was she confident to proceed with the surgical procedure.

The roles played by the pastor and the intercession team including visiting the congregant's home and fasting for her demonstrate how the community reacts and assists a person in difficult circumstances, thus practising Ubuntu through being empathetic and sacrificial to others (Gade 2012; Mnyaka & Motlhabi 2005). Equally, through testifying which was accompanied with financial donation (of her choice) to the church as a token of appreciation, the participant also fulfilled her own Ubuntu obligations of encouraging and reassuring others in similar or related situations. Similarly, Neba (2011) describes how the healed person or their family in Africa were expected to visit spiritual people that healed them with a token of appreciation depending on their abilities and resources, thus highlighting the cultural sustenance of health among the participants. Once more, despite well documented clashes between Christianity and African culture (See Biri 2012), the discussed practices such as sharing testimonies in Christian churches carry and complement the Ubuntu values that are embedded in the African Traditional Religion.

To further explore legitimate answers and relief to their suffering comprehensively, participants agentically sought services from healthcare providers they deem friendly and who appreciate their health beliefs in order to create a conducive space for medical pluralism. In most cases doctors of African background were preferred. Among the participants there were two doctors from Zimbabwe, one of them interestingly described the spontaneity and excitement African patients register when they see a doctor of African appearance and often, they would wait longer so as to be seen by an African doctor. Similarly, another participant confessed refusal to be examined by other doctors after he spotted an African doctor in one of the consultation rooms at a local surgery. Following his request to the receptionist to be booked in the consultation room being used by the

African doctor, he was told that his preferred doctor is fully booked the entire day. He opted to wait until the following day and the participant approached the doctor with a whole range of questions and information about the various medicines he was utilising. The second doctor also described the openness of African patients with African doctors, and apart from the clinical interaction, rapport was further created by discussing their resettlement experiences in Australia and various issues in their respective countries. However, for Bernal and Scharró-del-Río (2001) migrants' preference of healthcare providers of similar background is symptomatic of the absence of a culturally competent systems in the healthcare system in countries of settlement to inspire the minorities to use any of the available services. To address this, Alarcón et al. (2009) suggest inclusion of cultural components of minorities such as religion, tradition, spirituality and language as part of the questions that could be covered in the clinical interactions. Not as a way of departing from biomedical theories in care but to create awareness in doctors and nurses on who they are dealing with and the issues shaping health beliefs that needs to be considered such as the collective viewing of illness reported by the participants. Through Ubuntu and cultural knowledge of the participants, African doctors and nurses performed the role of "altruistic" healthcare workers (Jones 2002). Their cultural awareness created an environment for the participants to access biomedical help and the flourishing of their beliefs, hence promoting medical pluralism.

Similar to the Zimbabwean doctors in this study, Eng, Rhodes and Parker (2009) also report the utility of migrant healthcare workers in the United States as mediators between their communities and a western healthcare system through providing their community members with support to negotiate the system. Not only were the African doctors addressing the current health problems of their communities, but they were also key resources to understand illness symptoms and clarity of information from the internet. They functionally translated medical jargon used by other doctors which participants were unfamiliar with. In elaborating their roles, one of the doctors said:

> I think there are trust issues… like some ask me about the logic of going for various tests as advised by their doctors. But there is nothing wrong with asking the patients to go through several procedures, if one test does not help in the diagnosis another test is carried out, there's nothing amiss, I also do the same... (Male, 38 years old, Doctor, Zimbabwean)

Relatedly, another participant expressed their frustration when the healthcare system fails to meet their expectations as seen in their excerpt:

> GPs (General Practitioners) here are like switchboards; I honestly doubt their competence. They basically refer you for lab (laboratory) and blood tests, and after several tests they then give you a letter to a specialist clinic something they should have done from the beginning. Back home a doctor usually orders tests once and that's it. (Female, 32 years old, Student, Zimbabwean)

Based on the doctor's response in the earlier excerpt, the procedures the participant with the above excerpt complained about are part of an enhanced treatment process. However, the discrepancy emanates when the participants expect to get the same treatment pathways that they used back home, in Australia. Mismatches such as these between healthcare systems and users' expectations have been described as the "crisis of care" (Billings et al. 2006). Some of the factors noted to contribute to the crisis of care include clients familiar with more than one healthcare system which was the case with the participants. In many Southern African countries due to the complexities of the diseases they fight, common illnesses (headaches and sore throat) may be connected to more severe conditions such as malaria and rheumatic fever and, thus once suspected, drugs administration becomes part of the initial intervention (Karthikeyan & Mayosi 2009). Also, respiratory infections in developing countries are more likely to develop into serious health complications such as rheumatic fever which is life-threatening (Carapetis, Currie & Kaplan 1999). Further, the absence of adequate diagnostic infrastructure in many Southern African places (Moyimane, Matlala & Kekana 2017) is known to undermine clinicians' capacity for thoroughness in their diagnosis, thus providing medication right at the point of help-seeking proactively, rather than opting for a potentially more dangerous approach by delaying. On the other hand, western countries have comprehensive diagnostic equipment, and similar illness symptoms may be viewed differently in western and developing countries. Common symptoms such as headaches, tiredness and weaker muscles, may be associated with less harmful illnesses, therefore prescribing drugs prior to thorough diagnosis might carry marginal effects. Not only may the participants' behaviour towards the Australian healthcare system have been shaped by their experiences with a more precautionary health approach which contributed to medical pluralism as participants sought to look elsewhere to meet their health needs.

Earlier in this chapter I used an interview except of one of the participants, a medical doctor who mentioned that his clients of African background have some trust issues with other healthcare workers hence their preference of doctors from Africa. A 50-year-old male community leader also a healthcare worker was of the view that African healthcare workers were culturally sensitive. Even though they provided health services within western biomedical parameters similar to all other doctors, they connected with the issues some of the clients suspected to be causing illness and were generally not dismissive of the mystical health beliefs. While participants were not explicit that non-African doctors overlooked their cultural beliefs, considering that this has been quite an issue (the preceding Mental Health Chapter fairly covered this), there is a possibility that this was also the case for physical illnesses. What we see from these experiences of the participants is the power imbalances in clinical setups especially the lack of power of the patients to challenge the position of clinicians when they are unsatisfied. However, having healthcare workers of similar background who have a much more nuanced understanding of the nature of challenges users face addresses some of this power imbalance and provides a more productive clinical interaction. As McCormack, McCance and Klopper (2017) stress, given the importance of culturally appropriate initiatives as part of addressing this power imbalance, healthcare workers with a lived experiences and closer understanding of the issues shaping the health issues of specific communities are more beneficial.

The dual positionality of African doctors of being community members sharing the same health beliefs (spirituality) with other African migrants on one hand and being professional clinicians on the other hand not only complicated their positions, but also somehow promoted medical pluralism. One of the doctors explained that his compatriot and a church colleague asked for advice for his abdominal pains which the patient suspected were caused by witchcraft. Four different medical tests had failed to diagnose the cause of his pain. He was contemplating abandoning western services and travelling to Zimbabwe to seek traditional medicine. Lack of diagnosis of the abdominal pains was confirmatory to the participant that someone bewitched him. The timing of the question may have shaped the way the doctor responded to the question —he was asked just after a church gathering wherein the Pastor's main sermon was on ways to fight evil forces that were causing people to become ill. When asked on how he responded, he said:

> I said to him he had to decide and explore what he thought would work for him… umm it was a difficult question, I couldn't advise him to stop or to continue exploring what he thought was not working… maybe few more tests would help… or umm I don't know… (Male, 38 years old, Doctor, Zimbabwean)

There was ambivalence as he was unsure of what advice to give because of the contradictions between his professional life on one hand, and his religious and cultural beliefs on the other. As a doctor his professional belonging in the scientific arena was undermining his capacity to provide advice consistent with his and the fellow congregant's beliefs. He may have feared that an open concession about the spiritual or mystical basis of the abdominal pains would affirm the patient's suspicions thus undermining the ongoing treatment regime. At the same time, it could have been difficult to advocate for biomedical treatment, which was costly and not working. Perhaps himself as a religious person he also believed that there was indeed a spiritual attack behind the illness. Without clearly suggesting what the participant needed to do might have left the patient still in an unclear position of what therapy would work is likely to further alienate the doctor's compatriot from the available services.

Another participant, a church leader and a specialist nurse, at one of the church gatherings taught and encouraged her fellow congregants to be vigilant in prayer and fasting to overcome their illnesses as seen in her excerpt:

> I usually tell Zimbabwean … not wait for one thing, but to be resourceful, to be enterprising, to run around, ask your colleagues what works and where else can you get help, there are few herbs around and a couple of spiritual people. (Female, 62 years old, Community leader and nurse, Zimbabwean)

The ramifications of the positionality of a healthcare worker who is also a church member are that, although this was a church gathering, being a well-known healthcare worker meant that her advice is likely to be authoritatively taken by the church members, thus further shaping their approach to interventions. In both circumstances (doctor and nurse), their positions are also products of their social and cultural expectations of being useful to their community members, as Ubuntu expects them to, as well as their own relating with the indigenous health practices. The participants

working in the healthcare sector emphasised separating spiritual and professional life and underscored the importance of upholding their code of practice. Although the healthcare advice they gave was done outside clinical interactions, Foronda (2019) cautions about the dangers of the healthcare workers' culture in shaping the way they interact with clients, which may hinder services usage. Scheppers et al. (2006) discuss how the attitudes towards certain cultures by healthcare providers hinder minorities' access to services. In this instance it is the spiritual beliefs of healthcare workers from the minority cohorts that are likely to undermine their communities' utilisation of the available services. The advice some of them gave, which in some instances was contrary to their professional knowledge and practices, could have been a result of the impulsivity and emotionality of the non-professional spaces, especially the church, where they often interacted with their community members, and also their personas outside the professional life which made it difficult to separate spiritual from professional life. Odbehr et al. (2014) explain the conflict that may arise when healthcare workers' own feelings and beliefs have been intertwined with the faith of their patients. These authors reported that one of the ways the healthcare workers in their study dealt with such issues was to participate in religious faith expressions of their patients which was also somewhat the case for the participants in this study.

Alternative interventions

Participants also relied on homemade remedies such as using lemon, garlic, eucalyptus leaves, ginger, honey and gargling warm water with some salt. However, these initiatives do not exclusively fall under the African medications gambit and are not solely classified under the African scholarship. Reid et al. (2016) and Sandhu and Heinrich (2005) discuss similar practices among other groups of people in western countries. Because some of the plants (medicines) are also consumed as food, when analysing the data, I was particular in selecting the alternative interventions. Those medications or foods accompanied with symbolic and religious practices such as petitioning to the spiritual world, prayers and meditations were selected. Two community leaders also helped in this cause by clarifying that while African alternative medicine at face value is similar with other general health supplementing, theirs was embedded in the Ubuntu philosophy. That is, they were revealed to the living by the ancestors in order to safeguard the wellbeing of their living family members. In describing this practice and its connection to the supernatural world, one of the participants said:

> African interventions are pure and spiritual, if I have a headache, I can drink more water… if I have a diarrhoea or other illnesses, I don't bother going to a hospital, but I just use homemade solutions be it for diarrhoea, ear infection, flu and cold… but these interventions are accompanied with prayers to make the products holy and useful… (Male, 55 years old, Teacher, Zimbabwean)

Another participant, a 58-year-old female from Zimbabwe who is also of Christian faith asked me what I would choose between an African "natural and pure" medication and western drugs produced from the same natural products but mixed with artificial chemicals and that has no spiritual revelation. In her question, the participant draws on the spirituality dimension of Ubuntu to acknowledge the importance of the supernatural powers in their protective role and revealing health solutions to the living (Metz & Gaie 2010). Thus, choosing alternative medicine with a spiritual significance and those with supernatural origin is an agentic and holistic approach for efficacy maximisation. It addresses both the spiritual aspect, that is the disturbed relationships with the spiritual world as well as the physical aspect of the illness. At the same time, she emphasises the shortcomings of the biomedical intervention because it only treats the problem on the surface (physical) without addressing the root (spiritual) causes. This has been described in literature as the "numbing effect" (Sandell & Bornäs 2015) although the authors discussed this in the context of how medication is just used to make depressed individuals function in a neoliberal society but without addressing the actual disorder and the structural conditions producing the suffering. Similarly, Thomas (2010) report that Southern Africans in Britain considered Western interventions as inadequate, and non-Western interventions were popular because they inculcated a sense of holistic healing.

In highlighting the philosophical basis and the rationale for using traditional medicines over biomedical ones, several participants pitched the two as oppositional. One of the community leaders working in higher education took a Foucauldian approach of subjugated knowledges (Foucault 1980) to explain the difficulties of accessing their alternative medicine. He contended that it is in the interest of the biomedical system to suppress alternative medicines in order to preserve its hegemony, and the alternative medicine is minimally tolerated and regulated through the biomedical system in a way that does not harm the latter's commercial interest and biopower.

Neba (2011) also discusses the ideological basis for the sidelining of the African alternative medicines from a Marxist reasoning of the capitalistic system. He characterised the Western-centric biomedical system and its regulatory capacity to reign over the indigenous and communalistic health systems that lack profit orientation as an offshoot of, and mirroring, neoliberal values. The traditional African health approach grounded in communitarianism (Ubuntu) and philosophical foundations puts people's wellbeing over profit (Kasilo et al. 2019). Desborough and Keeling (2017) are also critical of the pharmaceutical industry for undermining people's use of traditional medicines, yet drugs such as aspirin and quinine that they sell are products of the same herbs and natural products traditional healers use. Neba (2011) reasons that as part of its propaganda agenda, biomedicine uses its best examples for marketing and worst-case scenarios to judge alternative medicine despite the latter being a rich healthcare system with various specialists. In his criticism of the biomedical system, especially its desire to superintend over alternative medicines, Kirmayer (2004) argues that while biomedical advocates vocally highlight the so-called dangers of the alternative health approaches, biomedicines uproot these from their natural efficacy environments, monopolise and market them at global marketplaces. To dispel the alternative medicine on whatever grounds is to essentially undermine people's beliefs and their senses of what they consider as being healed (Kirmayer 2004). The section that follows further engages medical pluralism, but at a transnational level.

Transnational health seeking

Medical pluralism also involved the utilisation of transnational medical landscapes, that is, the social processes, relatedness, and movements across boundaries (Hsu & Potter 2012) for health interventions. Elliott and Gillie (1998) discuss migrants' motivation to seek health services in their home countries as partly a reflection of the host countries' failure to accommodate their health needs, where migrants are typically discursively framed, by host countries, as either failing to adapt adequately, or as an alienated group. However, as people transcend the national space of the country they have migrated to, in their search for resources to meet their health needs, they transform their home countries from being nostalgically tied to fixed ancestral and remote homelands they moved away from, to become an ongoing part of their lives in a "contrapuntal modernity" according to Clifford (1997, p. 256). That is, they fashion and/or refashion their lives as an ongoing process through sustaining their traditional values within the transnational space,

utilising transport and communication infrastructural advances. As this section examines participants' seeking of various health services back home as a panacea for the failure to access the appropriate services in their country of migration (Australia), it is also demonstrated that participants would still have engaged in transnational health practices, because of their own agency, regardless of the state of the Australian health care system. Transnational health seeking, a concept used by Thomas (2010) to describe this practice of using international spaces in order to seek healthcare services not available or limited in the host country is central here in further illuminating participants' health practices.

While transnational health seeking was common among all the participants, those interpreting their illness from within an African Traditional Religion were more involved in the practice. Their cosmologically embedded health meanings and beliefs often required health rituals that make use of sacred places, trees, animal products, stones, and other inanimate products situated in their home countries to address their ill-health. As highlighted earlier in the chapter, an illness evidences, or is seen, as a manifestation and disconnection from their families including the ancestors as the living dead. For example, a 42-year-old male participant from Zambia explained that an illness to him or any of his family members is instructive that one of the family members has angered the ancestors. The participant, however, categorised the sins that attract punishment on a scale from less to more serious. The failure to obey basic instructions was considered a lesser sin, and thus would attract a lesser punishment than the more harmful sin of violence against a parent or failure to participate in the rituals to honour ancestors for instance. Those sins classified as severe are often punishable through illnesses while minor ones may be overlooked. The participant constructed his explanation within the Ubuntu philosophy, especially the importance of the spirits in influence the behaviour of the human beings through following the norms and values they imposed (Khoza 2012). In case a relative in the diaspora becoming ill, family elders back home are expected to approach spiritual healers, for example a spirit medium, traditional healer or a prophet, who in turn use their supernatural gift to enquire about the sin committed and the ritual process required for appeasement. Healing rituals included slaughtering of a cow and performing dances at the homestead of the ill person or praying and kneeling at the ancestors' graves in order to persuade them to forgive and help the sick person. The use of gestures or specific materials to manipulate the body, and divinatory practices were also some of the rituals mentioned:

> Usually, the traditional healer uses various techniques to penetrate the spiritual world and after doing so he tells the family what's required. The family can be asked to go into a sacred forest for rituals if their ancestors are wronged, ask for forgiveness to the family wronged… In most cases an animal is slaughtered, it can be a goat, an ox or a hen. (Male, 45 years old, Community leader, Zimbabwean)

The narrative of a tradesman also from Zimbabwe in his 40s, and an African Traditional Religion ardent believer corroborated this. He explained that on several occasions when he felt ill (here in Melbourne) a traditional healer was invited to visit their homestead back home. During the healing rituals, one of his brothers represents him. The belief is that through their (blood) relationship and connection, the healing can be ministered supernaturally to him while he is abroad. The participation of the participant's brothers and this supernatural healing is also a demonstration of the collective viewing of the illness in the African societies, as well as speaking to the very essence of Ubuntu in the brothers. They selflessly avail themselves for the wellbeing of their loved one who is physically away. At the same time, the participant understands the importance of the goodwill, assistance and the relationships with others to satisfy his most basic needs (Gade 2012; Wilson & Williams 2013), health in this instance. Participants' narratives thus clearly highlight the importance of cultural belonging for one to tap into the benefits of transnational health practices. Through transnational help seeking, their identity is constructed relationally through their interactions with those they share beliefs, norms and values and they mutually depend on for their social needs.

Illnesses suspected to have been instigated by witchcraft and jealousy such as sexual health problems and mental disorders and unexplained pain in their bodies were commonly associated with the practice of transnational health seeking. Fellow Southern Africans in Australia and some of the participants' friends and relatives back home were suspected to be engaging in evil forces and practicing witchcraft out of jealousy. When asked to elaborate on this, one of the participants said:

> … there is no distance in the spiritual world, you can be harmed from anywhere, someone doesn't have to visit you to do that. (Male, 42 years old, Tradesman, Malawian)

Relatedly, another participant did not see the necessity of travelling to his home country to be healed when he felt unwell. He argued that if evil spirits and witches could harm him while he is in Melbourne, he also can engage spiritually endowed people back home through his family for protective and healing purposes. A 45-year-old- male pastor from Zimbabwe reiterated the witchcraft belief through his experience of counselling people at their church. A few of the cases he encountered involved women who failed to conceive despite all clinical tests confirming their fertility and that of their partners. To them, witchcraft became the only logical explanation of their problems. While the participants such as the one in the excerpt above accessed the health services back home supernaturally, they still relied on the Ubuntu networks, the availability of social networks back home to help. The usefulness of the folks back home not only provided participants with the "cultural infrastructure" (Bryson 2007) for healing but was also therapeutic as it became a platform for addressing family conflicts and for strengthening relationships and interdependences.

In explaining communitarian approaches and commitments of the healing process, a 60-year-old male community leader from Zimbabwe, also an ardent believer of the African Traditional Religion, mentioned the importance of involving family elders back home because of their vantage position to identify the appropriate traditional healers. By appropriate he meant a genuine healer and one who causes the healing to happen through performing their duties within the Ubuntu parameters, especially adhering to his calling codes. Jo Wreford's work expands on some of the issues raised by the participant. Writing about the healing ritual ceremonies in Zimbabwe, Wreford describes how a traditional healer (*n'anga*) used chickens in their ritual to cast away evil spirits from an individual. The outcome of the ritual was a sullenness of the patient and intransigence of the hen's refusal to leave the spot the traditional healer had placed it. This was seen as the evidence of the ritual's unsuccessfulness (Wreford 2005). Such episodes are associated with the breaking down of Ubuntu values because the traditional healer was not "pure" at the time of the ritual, thus the ancestors' refusal to accept the sacrifice, and in such circumstances the healing might not be effected (Chavunduka 1994). The involvement of the family back home by the participant is therefore not only spiritual health seeking, but also to ensure that top specialists, those who abide by the Ubuntu values, is engaged.

This study has already shown that participants often disregarded the disagreements and the antipodal relationship in transcending, oscillating and exploring useful health interventions. The supernatural commonalities of their beliefs and the religious recognition and placement of God as superior to ancestors created an avenue to oscillate, supplement and substitute the two. Similar to the way African Traditional Religion believers made use of the services of African Pentecostal churches in Australia, Christian believers utilised services that can be classified as African Traditional Religion healing especially visiting traditional healers (through their families) and sponsoring family rituals financially. Those involved accused some of the churches with African roots in Melbourne of losing their African identity and values, thus they failed to fulfil the community's spiritual and social needs, yet they were established for these purposes. In stating some of the reasons for no longer using African Pentecostal churches in Melbourne, a 32-year-old female student from South Africa explained that usually her family back home always glowingly speak of a local traditional healer, thus she thought it is unwise to be religiously rigid and miss out on the "best intervention". Corroborating this, a 28-year-old female student from South Africa expressed her preference of seeking prayers and other spiritual help from the church leaders back home rather than to utilise the services of the Pastor of a similar church in Australia. She cites the waning away of important healing rituals such as exorcism and healing prayers for her seeking of spiritual services back home. One of the pastors from Zimbabwe concurred with this participant. The pastor blamed this on the ambition to attract congregants of other nationalities and cultures at the expense of the original congregants' traditional beliefs. As noted earlier in the second chapter of the thesis, Pentecostal Christianity went through some reorientation during its operationalisation in the African context to include some rituals and beliefs of the original indigenous religions part of it (Biri 2012; Mokgobi 2014). Sande and Samushonga (2020) stress that while Pentecostalism is usually wrongly conceptualised as a religion with a single identity, not only is it plural, but it is also culturally contextual, and is often problematic when two cultures collide. Anderson (2016) expounds that, unlike missionaries of other cultures, the African evangelists, bishops, pastors and prophets not only proclaim God as the saviour of the soul, but also one who heals the body and brings answers to barrenness, sickness, oppression by evil spirits, and liberation from other afflictions and bondage. Thus, in trying to grow the church through attracting congregants from other cultures, there is a departure from the African cultural contextualities, the very basis for their establishment and the reasons for attracting participants into those churches.

Apart from two of the participants who visited prophets and traditional healers when they travelled home for other businesses, transnational health was mainly accessed over the phone by getting healing messages, prayers and futuristic prophetic messages, and through using sanctified and sacred objects delivered to Australia via family and friends travelling from home. For example, one of the participants said:

> It's very normal to be asked to bring a dress, an artefact, food items, people may not be specific about the reason for importing clothes, salt, small stone cloth from Africa but if I get such a parcel, I usually associate it with spiritual healing from the prophets… had it not been for tighter border restrictions holy water and holy stones will also be imported. (Female, 50 years old, Nurse, Zimbabwean)

Studies by Clifford (1997) and Thomas (2010; 2013) among other recent studies show that migrants remain connected to their countries of origin's norms and values, thus ensuring fluidity of their citizenship between two countries. Through relying on "astronaut families", that is the non-migrating members of the family (Waters (2002), they remain as global citizens. This is a somewhat different approach to earlier cohorts of migrants who were more assimilative in host countries (see Alba & Nee 1997). At the same time, the nature of the relationship demonstrated communicates the very essence of Ubuntu. The desire to be useful and the realisation that one is legitimated as a "human being" through their ongoing participation in the community (Tutu, 1999). Thus, positioning one's "wholeness" through others — a person cannot be a human through himself/herself — one's community therefore is the epicentre of relational context; and, in authenticating their humanity, the community influences the way one helps others to access the appropriate health services.

While transnational health seeking was understandably associated with the use of non-scientific health explanations, interestingly there was also a cohort of the participants that sought biomedical health services in their home countries despite living in a country with a much superior healthcare system in terms of technological advances, funding, availability of the latest drugs, specialist services and doctor-patient ratio. Thomas' (2010) work in Britain demonstrates the inadequacies of the participants' home countries' healthcare systems through reporting that the Southern African

diaspora in Britain send biomedicines back home in order to help their relatives who struggle to afford the prohibitively expensive medication. Those importing pharmaceutical drugs and using biomedical services back home felt that the Australian health services are rigid, in the words of one of the participants:

> Here the GPs are very rigid, they just don't issue a prescription, and you must go through different tests, some of which are unnecessary and expensive, if you are lucky, you get only antibiotics prescription. Often in Africa you leave the GP's office or clinic with drugs or a prescription at the least. (Female, 32 years old, Student, Zimbabwean)

Other participants with similar accounts were a bit more tolerant of this "rigidity", if it came from GPs of other backgrounds, because they were considered unfamiliar with the context in which health is provided back home. They were less forgiving to clinicians of the African background who they stereotypically labelled as becoming "too Westernised", implying they were inconsiderate of the needs of African patients. For example, one of the participants had this to say:

> … I don't know what's wrong with us Africans, our African brothers and sisters have become too Westernised…, they subject us to the same costly procedures before getting treatment…Back home it was quick quick and it's fixed …not to be moved from one place to the other… (Male, 42 years old, Support Worker, Zimbabwean)

Participants felt the diagnostic procedures they were subjected to were both expensive and time consuming. Being attended by an African doctor raised hopes for quicker and less costly treatment. As a fellow African who is supposedly guided by the Ubuntu values of empathy, solidarity, and who has a deep connection to the economic struggles of fellow Africans, the expectation of swifter treatment was higher. The accusation that African doctors are inconsiderate and insensitive, comparing them with their colleagues back home further highlights the discrepancies in treatment procedures between their home countries and Australia, already discussed.

In using biomedical services back home, a 32-year-old male student from Zimbabwe who recently arrived in Australia not only used his doctor in Zimbabwe to validate information from the internet, but his doctor also authenticated the necessity of undertaking clinical tests and other procedures as would have been instructed by the Australian doctors. He also felt that as his doctor for eight years,

he had in-depth knowledge about his health which will be useful on the best remedies. The doctor back home "triaged" him based on the information provided over the phone corroborating it with the previous medical history. Through their telephone interactions, advice on what medication to buy, which specialist to visit, home remedies to use, or even to simply ignore the pain if he thought the symptoms minor was given. As useful as it seemed, the riskiness of this practice is glaring, nevertheless. There is a possibility of inaccurate medication, wrong diagnosis and delayed care associated with this practice (Crush & Tawodzera 2014). My discussion with one of the participants (a medical doctor) was illuminating, in that some of the participants were not impressed by the service they were provided with. He described the ecstatic excitement from the African patients when they see an African doctor in the consultation room. They often use this encounter to ask questions and clarify what they were previously told by other doctors. This is also supported by the accounts from other participants discussed earlier in the chapter, especially the opting to wait longer or coming the following day in order to be examined by an African doctor.

The relying on biomedical services back home could also highlight the differences in the operationalisation of biomedical services in different countries. As a result of the health liberalisation and the associated increased role of the pharmaceutical industry, insurance companies and banks, Kim (2019) argues that the neoliberal culture is eroding the classical professionalism underpinning the doctors' altruism and compassionate values in pursuit of profit. Muula (2006) asserts that some doctors engage in various practices aimed at maximising the volume of patients attended to rather than the quality of service so as to maximise their incomes, they have eroded the previously "sacrificial" akin to a "priesthood" values in them. Because of being of "foreign culture" which comes with many interactional challenges, some doctors may consider minority migrants as taking more time hence it is in their interest to manage them through what Mishler (1984) refers to as the "voice of medicine" (using technical knowledge and medical jargon). For those who have been previously exposed to a biomedical healthcare system where the neoliberal ideology is "less visible", where medicine is to some extent, still not seen as means to earn a living but an altruistic vocation (Muula 2006), and where communitarian ideologies such as Ubuntu still have an influence in how the services are rendered, maintaining a clinical relationship with previous doctors is strategic.

Through transnational health seeking, participants demonstrably were resilient, agentic and resourceful, which enabled them to overcome some of the health challenges experienced. At the same time, the nuanced use of transnational space to overcame distance barriers through using artefacts and technology underscored their identity as resourceful people rather than a cohort that simply accepts their fate (Beune et al. 2006; Brown, Avis & Hubbard 2007). In harnessing cultural capitals that emphasise Ubuntu, including their efforts to be a "human being" or humane to others, community members travelling to Australia carried the burden of bringing artefacts and other symbolic objects used in indigenous healing. Through these initiatives, we could argue, borrowing from the ideas of Geertz (1988), participants transformed their home countries from being fixed ancestral and remote places to become ongoing transnational networks for meeting social needs unavailable in Australia. As Hall (1992) stresses, the diasporic culture can consist of at least two identities that provides an opportunity for incorporating various solutions to the contextual problems. Participants retained the health norms and values of their home countries alongside utilising some of the locally available services. Through this, they were able to transcend geographies and live in more than "one world" or have multiple belongingness (Baldassar et al. 2016; Hall 1992; May 2011) as they strived to access appropriate services.

Conclusion

Somewhat similar to the previous chapter (mental health), this chapter sought to understand the participants' health issues including the health beliefs and spaces in which they seek help. However, this chapter was unique due to its specific focus on physical ailments, medical pluralism rationale and the transnational approaches to health. Generally, participants legitimised their suffering principally from a spiritual explanatory perspective for understanding the "why part" of the health problem. In most instances, an illness is connected to a disturbed relationship with the supernatural world, and the observable decline in one's health is thought to signify this. Nonetheless, the services commensurate with these cosmological beliefs and mystical forces instigating the illness are unavailable in Australia. As a resourceful people, and largely drawing on Ubuntu, Southern Africans used their agency to create spaces to access appropriate services in their neighbourhoods, particularly the African Pentecostal churches. These services were utilised by both Christian believers and African Traditional believers. While most of the participants' stories and health practices put mystical forces grounded in their traditional and religious beliefs

at the centre of instigating illness, because the illness is physically experienced, Western services that utilise biomedical theories were also important health services. Nevertheless, when accessing Western services, participants opted for African healthcare practitioners since they regarded these clinicians as considerate, accommodative of and sensitive to their spiritual health beliefs. That is not to say they disregarded the biomedical parameters in the clinical interaction; rather, they recognised and related to the issues raised by their African clients which created a safer clinical space for the participants. In utilising a variety of services for addressing both the spiritual and physical aspects of wellbeing, medical pluralism remained a central approach to health. At the same time, in the endeavour and exploration to access holistic health interventions and to maximise efficacy, there was oscillation, complementarity and substitution of traditional interventions (in their variety) with the biomedical system and vice versa. Considering the importance of specific geographical locations that are sacred in indigenous healing, as well as the healing practice requiring certain artefacts, plants, and the traditional healers largely in their home countries, transnational health seeking was one of the initiatives participants used to access the appropriate health. Some participants' utilisation of biomedical services in their home countries (through telehealth) yet living in a society with much superior services in terms of funding and technological advances not only indicates that availability of services goes beyond physical presence, but also the comfortability of using these services. Furthermore, the transnational health seeking by the participants also demonstrated how biomedical health system has operationalised and tailored to different contexts. However, to access health services back home, participants continually inserted themselves into the cultural networks both in Australia and home countries. The shared values of Ubuntu—humanness "African-ness", selflessness, communitarian — was a strategic cultural resource in the accessing of some of the appropriate and desirable health services.

CHAPTER SEVEN: CONCLUSION AND SUGGESTIONS

The introductory chapter (i.e., Chapter one) highlighted that what might be missing or scarcely available in literature is a comprehensive knowledge of the health issues of the migrants who are recent arrivals in Australia. Some of the cited studies (Biddle, McDonald & Kennedy 2007; Jatrana, Richardson & Pasupuleti 2017; Renzaho 2016) show that migrants from countries that are poorer economically and with less advanced health services enjoy good health when they first arrived compared to the people of richer countries where they resettle. Evidence from literature further highlighted that culturally and linguistically diverse people not only have higher vulnerability to health problems, but also face more challenges when accessing health services. While several related studies have been carried out with people of African background in Australia, specifically, this study sought to focus on people from Southern Africa who are much less represented compared to other cohorts of people from the continent's other parts. At the same time, most of the studies cited have been carried out focusing on African migrants researched humanitarian migrants. Considering the diversity of African migrants, the transferability of those findings might be limited. Thus, to understand the factors underpinning the disappearance of the 'healthy migrant effect' and other health issues, the study focused on one of the most recent arrival cohorts to Australia. The following three objectives guided the study:

1) To address factors that enhance, as well as factors that undermine wellbeing of Southern Africans in Melbourne.
2) To understand Southern Africans' health beliefs and the socio-cultural barriers to help-seeking and healthcare system utilisation.
3) To examine Southern Africans' coping strategies, health initiatives and the spaces in which health needs are sought and met.

The project sought to interrogate these issues by using dialogical interviews to ask questions of people from Southern Africa about their resettlement experiences, beliefs and ideologies shaping their health behaviour, and their experiences of using the healthcare system. As the project was also interested in examining the Southern Africans' health beliefs and the other services that they use for enhancing their health wellbeing, participant observation was also utilised to collect data

at various social gatherings. Following the methodology chapter (i.e., Chapter three), the study findings were broadly organised into three related themes discussed as chapters.

To respond to the first research objective and to answer the related first research question 'What are the resettlement experiences and factors that undermine the wellbeing of Southern Africans?', and also as part of context setting, the first findings chapter (Chapter four) discussed the environmental and socio-cultural factors that might be elevating Southern migrants' susceptibility to health problems. While Australia is a land of opportunities to the participants to enjoy a decent life, gain quality education and generate an income to support their loved ones back home, it is also a place of loneliness, stress and a separation from the social networks that provide emotional and material support. The nature of responsibilities Southern Africans have, especially Ubuntu expectations and obligations (financially supporting their extended families back home) essentially entails living dual lives which come with a higher financial burden. This was even more pronounced among student participants who, apart from supporting their relatives back home, and dealing with across-the-board studentship pressures, also needed to work to raise tuition fees and meet their living costs. These responsibilities generally meant overworking, little options in jobs selection and working times, and irregular circadian rhythms. Physical and mental wellbeing were not always a priority compared to their financial obligations. At the same time, in order to negotiate the work-limit rules and largely working in poorly paying jobs meant that this cohort were at the mercy of exploitative employers. Such problems were not only confined to student participants; temporary skilled visa holders and those with indefinite stay were deskilling after failing to secure employment in commensurate jobs. Apart from low pay and exploitation, these jobs undermined the participants' social identity, social security, social status and their sense of achievement which all created stressful circumstances. On the other hand, being a racial and ethnic minority in a country imagined as white, and dominated by whites and, to some extent, other ethnicities, Southern Africans also had challenges of coping with racism and discrimination and the associated pressures. Most of the stories and experiences from the participants revealed that racism, in its variant forms (intercultural, overt or covert), fosters a sense of exclusion, unbelonging, self-doubting, limited opportunities and poor access to not only health services, but also other socio-economic opportunities protective of good health. Despite this elevated susceptibility, participants generally had lower usage of the mainstream health services because of various reasons.

In further trying to make sense of the lower usage of the available health services, and in answering the second research question 'How are health and illness perceived by Southern Africans, and in what ways do these perceptions influence their help-seeking and healthcare system utilisation?', the study explored health beliefs, knowledges and philosophies informing and shaping participants' understanding and interpretation of personal difficulties and illnesses. Chapter five, "Mental Health," clearly demonstrated that ethnocultural explanations, especially religious, are largely used to interpret the illness. Because most of these ethnocultural explanations mainly focus on extreme symptoms of being "crazy" and a total loss of the mental faculties, severe stresses, depression and anxiety among other disorders connected to their daily struggles were not deemed important enough to warrant help seeking. For some who intended to seek help for these disorders following embracing them through familiarity, the labelling and stigmatising which is rife in the communities, particularly the association of help seeking with weakness, also undermined services utilisation. This conceptualisation therefore largely renders the biomedically developed mental health services of limited utility in responding to the communities' needs. As participants responded to the unavailability of services consistent with their religious beliefs, values and ideologies, they demonstrated resilience and resourcefulness through creating their own cultural spaces to access the appropriate services. These included assembling to form pan African churches and consulting culturally resourced individuals in their communities. The search for appropriate services also extended to their home countries through using ICTs and Ubuntu which was also revelatory of the endurance of participants' indigenous beliefs postmigration. This discussion also formed part of the answer to the third research question 'What services do Southern Africans use to deal with health problems, and how accessible are these services?'

While indigenous beliefs remained central in the interpretation of mental difficulties, the importance of acculturation as a force socially influencing dissimilar people (Gibson 2001) in terms of health beliefs was witnessable, especially among those participants working in the care sector. Severe stress, depression and anxiety and other disorders explained using the biomedical model had become part of their mental illness definition. Through this they benefited from the mainstream services. Nevertheless, these were of little benefit according to some participants because health workers neglected clients' culture, its importance in setting normality and deviant

parameters, symptom reporting, and some of the embedded explanatory theories of the illness. Therefore, it should not escape our attention at the empirical levels that while the utilisation of cultural and religious services underpins the identity of a particular people, the utilisation of these cultural services and the failure to seek help from mainstream services highlights the unsuitability of the latter in their current form as far as the health needs of Southern Africans are concerned.

The final findings chapter (i.e., Chapter six) focused on spirituality, health and religion, and contributed further to answering the third research question, highlighting the plurality of health services used. It differed to the mental health chapter through its specific focus on physical health, a clear medical pluralistic approach and the phenomenon of transnational health seeking. Physiological illness evidences a disturbed relationship between the living and the supernatural forces that can be fixed by the former's adherence to the latter's codes. What has also been shown is that associating illness with cosmological beliefs and mystical forces such as witchcraft, curses and ancestral punishments puts indigenous health services such as the African Pentecostal churches, traditional healers and prophets at the centre of the interventions. While the supernatural world is considered to play a crucial role for either permitting the illness or causing the healing to take effect, its physical manifestation extends the intervention styles to various physical processes for a holistic approach. In addition to herbalism and other indigenous physiological interventions, for a comprehensive health intervention there is a "therapeutic alliance" wherein biomedical services are engaged to treat the physical aspect of the illness that would have been triggered by the developments in the spiritual world. Engaging biomedical services for a holistic intervention highlights an important difference between the way mental illness and physical illness are addressed in the Southern African communities. What this entails is that Western services and indigenous interventions both continue to be central health initiatives utilisable in the quest for a holistic intervention. Thus, the medical pluralism exhibited by the participants is further evidence of a continuation of their practices and culture postmigration. However, in utilising the mainstream services, healthcare practitioners of African background were preferable for cultural and religious reasons. That is not to say that the African clinicians somehow departed from the professional guidelines which their colleagues follow; rather, their cultural background provided a commonality, through which they could recognise the indigenous beliefs and dimensions raised by clients of African background. Similar to other clinicians, their treatment regime remained

biomedical, but because they did not dismiss the cultural issues participants raised, this created a much more congenial interactional space. And considering the socio-economic struggles they faced, participants tactically accessed biomedical services through informally consulting their friends working in the healthcare sector, and self-triaging via the internet.

Utilising both indigenous and biomedical services was not only part of a holistic and complementary approach, but also an oscillation and substitution of either system with the other due to frustrations of failing to get the desired results. Nevertheless, this relationship, more importantly, highlights that the philosophical clashes between Western and non-Western health practices, particularly the castigation and dismissal of the latter by the former as illogical, archaic and irrational, and as a practice it should manage, licence and supervise are no barrier when people seek to maximise efficacy. The practices of the participants are also a reminder that despite its hegemony, biomedical interventions are not always adequate to deal with every illness. People engage in several interventions as shaped by their health beliefs, histories, knowledges, availability and accessibility of services, individuals' preferences, and socio-cultural expectations. Particularly this was the case for a cohort that come from a subcontinent region where 70-80 per cent of the population use a range of non-biomedical treatments (Peltzer et al. 2008).

Although the participants created their own culturally appropriate health services especially through religious gatherings and spiritually embedded homemade remedies, the Australian context still lacked some of the critical "healing ingredients" such as sacred places, specific plants and traditional healers and spirit mediums among other experts. As these are only found in their home countries this further required agency and resourcefulness. The availability of ICTs provided an infrastructure for tapping into those services especially through tele-diagnosis. Artefacts and other symbolic products carrying the healing power were sent to Australia through family and friends. The utilisation of biomedical services in home countries, yet living in a country with a superior healthcare system in terms of resource allocation and technological advancement, reminds us that health availability goes beyond a mere presence of services. The experiences of those who took part in this study illuminate the usefulness of trust and comfort of clients to disclose issues, including their various health beliefs to their clinicians. Hence, some of the participants felt that their doctors prior to migration would still do a better job postmigration, notwithstanding the

inadequacies of the virtual and telephonic diagnoses. As one of the participants stressed (page 130), there should be a connection and a sense of being "cared" for rather than just being "treated". Alongside indigenous beliefs, this contributed to biomedical transnational health seeking.

Due to its grounding and rootedness in the traditions, religions, humanistic ideologies and values of Southern Africa, Ubuntu theory occupied a central role in the interpretation of the findings. When discussing the environmental constraints and financial obligations of the participants, Ubuntu was particularly utilisable in explaining the material and financial burden of the participants to support their loved ones back home, as well as to cope with many financial needs in Australia. This was more pronounced among the participants who were students and with families. In addition, the absence of Ubuntu networks in Australia elevated their emotional, social and financial hardships. Working to meet these financial obligations effectively meant that one's wellbeing is usually not a primary consideration. Notwithstanding the health consequences, financially supporting loved ones back home, as well as drawing on the health services back home through social networks, the Southern African diaspora and their loved ones both relied and sustained humanness, selflessness and communitarianism values of Ubuntu. It is Ubuntu as well that facilitated the rallying and creating of appropriate spaces especially the church to assemble in Australia and access spiritual services. Not only did Ubuntu's selflessness, sacrificial ethos and corporatism help in spiritual healing, but information about outstanding biomedical services for physical illnesses, and community networks protective and therapeutic to mental health difficulties were also fostered in these Ubuntu settings.

Interventions and recommendations to improve health and wellbeing for Southern Africans

Migration has reorganised societies; cosmopolitanism, multiculturality, differences and non-homogeneity are now the new normal in many migrant receiving societies. In recognition of these new realities, Australia, a country founded on immigration (Modood 2013) became one of the first countries to embrace multiculturalism as a discourse and a policy in order to ensure that the benefits the country offers are equally enjoyable across the board. Without overlooking the ground covered in realising this, this project and many other studies, some of which have been cited in this research, have highlighted those institutions, including the health systems have not yet been

fully modelled consistently with the country's cultural diversities. This thesis has aimed to gain a much more comprehensive insight into this sociological phenomenon, especially the role of socio-cultural issues in help-seeking and healthcare system utilisation, which in turn is useful in suggesting how the associated challenges could be addressed. Based on its findings, the research suggests possible interventions.

The research repeatedly demonstrated a lack of culturally appropriate interventions to the specific needs of Southern African migrants in Australia. The cultural and religious issues of various users need to be considered by clinicians to enhance their health access. Of course, healthcare systems in Western societies are increasingly embracing "culturally appropriate" services partly as a recognition of the shortfalls of using standardised approaches, and the marginality of minorities in terms of health access. For example, the Australian healthcare services have been tailored to the specific needs of First Australians community, refugees and some "majority-minority" (some Asian communities). While noting the importance of embracing a culturally appropriate model in Australia, especially the awareness of religious and cultural differences, Spitzer et al. (2019) argue that there is still a tendency by some healthcare workers of importing their own cultural beliefs (what they individually consider proper). Similarly, the evidence from my research on the health experiences of Southern African migrants shows that more needs to be done as some groups are much more marginalised. As has been argued, when advocating for a culturally competent health model, Kirmayer et al. (2011) stress the centrality of culture in symptom reporting, illness experience, illness severity, triggers, treatment process and other associated behaviours. Waldron (2010) also highlights the central role of people's specific health beliefs in their utilisation or lack of utilisation of the health services. However, the participants felt that their cultural values were not considered, which contributed to their disinterest in utilising the services when the need arose. From the participants' experiences, the Australian healthcare system may not be seen as culturally appropriate, even if significant strides have been made in this regard. Therefore, more needs to be done particularly on the health needs of the newly arrived minority groups.

The difficulties encountered by the participants reveal sometimes unbridgeable gaps between the participant and service providers. This is manifest especially on issues where there is seemingly a clear discrepancy of the participants' culture and what is now considered acceptable and

progressive to ensure wellbeing. This is well exemplified by the experiences of one of the participants going through some marriage struggles (page 125). The marriage counsellor failed to appreciate that the participant values marriage in a particular way in his culture— and the advice she provided using her cultural frame was abominable to the client. The literature reviewed and discussed in this thesis, concerning the institution of marriage in western societies, especially Gidden's (1992) and Cherlin's (2010) perspectives, has highlighted the different ideologies that might have shaped the counsellor's perspective, which are fundamentally different to the orientation of her Southern African client. Thus, in implementing a culturally conscious approach Sue and Sue (1999) see it as a greater call on the part of healthcare personnel to be conscious of their own cultures, acknowledge that what they value or consider important is not necessarily what migrant client users consider central. It is an ongoing self-reminding that it is the healthcare user not them (healthcare workers) at the centre of the intervention. The failure to take this self-critical and reflexivity approach, and using one's own cultural understanding of illness when dealing with people of other cultures promotes withdrawal from the services according to White and Chalmers (2011). Indeed, the experiences of those who participated showed that withdrawal from the services was one of the many consequences of cultural gaps. These challenges are likely not only confined to health issues, but are also evident in other aspects of life, thus affecting the general integration of Southern Africans in Melbourne and Australia, and the effectiveness of multiculturalism. Having a sense of being unwanted and a feeling of unbelonging as a "reality" influences attitudes and socio-cultural behaviour. One inevitable corollary of this is the impact on people's community engagement, where people go for recreation, and how they understand and construct their society. Stories such as withdrawal from going to the local recreational places and questioning of one's Australianness as long they are of the African origin and with a darker skin pigmentation exemplify this. Thus, to implement a culturally competent approach is not only one of the corrections to the flawed framing of universalising of human beings and health interventions, but also a way of promoting multiculturalism and strengthening the Australian story.

While culturally competent models tend to face some form of resistance from the mainstream as they are interpreted as symbols confronting the norm, or an attempt to depart from the core culture, these models are not destabilising ideologies but only concerned with promoting access to services. They do not seek to overhaul the system, but rather to understand and acknowledge the

heterogeneity of the users and the realisation that life experiences, beliefs, religions and orientations have an important role in legitimising the illness. The rationale is neither to recruit nor to retrain healthcare providers to become ethnocultural workers, but to take a respectful, considerate and a non-judgemental approach when interacting with clients from other cultures. This is of particular importance as most participants, especially on mental health issues, complained that the healthcare workers dealt with the issues from their own perspectives and culture not from the position of the clients. With this awareness the possibility of healthcare workers importing and applying their own cultures at the workplace can be minimised, which may not only ensure that health services are appropriately resourced, but also promote cultural change and further adoption of client-centred approach in health provision.

A culturally conscious model has, however, also come under criticism due to its conflation of culture with race and ethnicity, and presenting culture as something fixed and static (Carpenter-Song, Schwallie & Longhofer 2007). Notwithstanding the validity of this criticism, based on the issues raised by the participants it remains a sound alternative especially in terms of the acknowledgement of the particular role of religious and indigenous ideologies in their lives and wellbeing. Incorporating this in Australia may include making cultural and religious questions an important part of the clinical interview instead of treating these as ignorable, primitive and archaic (as was the case in some instances) that must be anthropologically transformed through using western theories.

Tapping into the community

The research utilised Ubuntu theory, an Afrocentric framework, because of its ontological situatedness in Southern African epistemologies, traditions, norms and value systems, to make sense of the participants' lifestyles and health practices. The overview of Ubuntu in the thesis' second chapter showed that Ubuntu is basically a set of beliefs, values and expectations that are embedded in the indigenous Southern African traditions and cultures of collectivism, interdependence and humanity for meeting people's daily needs (Schiele 2000). We have seen the importance of Ubuntu (ism) — the ethos and principles that shape the interpersonal relationships and expectations— the collective and collaborative responsibility for survival through inculcating a sense of sympathy, empathy and sacrificial actions to help others, as well as the importance of

traditional institutions, and social networks for wellbeing. This philosophy provides a solid ground for mainstreaming the participants' socio-cultural values to enhance their wellbeing.

We have also seen that participants extensively commented that their health beliefs and socio-cultural issues are disregarded in most health care interactions, and this significantly contributed to their low use of the services. The termination of using the services midway through treatment, as was the case with several participants, highlights their frustration, whether they initially utilised it as a substitute to the unavailability of the appropriate care, or as part of their normal health practice— medical pluralism. However, the preferencing of healthcare workers from their own home countries is worth noting. It was an opportunity to seek clarifications on health advice from other clinicians which participants were less sure of, as well as seeking biomedical services in an environment that is not dismissive of their beliefs and ethnocultural explanations of illness. Therefore, tapping into the culture of Southern Africans for a more culturally sensitive healthcare approach is crucially one of the ways to enhance their wellbeing. Community leaders suggested using elderly people in their communities as lay workers because of their cultural knowledge in dealing with marriage problems, bereavement issues and raising of children who usually suffer from cultural confusion. In Chapter five, I discussed how one of the participants struggled to cope with his mother's loss despite using several counselling services at his university until he met an elderly man from his country (page 130). Another participant also stressed those from Africa have lesser chances of utilising allied health workers such as psychologists and social workers because most of these workers lack an understanding of the foundations of the Southern African culture. Rather, community elders and pastors play this role within the dictates of Ubuntu and their traditional institutions. Thus, using such people who are more culturally attuned to the community's values, and well positioned to identify specifically important issues in their communities, is likely to contribute to increased usage of services. It is imperative to note that such initiatives are also being used in Southern African countries such as Zimbabwe to ensure that such services are utilised. As part of dealing with the workers' shortages, cultural issues and stigma that constrain help-seeking in mental health, a Zimbabwean-based psychiatrist Dickson Chibanda initiated a "grandmother/friendship benches" program (Cavanaugh 2017). The initiative used culturally resourced individuals, especially community grandmothers who already had the trust and respect of the community, in providing mental health services but without categorically

referring to them as such. They provided home-based care and health education through discussing life issues in public spaces such as clinics and workshopped the challenges community members faced to address depression, anxiety and other mental health problems (WHO 2018). Writing about his psychiatry practice in Zimbabwe, Mangezi (2020) also credits the success of their practice to their consideration of the values and beliefs of their clients in their practice. Not only will similar/ related initiatives assist in the timely access of services, but they are also likely to lower the disease burden and higher bills associated with delayed interventions and involuntary use of services.

One of the participants, a medical doctor, suspected trust issues among people from Africa. In most of his clinical encounters with people from Africa, his clients sought to verify what they have been told by other doctors including the necessity to follow up on all the diagnostic procedures they would have been advised. Additionally, other participants opted to go back without treatment and return on another day so as to be attended by an African doctor which might also point to trust issues. Incorporating knowledgeable individuals in the Southern African community as bicultural workers may alleviate some of the difficulties raised. Eng, Rhodes and Parker (2009) stress the importance of community-based health workers as conduits between patients and service providers and as knowledge brokers linking the community members with the actual service they require including using their own experiences when they were still amateurs. Martin and Zweben (1993) emphasise the importance of the family in the using and disusing of medication and healthcare services because their advice is highly valued by the patient. For communities that are communitarian and that value and rely on their family and other social networks, utilising the services of the people with whom they share many cultural aspects is further likely to enhance services usage. At the same time, because of their medical plurality, utilising community leaders and resourced individuals in their respective communities can be part of a holistic approach to health. While this is crucial in addressing some of the issues contributing to the waning away of the healthy migrant effect, future research could explore how this can be best done considering the self-stigma in these communities. Byrow et al. (2019) among others note that in minority communities, users also tend to avoid utilising the services in their own communities because of concerns about confidentiality breaching, and the stereotyping of various illnesses with a jinx and supernatural punishment.

Some Southern African males experience a sense of being emasculated when in a society that they have migrated to, they take on tasks that in home countries have been constructed as feminine. In utilising the cultural services back home for their marriage challenges, it has been shown that the advice given did not consider or take in to account the realities of living in Australia and other Western countries. Because this cultural gap exacerbated these problems, engaging the services of community leaders and elderly members of the community in Australia could bridge this gap. Their lived Australian experience puts them in a position to be cognisant of the realities and the pressures of living in a highly complex society and its demands, while having the wisdom to package the message in a way that is culturally acceptable.

Cultural humility

In this thesis there has been an extended analysis of the significance of Ubuntu in moulding health behaviours. One of the key revelations in this study was the importance of the cultural frames and the endurance of indigenous ideologies in explaining illness. At the same time, through acculturation people can further embrace new cultures and health theories postmigration. Thus, illness interpretation becomes a product of the culture and experience of the home country and the values of the countries of resettlement. This in-betweenness, while it offers an opportunity for multiple interventions, creates a clinical gap, particularly when the health ideologies of places of origin that lack the cultural and hegemonic power compared to dominant health ideologies, are overlooked by the healthcare providers. Some of these challenges are addressable through the concept and practice of cultural humility. In societies characterised by power imbalances such as contemporary multicultural countries (Australia included), cultural humility refers to, "a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals. The results of achieving cultural humility are mutual empowerment, respect, partnerships, optimal care, and lifelong learning" (Foronda et al. 2016, p. 213). Embracing cultural humility can be useful for one's self-awareness, for recognition of one's strengths and biases emanating from one's own values, beliefs, behaviour, and by realising that these have an effect in the clinical interaction (Foronda 2019). As healthcare workers become more conscious and reflect on the effect of their cultures and worldviews and being aware of the power imbalances in the clinical set up, they foster "humbleness" in every interaction with every individual. Not only does this self-critique flatten the power differentials (Foronda 2019), it is also

an ongoing opportunity to learn for best possible results. The likely outcome of cultural humility is optimal care, empowerment, partnerships, care relationships and ultimately the increased use of the available services, thus the addressing of some of the aspects contributing to the waning away of the healthy migrant effect. Obviously, the impacts will not be instant; however, it is conjectured that if consistently done, with ongoing deliberation and evaluation and effort, some ground can be covered.

Research contribution to new knowledge and future research

As explained in the introductory chapter, there is relatively little research that has been undertaken on the resettlement and health issues of the Southern African community. What future projects could research is the ways in which cultural humility can be part of health training for healthcare workers and explore ways in which the cultural values of the clients can be accommodated in the clinical set up. This should go beyond the available services such as alternative medicines which are largely for the majority-minority of the migrant communities (for example, those from India, China, and the Middle East in Australia), but to appreciate the heterogeneity of the migrant groups and endeavour to incorporate the health systems of the much smaller communities. Future projects could also explore the ways in which the community stigma can be overcome in Southern African communities in order to promote the utilisation of the available services in these communities. Particular focus should be put on how this can be done in ways that do not overlook the beliefs and ideologies of explaining the illnesses. Throughout the thesis, it has been shown that the epistemologies, traditions, norms and value systems of Southern Africans carry an enormous weight for health matters (from the understanding of the illness, interpreting and reporting it and the initiatives taken to address is) thus initiatives informed by the participants' culture is important for a more impactful intervention. A good place to start is to explore how the culturally resourced individual, such as pastors and community leaders, could be part of the health services.

Study limitations

In Chapter three, Methodology, I pointed out that majority of the research's data was collected through interviews with 28 Southern Africans living in Melbourne and through attending various community events, especially those held at churches. Collecting data through a smaller number of in-depth interviews and observational data mainly at four churches was critical in illuminating

Southern Africans' experiences of utilising the health services and their resettlement issues in a way that other methods could not. The thesis conclusion should be contextualised to the individuals who participated in this study and the places where participant observations were carried out. While there was a deliberate effort to have a diverse sample using gender, age and nationality among other social markers, only five countries out of 16 Southern African countries were covered. Furthermore, half of the 28 individuals in this study are originally from Zimbabwe which to some extent might have produced skewed results. Although many Southern African countries have English as their official language, the fact that it is not the participants' first language might have alienated those that feared that they will be judged through their English language answers from taking part in the study. Also, some Southern African countries notably Mozambique, Angola and the DRC use Portuguese and French as their official languages hence their English language skills may have been further limited. Even among those who participated, some could not clearly communicate their points, as the issues they sought to articulate are deeply embedded in traditional practices with no readily translatable English words. All the participants were either holders of a tertiary qualification or studying towards one which may have skewed the sample towards the highly educated hence not a truer representation of Southern African community in Melbourne. The observed data is also a product of the events at only four churches (although each attended several times), and other social gatherings such as community meetings and social sporting events. Collecting data through participant observation at places of high emotionality and experiential attachments meant that as I participated in the events, I might have been naturally consumed with certain proceedings and thus missed some of the data. In Chapter three I discussed the ambiguity and complexities of being the researcher and the researched which could have affected the research process and the findings.

In concluding this thesis, returning to the issues raised in Chapter one concerning health access and factors detrimental to the wellbeing of migrants, in this particular case, those from Southern Africa, is imperative. Through a discussion of these issues, and an interpretation of the challenges faced by the participants, as well as the health initiatives, this thesis has largely been guided by Ubuntu. Ubuntu underscores the social connectedness of a group of people through culture, and the role of their beliefs in legitimating health problems, as well as the ways in which interventions

can be corporately and holistically sought. Based on the participants' experiences and stories, migrants' health should thus be understood as multidimensional, some factors of which are common and generally understood while others are complex and difficult for many service providers to understand. Only a small proportion of these factors have been illuminated in this thesis. For a much more comprehensive insight into the health of Southern African migrants, their health beliefs, the waning of the healthy migrant effect, and the ways in which the health services can be adjusted to be more accommodative to the minorities and subsequently lower the disease burden, further empirical investigations are required.

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