Meaning of Health: Migration Experience and Health Seeking Behaviour of West African Women in Australia.

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

School of Nursing and Midwifery, College of Health and Science, University of Western Sydney

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Dedication

This thesis is dedicated to the glory of God
Acknowledgements

I would like to acknowledge a number of people who have helped and sustained me throughout this PhD journey.

First, I thank my family who journeyed with me in prayers through thick and thin. I am very grateful to my darling husband Samson Olumide who embraced my yearnings and strategically supported me throughout the journey. He was my 24 hours supervisor in encouragement, in technical support when I am lost on the computer. He kept our home when I spent family time in the Uni. Sam, words of mouth cannot express my love for you, I say thank you. To my precious children, Oluwadara, Oluwafisayo and Oluwafemi, I really appreciate your support and understanding when mummy locks herself up in the study. Your words of encouragement have seen me through.

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I am grateful to all the women who participated in this study without whom this thesis would not be possible. I am grateful to them for sparing their time and for providing me with the rich data for this study.

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I am also very grateful to the Pastor and all the members of the Redeemed Christian Church of God, Restoration Assembly, Sydney for their prayers and words of encouragement.
Statement of Certification

I, Olayide Olayemisi Ogunsiyi hereby declare that the work presented in this thesis submitted in fulfilment of the requirements for the award of Doctor of Philosophy in the School of Nursing and Midwifery, College of Health and Science, University of Western Sydney to the best of my knowledge is wholly my own work except otherwise referenced or acknowledged. I certify that I have not submitted this thesis in part or fully for a degree in this or any other educational institution.

...........................................................
(Signature)
Style, notation and format of interview transcripts.

Pseudonyms are used for each participant against the direct quotes within the text. To enable the reader to dialogue with the text and facilitate understanding of the text, the transcripts have been edited. Particular attention was paid to retaining the meaning and context of the original text where words were omitted or inserted. Facilitative sounds, repetitions and hesitations used by the researcher such as ‘err’s and/or ‘umms’ have been omitted where they do not add to the meaning of the quotation.

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<td>Bold text</td>
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List of Abbreviations

- ABS: Australian Bureau of Statistics
- FGM: Female genital Mutilation
- DIMIA: Department of Immigration, Multicultural and Indigenous Affairs
- WHO: World Health Organisation
- N/n: Frequency of response
List of Publications, Conferences and Presentations

Refereed journal article:


Sent for Publication:


Conferences attended with dates

International


Australia. Royal College of Nursing Australia, Annual Conference.
Perth Western Australia, September 25-27, 2008.

National

Presentations

Abstract

Health concepts strongly influence people’s health seeking behaviour. In an increasingly multicultural Australia, the cohort of patients presenting for health care services are from cultural backgrounds that may have different concepts of health from that of the health care providers. West African immigrant women are among the recent immigrants to Australia who may have a different notion of health from the dominant western philosophy that guide health care provision in Australia. Understanding the meaning of health for these women and its influence on their health seeking behaviour will assist nurse in effective healthcare delivery.

This qualitative study explored the meaning of health and the impact of this meaning on West African women’s health seeking behaviour. Guided by constructivist assumptions, participants were recruited through the snowballing technique. Twenty-one West African women living in Australia and willing to participate in the study were engaged in face-to-face audio-taped interview. Through continuous interplay of data collection and data analysis, four emerging themes namely being healthy, being spiritual, being a migrant and encountering health care system were identified. Findings revealed that West African women’s meaning of health incorporated biomedical ideas, belief in mystical forces and the participants’ social positioning as women. The women waited for physical symptoms of illness before presenting at health care facilities. Most of them believe that mystical forces such as witches, wizards and evil eye can cause illness. Patriarchal subservient positioning encouraged by traditional African culture subjected these women to domestic violence experience and overwork. Furthermore, the study revealed that West African women’s meaning of health was the major determinant of these women’s health seeking behaviour. It determined the type of health care services used by these women.

The findings from this study demonstrate that meaning of health, migration experience and the participants’ personal experiences with the health care
system are fundamental to their health seeking behaviour. The women’s meaning of health is subjective, dynamic and it is influenced by a combination of world views. Despite a high level of educational achievement as well as occupation of most of the women, belief in higher mystical forces was a significant cultural framework supporting their explanations of health. As immigrants these women experienced isolation and they had positive and negative experiences as they encountered the health care system in their new country. Influenced by their cultural belief and their experiences of settling in a new country, these women underutilised health care services in Australia and delayed access. It is suggested that provision of health care services aimed at meeting these women’s health care needs should incorporate these women’s meaning of health to enhance their participation. Implication of the study for nursing practice and recommendation for further research were also suggested.
CHAPTER 1: INTRODUCTION

1.1 Introduction
This chapter provides an introductory background for this research. It presents my story as a West African migrant woman in Australia as well as an introduction of Africa and West Africa. The chapter identifies the aims of this study and the research question. It also presents the significance of the study and a brief outline of the structure of the thesis.

1.2 Background
Understanding the meaning of health for people, especially recent immigrants, is important in understanding their health beliefs and health seeking behaviour (Labun & Emblen, 2007; Shuster, Clough, Higgins, & Klein, 2009; Stibich & Wissow, 2006; Weerasinghe & Mitchell, 2007). Evidence suggests that the meaning of health varies from individual to individual and this meaning may be influenced by a number of worldviews (Aina, 2004; Almgren, Magarati, & Mogford, 2009; Bardin, 2002).

An individual's meaning of health shapes and is shaped by their psychosocial and cultural background (Almgren et al., 2009; Chan, Cheung, Mok, Cheung, & Tong, 2006). Thus, an individual's meaning of health is dynamic and influenced by life experience. One such life experience can be migration. Migration and resettlement has a profound effect on individuals (Bhugra, 2004; Chou, 2009; Shin, 1994; Shin & Shin, 1999). Changes of physical and cultural environment and lifestyle can influence all aspects of the immigrant's life. The migration experience and its influence on immigrant health are well documented (Chou, 2009; S. Kennedy & McDonald, 2006; Y. M. Lee, 2007; Procter, 2006). Immigrants are exposed to the stress of isolation, adapting to a new country and encountering a different health care system (Bhugra, 2004; Kennedy & McDonald, 2006; Shin, 1994; Shin & Shin, 1999). Understanding the meaning of health held by health care consumers may enable health care providers to revisit the meaning of health promotion in the context of an individual's life situation.
A person’s understanding of the meaning of health and health belief is seen as having a strong influence on their health seeking behaviour. Meaning of health determines the type of health services that are patronised or considered relevant (Hultsjo & Hjelm, 2005). It also influences the point in time when the individual presents to health services and the symptoms for which they seek medical intervention (B. O. Abiodun, 2005; Bardin, 2002; Han & Ballis, 2007).

Understanding individual perceptions of the meaning of health is important in the context of a multicultural society, such as Australia, where the cultural backgrounds of health consumers and providers differ. The importance of this health perception is reflected in the literature where the meaning of health has been explored from the perspective of a number of different groups of people; such as, the Japanese elders in the United States of America (USA) (Takahashi, Liehr, Nishimura, Ito, & Summers, 2005). There appear to be no published studies describing the meaning of health held by West African immigrant women in Australia.

Understanding the meaning of health for West African immigrant women will enhance our knowledge about how the health concepts held by these women shape and are shaped by psychosocial and cultural factors (Justo & de Andrea Gomes, 2008). Meaning of health is subjective and those subjective components may interfere with treatment compliance and adherence to medical advice (Lyyra, Leskinen, Jylha, & Heikkinen, 2009; Shuster, Clough, Higgins, & Klein, 2009). These attributes are reflected in the health service demand, continuity and persistence with the chosen treatment (Justo & de Andrea Gomes, 2008).

The provision and promotion of health cannot be improved without an understanding of the meaning of health and health seeking behaviour of health care consumers (Allicock, Sandelowski, DeVellis, & Campbell, 2008; Shuster et al., 2009). Despite this, the interrelationship of these constructs has not been explored and described for West African immigrant women in Australia. This study will address this gap in our knowledge and the findings
will provide useful insights to assist in the provision of holistic health care to this group.

1.3 My story as a West African woman in Australia
I came to this research as a West African woman, immigrant, nurse, mother and wife. I was 35 years old when I migrated from Nigeria with my three children. We joined my husband who had been in Australia for about 18 months. I obtained bachelor and Master of Science degrees in Sociology from Nigerian universities prior to immigrating to Australia and had a promising career as a Sociology lecturer. As a young child my first language was Yoruba.

As a migrant, I had difficulty in dealing with cultural differences between my country of birth and Australia. I experienced linguistic misunderstanding and had to develop practicable strategies in mothering my children. I had to retrain and learnt how to be a student in a technologically advanced country.

Through my clinical nursing, I have experienced and witnessed that care has not always been individualised as people are not always treated according to their cultural beliefs.

I acknowledge that my health belief and behaviour have changed. I recognise that my nursing training has also broadened my health perspective. On reflection, I wonder if other West African women in Australia have similar experiences to my own and felt it important in order to provide quality health care these experiences needed to be documented.

1.4 Africa: Geographical location and features
Africa is bounded by the Mediterranean Sea to the north, the Atlantic Ocean to the south and west and the Indian Ocean to the east (Ajayi, 2003). With a land area of approximately 30.3 million square kilometers, Africa occupies approximately one quarter of the world total land area (Ajayi, 2003). It is about three times the size of Europe and covers an area larger than the
North and the Central America (Ajayi, 2003; Binns, 1994). It is the most tropical of all the continents with approximately 43% of the continent lying between the tropics of Cancer and Capricorn (Ajayi, 2003; Binns, 1994; Fordham, 1972).

Africa is a continent of many countries, numerous people, languages and cultures (Idowu, 1991). The distribution of countries in Africa is shown in Figure 1 below. It is a multi-religious continent. The most practiced religions with over one hundred thousand adherents are the African traditional religions (12.3%), Christianity (45.9%), Islam (40.5%), Hinduism (0.3%), Buddhism (0.1%), Baha’i (0.2%) and Judaism (0.1%) (Isizoh, n.d.).

1.4.1 West Africa: geographical location and people

West Africa is one of the regions of the African continent. The area known as West Africa is identified by the red boundary in Figure 1. It is characterised by great length of geography, bioregions and cultures (Ajayi, 2003; Fordham, 1972). Geographically, it is located between longitude 15 degrees East and 18 degrees West and latitude 4 degrees North and 20 degrees North (Ajayi, 2003). The West African region is bounded by the Atlantic Ocean to the west and south and the Sahara Desert to the north. To the east it is bounded by the Republic of Cameroon, Adamawa, the Mandara mountains and Lake Chad (Ajayi, 2003; Fordham, 1972). West Africa lies within the tropics and its average temperature ranges between 20 to 33 degrees Celsius (Ajayi, 2003). The region extends from tropical areas with large rain forests in central Africa, through tropical and subtropical climate zones with mixed forest and grasslands in the west, along the Gulf of Guinea, to the dry Sahara Desert in the north. West Africa spans about one-fifth of the total area of Africa (Ajayi, 2003; Binns, 1994; Fordham, 1972). It has a total area of approximately 6,143,000 square kilometers (Ajayi, 2003).

The United Nations’ definition of West Africa, comprising 16 countries, is recognised in this study (Ajayi, 2003). All countries, excepting Mauritania, are members of the Economic Community of West African States (see Figure
There are many ethnic groups in the region with hundreds of languages spoken; however, each of the countries has a colonial language as their official language (Binns, 1994; Fordham, 1972).

Figure 1: Map of Africa

Source: [www.africaguide.com](http://www.africaguide.com)

1.5 Migration of West Africans to Australia

There is limited literature on the migration trend of Africans to Australia. Within the few citations, there is inconsistency in the recorded period and population of these initial African immigrants. However, migration of Africans to Australia dates back to the pre-World War II period. Most of the African born migrants arriving in Australia pre-World War II were of European origin.
These were typically individuals whose parents had previously migrated to South Africa, Zimbabwe and Kenya (B. Kennedy & Lucas, 2001; Oyelodi, 2001). There is also a large community of East Africans in Australia (Alexander, 2001). Since the 1980s there have been increasing numbers of immigrants from Eritrea, Ethiopia, Somalia and Sudan, with many arriving in Australia under the refugee/humanitarian migration category (Kennedy & Lucas, 2001; Oyelodi, 2001).

Immigration of West Africans began in the mid 1960s with the arrival of students from Ghana and Nigeria (Okai, 2001). The population of West Africans increased after the abolition of the white Australian policy to incorporate the refugees and other professionals. The majority of these West African immigrants were under 35 years of age and had tertiary education (Okai, 2001). In 1996, there were 3,077 West Africans in Australia and Nigeria and Ghana constituted the main countries of origin for these immigrants (Okai, 2001). There was no accessible data for West Africa from Australian Bureau of statistics (ABS) on 1996 census. However, according to the Australian Bureau of Statistics, the 2001 census reported that a total of 4,743 people indicated that they were originally from West Africa (ABS, 2004). The ABS (2004) reported that 1,903 were female representing 40% of the total population. The ABS record also showed that two of the English speaking countries in the region, namely Nigeria and Ghana, had the highest number of migrants living in Australia. While Nigeria had a total of 1,738 migrants, Ghana had 2,040 people living in Australia.

In the 2006 census, the population of West Africans in Australia was more than double that of the 2001 census (see Table 1). Immigrant women from Nigeria and Ghana were chosen for this study because they were the most representative West African countries of origin in Australia. Shared language between researcher and participant was English and this increased the likelihood of collecting meaningful qualitative data. Despite the increasing number of West African immigrants moving to Australia, little is known about their meaning of health and their health seeking behaviour.
A number of studies have investigated the health experiences of immigrants. Amongst these Shin and Shin (1999) studied the experiences of Korean immigrant women in the United States of America (USA) while Jirojwong and Manderson (1999) studied Thai immigrant women in Australia. However, no research has focused on the meaning of health for West African immigrant women in Australia.

Table 1
Population of West Africans in Australia 2001 and 2006

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<tr>
<th>Countries</th>
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<td><strong>Total</strong></td>
<td><strong>2,840</strong></td>
<td><strong>1,903</strong></td>
<td><strong>4,743</strong></td>
<td><strong>5,206</strong></td>
<td><strong>4,499</strong></td>
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<td>% Female</td>
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<td>46%</td>
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Source: Adapted from Australian Bureau of Statistics (2006, 2001) - Census of Population and housing cat No 2068.0 census table

1.6 Aims and research questions for the study
Understanding the meaning of health for health care consumers is pivotal to the achievement of holistic and culturally competent health care delivery in a
multicultural society such as Australia. There is a gap in knowledge about the meaning of health for West African immigrant women who are among the most recent immigrants to Australia.

This study aims to fill this gap in knowledge by exploring the meaning of health to these West African women who may have another notion of health different from the dominant western perspective in Australia. The study also aims to explore how West African women’s meanings of health influence their health seeking behaviour in Australia. West African immigrant women in this study refer to first generation migrant women from Ghana and Nigeria who are currently living in Australia.

The research questions for this study are:
What is the meaning of health for West African women in Australia?
How does West African immigrant women’s meaning of health determine their health seeking behaviour in Australia?

1.7 Significance of the thesis
This study has the potential to contribute to nurses' knowledge about the meaning of health for immigrants, specifically West African women who resettle in Western countries. The health care provision in these countries is based on a Western conceptualisation of health. As a result of this assumption, the meaning of health for immigrants to these countries, are rarely studied or understood in the provision of health care for these immigrants. The provision of health services for these immigrants may not be informed by adequate understanding of what these immigrants consider as health care needs and consequently the health care needs of these immigrants may not be met. This may then result in a waste of public funds, immigrants' dissatisfaction with health services and an underutilisation of health care resources.

This study proposes to provide an avenue for health care professionals in Australia to extend their knowledge base about the meaning of health for
West African women. This knowledge may improve the quality of care provided to these women.

This study also advocates the provision of holistic health care. This incorporates all aspects of care including physical, psychosocial and spiritual (Ernst, 2007; Phillips, 1996; B. Taylor, 2003). Whilst health care literature currently identifies the need for the provision of holistic health care, there remains a paucity of literature that links holistic care to the health care needs of immigrants and minority groups. In order to meet these health care needs, it is important for health care providers to understand the meaning of health for those health care consumers from non-Western backgrounds. In a multicultural society, the frequency of contact between health care consumers from non-Western backgrounds and health care providers will inevitably increase. Understanding these consumers’ meaning of health will provide valuable knowledge about their health and illness beliefs, which have rarely been studied (Hjelm, Nyberg, Isacsson, & Apelquist, 1999).

Currently there appears to be no scholarly evidence of an understanding of West African women’s meaning of health. Health provision for these women has been informed by the dominant biomedical model, which typically informs health provision policy in Western countries, such as Australia. Exploring the meaning of health for West African women is significant for a number of policy frameworks.

Understanding immigrants’ meaning of health, health beliefs and health seeking behaviour is crucial for health care policy. This understanding may inform the formulation of health policies, programs and interventions that will be culturally acceptable to these immigrants. Exploring the meaning of health for immigrant women, specifically West African women in Australia may also provide opportunities for these immigrants to narrate their immigration experience. Understanding these women’s immigration experience may inform the development of immigration policy and other interventions that will ameliorate the difficulties experienced by immigrants in their new countries.
This study is significant to the society. Understanding these West African women’s meaning of health may inform the provision of health information that may lead to health promoting behaviour. When these women adopt health-promoting behaviours, their health status in Australia will be enhanced. Not only is these women’s health promoted, their family’s health is improved considering women’s role as care givers and society’s health at large is improved. It is now important to present the structure of this thesis.

1.8 Structure of the thesis
This thesis is divided into seven chapters. Chapter one provides the introductory context for the thesis. It focused on the background to the study, presented my story as a West African woman living in Australia and introduced the geographical location and people of West Africa. The aim of the study and research question, the significance of the study and its structure has also been provided in Chapter One.

Chapter two presents a review of literature relevant to the meaning of health, meaning of health to West African women and the general notion of health seeking behaviour. A review of relevant literature on migration and migration issues is also presented.

Chapter three focuses on the study methodology. The naturalistic paradigm described by Lincoln and Guba (1985) and Guba and Lincoln (1989) was chosen to guide this study. The rationale for the choice of naturalistic inquiry and the associated methodology are presented. Furthermore Chapters Four and Five present the findings of the study and emerging themes.

Chapter six discusses the findings as they relate to the reviewed literature, data collected from the women and my own pre-understandings. It also explores the implications of these results for the participants, social policy makers, health care and health professionals. Drawing on conclusions, recommendations for further research are tendered. Chapter Seven
summarises the study, presents the implications and gives recommendations for further studies.

1.9 Summary
This chapter has provided background information and an overview to this study. It is important to identify the position where this study is situated in the literature. Chapter two is focused on the review of relevant literature to this study.
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction
This chapter presents an overview of significant aspects of the literature relating to the health experience of people living outside their countries of origin. Generic aspects of literature on the meaning of health and the meaning of health for West African women are presented. Available resources on health belief, health seeking behaviour and migration are also reviewed.

2.2 Meaning of health
A review of the literature revealed that rather than proffering definitions of health, a significant number of studies attempted to provide a deeper understanding of health (Aina, 2004; Kaddour, Hafez, & Zurayk, 2005; Labun & Emblen, 2007; Weerasinghe & Mitchell, 2007). Evidence suggests that there is no common view about the meaning of health (Aina, 2004; Kaddour et al., 2005; Labun & Emblen, 2007; Weerasinghe & Mitchell, 2007). It varies from individual to individual and this meaning may be influenced by a number of worldviews (Aina, 2004; Bardin, 2002; Kheong, 2003; K. M. King, 2000). Worldviews of health are described through a number of models: these include the biomedical model (B. O. Abiodun, 2005; Bardin, 2002; Kheong, 2003; T Koch, Webb, & William, 1995), the behavioural model (Doyal, 1996; Ghaddar, Shamseddeen, & Elzein, 2009; Weissman, 1998; Weitz, 1996) and the socio-ecological model (Marshall & Altpeter, 2005; McCarthy, Ruiz, Gale, Karam, & Moore, 2004; Swanson & Wonjar, 2004). It can also be explained from a gendered perspective (Keskinoglu et al., 2007; K. M. King, 2000). Even though these major worldviews of health may not adequately explain the meaning of health held by all groups of people, they provide a convenient baseline for understanding people’s understanding of health.

2.2.1 The biomedical approach
The biomedical approach focuses on health as the absence of illness or disease (Ivanitz, 2000; Morgan, Calnan, & Manning, 1993; Tetrick, 2002). It offers a scientific explanation of health and takes into account the physical manifestation of illness (Ahmed, Kolker, & Coelho, 1979; Engel, 1977; Ivanitz,
2000). Based on the Cartesian dichotomy between mind and body (Lock & Scheper-Hughes, 1996), the body is perceived as part of a natural world, and diseases are presented entirely as physical entities occurring in specific locations of the body (Balog, 2005; Ivanitz, 2000). This model’s primary emphasis is around the physiological disease process and curing diseases through scientific management of symptoms (B. O. Abiodun, 2005; Bardin, 2002; L. Bennett & Duke, 1995; Han & Ballis, 2007; Kheong, 2003). Thus, biomedical notions of health concentrate on disease and illness rather than health (B. O. Abiodun, 2005; Bardin, 2002; Bell, 2000; Hummelvoll & da Silva, 1994), with the focus being on the level of exposure to germs and conditions that expose people to infection (Cockerham, 1978; Marks & Worboys, 1997). Kermode (2004) observed that within the biomedical model, “health outcomes are measured by default- by apparent reductions in disease and illness” (p.3). Through its scientific approach, it has been argued since the 1960s and 1970s that treatments are initiated for the unhealthy patients with a focus on disease and system pathology (B. O. Abiodun, 2005; Bardin, 2002; Bell, 2000; Hummelvoll & da Silva, 1994). This is a very narrow approach to health and precludes a broader and deeper understanding of health.

Even so, the biomedical approach constitutes the dominant model guiding health provision. The substantial decline in the death rate, which coincided with the spread of this approach in 19th century Europe and the specific aetiology theory of disease, added credibility to the effectiveness of this model (Ahmed et al., 1979; Engel, 1977; Morgan et al., 1993). It was particularly recognised and distinguished from previous approaches in terms of its effectiveness in controlling disease and improving the health of people. It was documented that between 1851 and 1971 the death rate in England and Wales declined from 22.7 per 1000 people to 12.5 per 1,000 people (McKeown, 1979). Seventy-six percent of this decline was due to a reduction in mortality from infectious diseases (Ahmed et al., 1979; Engel, 1977; Morgan et al., 1993).

The biomedical model not only gained recognition in the clinical knowledge of disease, its dominant role in the academic study of disease was also noted in
the literature (Ahmed, Kolker & Coelho, 1979; Tetrick, 2002). The successful causal link between germs and disease was considered the most significant singular idea in the history of medicine (Ahmed et al., 1979; Tetrick, 2002). Twaddle and Hessler (1977) considered this achievement as the greatest weapon in the battle against disease. This emphasis on immunisation and treatment was generally acclaimed as the beginning of an era of optimism in which it seemed possible to eradicate all illness of mankind (Ahmed et al., 1979; Engel, 1977; Morgan et al., 1993; Twaddle & Hessler, 1977).

Despite the recorded achievements and dominance of the biomedical model of health, its assumptions have been criticised for a number of reasons (Ember & Ember, 1985; Engel, 1977; Helman, 2000; Levin & Browner, 2004). Firstly, this model has been increasingly criticised for not giving adequate consideration to socio-psychological dimensions of health and illness (Bardin, 2002; Bell, 2000; Helman, 2000; Kheong, 2003; Milford, Kleve, Lea, & Greenwood, 2006). Secondly, it is also criticised for its “quick fix” approach to treatment (Ahmed et al., 1979; Helman, 2000; Morgan et al., 1993). To be free from sickness does not connote health (Perry & Woods, 1995). Thirdly, it is criticised for being gender biased (Rogers, 2004). More holistic studies have shown that influences, such as behaviours, socio-cultural background, gender, and life experiences underlie the meaning of health.

**2.2.2 The behavioural approach**

The behavioural approach argues that lifestyle issues and behavioural factors influence people’s health (Beech, 2000; Kaplan, 1985; Kelly & Maloney, 1992; Piko & Kopp, 2004; Stefansdottir & Vilhjalmsson, 2007; Wallace & Tennant, 1998). This approach emphasises that human behaviour is complex and these behaviours must be understood to maintain and improve people’s health (Stefansdottir & Vilhjalmsson, 2007; Wallace & Tennant, 1998). Proponents of this approach identified behaviours including smoking, drinking, and drug-abuse as destructive behaviours that are detrimental to health (Beech, 2000; M. P. Kelly & Maloney, 1992). As such, this approach contended that certain cognitive behavioural changes are crucial in
maintaining health (Kaplan, 1985; Piko & Kopp, 2004; Stefansdottir & Vilhjalmsson, 2007).

The behavioural approach considers health as a group concern rather than that of individuals alone (Beech, 2000; M. P. Kelly & Maloney, 1992). There are empirical studies that suggest that people’s health behaviour impacts on people around them (Boye et al., 2001; Myrin & Lagerstrom, 2006). Boye et al (2001) utilised the General Health Questionnaire and the Perceived Family Burden Scale to explore the relationship between relatives’ distress and patients’ symptoms and behaviours. This Norwegian study focused on 50 relatives who maintained close contact with 36 patients hospitalised for schizophrenia. Findings showed that the relatives’ distress was related to their account of the behaviours displayed by patients. These relatives explained that they had limited time for rest and leisure. They had to take time off from work to visit family members and often suspended tasks to attend to their unwell relative’s needs. These relatives were always anxious about the mental health status of their family members.

Although the behavioural approach has enhanced the understanding of the concept of health by making reference to collective responsibility, it was criticised for undermining the experience of suffering that illness may bring on the affected individuals (Brady, Kunitz, & Nash, 1997). Family members and others closely involved with a patient may be sympathetic but may not fully comprehend the exact level of pain experienced by that person. The behavioural approach has also been criticised for its tendency to raise “scapegoats” responsible for the society’s predicament (Brady et al., 1997). Nevertheless, it has broadened our knowledge that behaviours may have a significant impact on health. This is of particular concern in sexually transmitted diseases like HIV/AIDS (Bardin, 2002; Bell, 2000).

2.2.3 The socio-ecological approach
The socio-ecological approach emerged as a result of the recognition that health is a product of cultural and social conditions. Proponents of this perspective perceived health as a social construction, whereby ill health is
believed be a result of poor social conditions (Marshall & Altpeter, 2005; McCarthy et al., 2004; Swanson & Wonjar, 2004). This social ecological model advocated proactive social and political intervention, instead of dealing with illness after its occurrence (Marshall & Altpeter, 2005; McCarthy et al., 2004; Swanson & Wonjar, 2004). Sociologists, who were the main advocates of this perspective, were especially interested in exploring how different societal groups define health and illness and sought to understand how social forces moulded differences in people’s health.

Even though the socio-ecological approach contributes to the understanding of health, it does not take into account inherited medical conditions and other factors unrelated to social circumstance which may have a tremendous impact on health. This gives weight to the argument that a multifocal view of health may provide a deeper understanding of the concept (Bardin, 2002; Bell, 2000; E. B. Daly, 1995; Swanson & Wonjar, 2004).

2.2.4 The gendered notion of health

The emergence of the women’s health movement in the 1960s and the growth of feminist theory presented a significant challenge to the biomedical model of health (McCool, Smith, & Alberg, 2004; Zimmerman & Hill, 2000). The women’s health movement, while actively questioning and confronting medical assumptions and practices, offered an alternative pattern of conceptualising health. This movement observed and challenged the male dominance in medicine (Weissman, 1998). The argument central to the women’s health movement was that the dominant biomedical model of health care significantly contributed to the overall inadequate health care for women (R. L. Johnson, 2005; McCool et al., 2004; Nichols, 2000). The biomedical model considered male and female as discrete biological categories while the feminist movement introduced the notion of gender to our understanding of health by considering male and female as social constructs (Sabo, 1999; Sabo & Gordon, 1995).

The gendered notion of health has been variously criticised (Brancati, Kao, Folsom, Watson, & Szklo, 2000; Peckover, 2002). It is criticised for
undermining the biological gender differences in health experiences that are not social constructs (Brancati et al., 2000; Khaw, 1993). Reference has been made to the biological differences in experiences with certain chronic diseases like type 2 diabetes mellitus (Al-Nozah et al., 2002; Brancati et al., 2000) and cardiovascular diseases (Khaw, 1993; Sartori-Valinotti, Iliescu, Fortepiani, Yanes, & Reckelhoff, 2007; Stoney, Davis, & Mathews, 1987). However, this approach is relevant to this current study as West African women’s perception of health may be due to their social construction as female, which may also be informed by their cultural background.

2.2.5 Cultural notion of health
Proponents of the cultural meaning of health argue that culture has a significant influence on health beliefs and health-related behaviours (Kwok & Sullivan, 2006; Lynam, Browne, Kirkham, & Anderson, 2007; Spector, 2000). A number of studies have explored the role of culture in shaping the meaning and conception of health and the associated health practices of immigrant populations (Banks-Wallace & Parks, 2004; Bito et al., 2007; Hsiao, Klimidis, Minas, & Tan, 2006; Kwok & Sullivan, 2006; Papadopoulos, Guo, Lees, & Ridge, 2007; K. M. Russell & Shedd-Steel, 2003). Findings of these studies revealed that traditional cultural beliefs and practices influenced health behaviours, and practices in the migrants’ new country reflected the culture’s enduring characteristics (Lynam, Browne, Kirkham, & Anderson, 2007).

2.2.6 Contemporary contribution to the meaning of health
Modern philosophers like Heidegger (1889-1976) and Gadamer (1996) have also added to our understanding of health by suggesting that meaning is subjective. They argue that the meaning that something has for one individual may vary from that of another person. Gadamer (1996), a German philosopher, attempted a hermeneutic exploration of the nature of health over a period ranging from 1963 to 1996 and described health as a puzzle, which in certain ways escapes the objectifying scientific method. He alluded to the nature of health as sustaining its own proper and natural balance. Gadamer (1996) emphasised that the reason why all aspects of health cannot be measured is because it is a condition of harmony with oneself that cannot be
overridden by external patterns of control. It is important to understand the meaning of health for West African women in order to understand their health experience and health care needs in Australia.

2.2.7 Understandings of the meaning of health for women in West Africa

The meaning of health influences opinions of and interaction with the health care system (Abrums, 2000; K. M. Russell & Shedd-Steel, 2003). Understanding the meaning of health for West African women can potentially enhance the knowledge of their health care behaviour and dealings with the dominant biomedical health care system in Australia. It is important to understand the meaning of health for these immigrant women as their notion of health may affect their self-reported care-seeking and self-care practices (Hjelm et al., 1999). As emphasised by Heidegger (1889-1976), meaning “is that from which something is understandable as the thing it is” (M. King, 1964, p. 6). According to Heidegger, it is the world that somebody belongs to and the associated background worldview that constitutes the framework in knowing what something means (Heidegger, 1962).

African philosophy asserts the existence of two interwoven and inseparable, yet distinguishable, worlds of the spirits and humans (B. O. Abiodun, 2005; Aworeni, 1998). The Akan tribe of Ghana for example classified the spirit world as consisting of the Supreme God “Onyame”, divinities or gods, ancestors and charms or amulets (Larbi, n.d.). African traditional belief recognises the multiplicity of spirits serving different purposes in maintaining stability of various organs of the body and that the way the humans relate to the spirit force determines their health and wellbeing (Larbi, n.d.).

A number of scholarly works have focused on the meaning of health for Africans (Ademuwagun, 1978; Gbadegesin, 1991). Like most people, to be healthy or well for the Yorubas of Nigeria is to be able to attend to daily activities and have a strong mind and body (Ademuwagun, 1978; Gbadegesin, 1991). The traditional African belief acknowledges the mind/matter duality within which the body, mind and spirit are considered to
be distinct. However, the interrelationship among body, mind and spirit are integral aspects of health (B. O. Abiodun, 2005; Kheong, 2003). To be healthy is to have a strong body, “iler”, and to be unhealthy is to have a weak body “ailera” (B. O. Abiodun, 2005, p.215). The body, to the Yorubas does not refer to the physical body alone but it consists of the “soul, spirit and psyche” (Gbadegesin, 1991, p. 127). Their notion of health “alaafia” means more than physical health. It “refers to a person’s, physical, social, psychological and spiritual wellbeing” (Ademuwagun, 1978, p. 89-97). This notion of health is similar to the World Health Organisation (WHO) (1946) definition of health. To be unhealthy or unwell means a breakdown in one’s physical, psychological or spiritual well-being. Illness connotes a situation of imbalance in the order of nature of one’s whole existence and to be healthy means a balance in the nature of the person’s whole existence (B. O. Abiodun, 2005).

A significant observation from the literature was that patients were referred to in the African worldview as being ill rather than having a disease, because of the belief that there is no disease in their bodies (B. O. Abiodun, 2005; Abrums, 2000; Gbadegesin, 1991; Sogolo, 1983). These scholarly works identified traditional African perspective of illness causation from the natural and supernatural point of view (B. O. Abiodun, 2005; Bichmann, 1979; Gbadegesin, 1991). Treatment and medicinal knowledge is a reflection of the African dualistic worldview whereby a combination of traditional healers, “doctors” (herbalists) and diviners are used. The traditional doctors have extensive knowledge of herbs, plants, roots and herbal medicine, however the diviners are the spiritual medical personnel who are experts in accessing the secret of spiritual forces and medicinal use of herbs (Gbadegesin, 1991).

2.2.8 Meaning of health for African women

The meaning of health for immigrant West African women is largely invisible in scholarly work however there is some literature, which focuses on the meaning of health for African women. Most of the studies that have explored the meaning of health for African women focus on the meaning of infertility for
African women living in Africa (O. A. Abiodun, Adetoro, & Ogunbode, 1993; Okonofua et al., 2005; Richards, 2002). According to the literature, infertility means disrespect, shame, considerable social pressure and matrimonial insecurity for African women (O. A. Abiodun et al., 1993; Okonofua et al., 2005; Richards, 2002). In many traditional African cultures, motherhood is the main avenue for women to obtain high social status and respect (O. A. Abiodun, Adetoro, & Ogunbode, 1993). By bearing children, the African woman guarantees the continuity of the community as well as the immortality of the parents and ancestors whose descendants would remember them (Christian, 1994). This demand places considerable pressure on infertile women and presents some stressors when pregnancy is delayed (Waszak, Severy, Kafafi, & Badawi, 2001).

Richards (2002) utilised epidemiological literature and qualitative interview data to explore the meaning of infertility and treatment choices for women in the Republic of Cameroon. Drawing participants from church groups, youth groups and the community, fourteen group interviews were conducted. For the participants in this study, infertility meant inability to have a child at the time one wants, which they attributed to contraception, abortion and spiritual forces like witches, wizards and evil eyes. The findings reported that the participants believed that jealous female relatives like the husband’s sister or co-wife can “eat their fetus” thereby preventing conception or bringing about abortion (S. C. Richards, 2002).

Similar findings were reported in a Nigerian study that explored the meaning of infertility (Okonofua, Harris, Odebiyi, Kane, & Snow, 1997). This qualitative study was part of a larger study of 1,200 married women aged 15-45 years drawn from rural and urban parts of the Ile local government area, Nigeria. The published article was the result of 25 follow-up focus group discussions with key informants, comprising 105 women and 118 men. Though this published aspect of the study was not exclusive to women, findings provided insight into one aspect of the meaning of health for African women. Findings showed that infertility is not usually discussed and when discussed it is done with caution and privately. The groups believed that witches were mostly
responsible for infertility. The common consequence of infertility was reported to be expulsion of the woman from the matrimonial home with or without divorce (Okonofua et al., 1997).

There is limited published information on other aspects of African women’s meaning of health. One of the few studies focused on the meaning of reproductive-organ disease for rural Gambian women in West Africa (B. O. Abiodun, 2000; Walraven et al., 2001). Using questionnaire method to gather information from 1,348 women between the ages of 15-54 years, findings showed that the experience of reproductive-organ disease for these women meant a loss of matrimonial security (Walraven et al., 2001). In this rural African setting where women had limited education and little access to formal paid employment, they relied on their fertility and the number of children they had for strength, and these children constituted their assets. Having a diagnosis of reproductive-organ disease caused a great burden on every aspect of their lives. Also, the woman’s position both in the community and the family became insecure because of such diagnosis. (Walraven et al., 2001).

Similarly, a study conducted in South Africa on the meaning of health for women experiencing HIV/AIDS (Motsemme, 2007) utilised a socio-historical approach to portray how people’s social positioning may influence the meaning they attach to issues that pertain to their health. These women, informed by their previous experience of displacement, perceived sex as a way of maintaining a feeling of meaning in life in meaningless and hopeless situations. For these women, sex created a sense of empowerment and they used their bodies as agents in sustaining hope in life.

Stevenson, Fitzgerald and Banwell (2007) in a study of East Africans living in Australia did not specifically focus on women; however, offered insight into the meaning of health for Africans in Australia. Findings showed that chewing of Khat (Catha edulis), a restricted stimulant in Australia, has a different meaning to the East Africans. It is traditionally used in religious devotions and constitutes a medium of social integration. As a result of the meaning that
these Africans attached to the chewing of Khat, they do not regard it as hazardous to their health (Stevenson et al., 2007).

In summary, no singular explanation can adequately explore the meaning that health has for people. The biomedical, behavioural, socio-ecological, gender considerations and modern philosophers have all enhanced our understanding of the meaning of health. These approaches revealed that meaning of health varies with people and from one culture to another. The meaning of health for West African women in Australia is not well documented in scholarly literature. In order to pursue the meaning of health for West African women in Australia, it is also important to explore the major theories of health seeking behaviour, and the link between meaning of health and health seeking behaviour.

2.3 Health seeking behaviour

Understanding health seeking behaviour enhances the knowledge of people’s health experience and reduces delay in diagnosis. It improves treatment and compliance as well as assists in developing health education strategies (Shuster et al., 2009; Steen & Mazonde, 1999). Despite this importance, conceptual clarification of health seeking behaviour is not clear in the literature as it is sometimes used interchangeably with health behaviour (Adeoye, Ogbonnaya, Umeorah, & Asiegbu, 2005; K. S. Johnson, Elbert-Avila, & Tulsky, 2005; Peltzer & Ajegbomogun, 2005). Studies on health seeking behaviour explore people’s behaviour towards their health, which is reflected in their interaction with the health care system (Khan & Pillay, 2003; MacKian, 2003).

In understanding people’s interaction with the health system, researchers ponder on factors that enhance the use of health services, and issues that may explain different actions taken by people in different situations concerning their health (Khan & Pillay, 2003; MacKian, 2003; Peltzer & Ajegbomogun, 2005). Tipping and Segall (1995) attempted to categorise various studies that focus on those concerns about facilitators of health services and determinants of health behaviour. According to Tipping and
Segall (1995), while some studies approached these concerns by considering actions taken by people when they become ill (health care seeking behaviour), others approached the debate by focusing on the actions taken by people in maintaining their health (health behaviour). These two categories and their major assumptions are presented below.

2.3.1 Health care seeking behaviour

Studies on health care seeking behaviour focus on the level of people’s interaction with the health care system when they become ill (Foley, 2005; Khan & Pillay, 2003; Wessel et al., 2004). The studies analyse people’s utilisation of health services with greater tendency towards promoting the use of Western health services and discouraging self-care and alternative health services (Foley, 2005; Ortiz, Arizmendi, & Cornelius, 2004; Sword, Watt, & Krueger, 2006; Wessel et al., 2004). Tipping and Segall (1995) however, observed that the decision to utilise a particular medical outlet is determined by a complexity of socio-economic variables like gender, age, culture, people’s social status, the type of illness, access to available services and perceived quality of the services.

In making decisions about their choice of health service provider, people consider the barriers in accessing the health services (Foley, 2005; Ngom, Debpuur, Akweongo, Adongo, & Binka, 2003; Sword et al., 2006). These barriers, which may be social, geographical, organisational or financial are then assessed before the perceived most accessible channel is utilised (Foley, 2005; Ngom et al., 2003; Tipping & Segall, 1995). Access issues are a significant aspect of the choice made by people in their health care seeking. Penchansky and Thomas (1981) described access as the combination of affordability and accessibility.

Health service choice may be formal, Western medicine, or informal, traditional medicine, or a combination of Western and traditional health care. This pattern of health care choices, according to Tipping and Segall (1995), may suggest the increasing attention towards complementary and alternative medicine. It is important to understand the issues involved in people’s health
care seeking behaviour as the West African immigrant women in Australia may prefer an alternative health care channel different from the formal, Western health care predominant in Australia.

2.3.2 Health behaviour

The concept of health behaviour did not attain a high level of significance until the twentieth century (Armstrong, 1988). The term "behaviour" was used to portray some uniqueness in the movement of living things, but there was no conceptual connection between behaviour and health until the nineteenth century (Armstrong, 1988). Even after the linkage, early development and usage of the term were not conceived conceptually but only served as a broad envelope for all behaviour related to health and illness (Armstrong, 1988). However, Kasl and Cobb (1966) attempted a conceptual clarification of health behaviour by differentiating health behaviour from illness and the sick-role behaviour. Health behaviour then became equivalent to preventive behaviour in as much as it consists of utilisation of health care services for the assumed purpose of upholding one’s health and avoiding the effects of illness (R. Anderson, 1988).

A number of theories and models have been developed in understanding health behaviour. The most popular of these are referred to as the cognitive theories.

2.3.2.1 Cognitive theories of health behaviour

The cognitive theories and models, which explain health behaviour, emphasise “individual cognition and reflection” (Conner & Norman, 1996, p. 179). These theories are generally described as learning theories with the argument that learning a new and seemingly complicated pattern of behaviour like changing from a deskbound to an active lifestyle, or quitting smoking, usually demands a modification of some aspects of the previous lifestyle (Eakin et al., 2007; Munro, Lewin, Swart, & Volmink, 2007; Noar & Zimmerman, 2005). These entire learning theories centre around assumptions that before lifestyle changes occur, certain decision trails take
place within the individual (M. H. Becker, 1974; Gebhardt & Maes, 2001; Rosenstock, 1974; Stroebe, 2000).

There are assumptions that attitudes and beliefs, in addition to the expectations of future actions and outcomes, are important aspects of the decision trail and crucial determinants of health related behaviour (Gebhardt & Maes, 2001; Stroebe, 2000). There are a number of cognitive theories but only those considered relevant to this study, will be presented. These are the “health belief model”, “the theory of reasoned action or theory of planned behaviour”, and “the social cognitive theory”.

2.3.2.1.1 Health belief model
The health belief model proposes that before a person adopts a health promoting behaviour, a rational assessment of the balance between the barriers and benefits of action is assessed (M. H. Becker et al., 1979; Blackwell, 1992). This model explains that the individual will consider the seriousness of a potential illness, the risk of contracting that illness, or the level of susceptibility to that illness (Armitage & Conner, 2000; Champion & Menon, 1997; Strecher & Rosenstock, 1997). The individual will also consider the difficulties or barriers in taking up the healthy action and then assess the benefit of adopting the healthy lifestyle (Armitage & Conner, 2000; Champion & Menon, 1997; Strecher & Rosenstock, 1997).

The health belief model is illustrated in the following story adapted from the literature (Davidhizar, 1983; Roden, 2004): Mrs Nuggett is contemplating quitting smoking (health enhancing action) following her doctor’s advice regarding the increased risk of smokers developing lung cancer. Mrs Nuggett will consider the seriousness of lung cancer (perceived severity) and will consider her risk of contracting lung cancer - her father was a smoker and he died of lung cancer (perceived susceptibility). The health belief model also suggests that Mrs Nuggett will further consider the difficulty in quitting smoking: she works in a tobacco company, her husband is a smoker and most of her friends are smokers (perceived barriers). She will also consider what she will gain by quitting smoking; a healthy life (perceived benefits).
Thus, according to the assumptions of the health belief model, if the perceived severity, the perceived susceptibility and perceived barriers are higher than the perceived benefits, Mrs Nuggett will not quit smoking. However, if the perceived severity and susceptibility are high, but the perceived barriers are low and the perceived benefits are high, she is more likely to quit smoking.

This model has been extended to incorporate self-efficacy, that is an individual must also have a certain level of confidence in his or her ability to adopt the healthy behaviour (Rosenstock, Strecher, & Becker, 1988; Strecher & Rosenstock, 1997). It is also suggested that the individual needs prompting as in the case of Mrs Nuggett. Mrs Nuggett may need periodic prompting to avoid social outings with smokers as these may compromise her resolve to quit smoking.

The health belief model has been used in a number of studies to predict people’s health behaviour (Sapp & Weng, 2007; Yarbrough & Braden, 2001) and in explaining health related actions (Yarbrough & Braden, 2001). It has been widely used to explore people’s preventive health behaviours, risk behaviours and sick-role behaviours (Sapp & Weng, 2007; Sullivan, Pasch, Cornelius, & Cirigliano, 2004; Yarbrough & Braden, 2001).

This model has been used to study immigrant women particularly in relation to their breast screening behaviours: Chinese American women in USA (Lee-Lin et al., 2007); Filipino, Chinese and Asian-Indian women in USA (Wu, West, Chen, & Hergert, 2006) and South Asian immigrant women in Canada (Ahmad, Cameron, & Stewart, 2004). However, the application of this model to the health behaviour of West African women in Australia is not discussed in the literature. The women’s perception of different chronic diseases, their susceptibility to these diseases and willingness to adopt health related behaviours in Australia are yet to be explored.

The health belief model has been criticised for its inconsistency in predicting behaviours (McKenna & Horswill, 2006; Yarbrough & Braden, 2001). It was
criticised for over-emphasising the individual decision making process without recognition of the societal factors that may be beyond an individuals' control (Bandura, 2000; Munro et al., 2007). However, it is considered relevant for this study, as the West African women in Australia may need to adopt some health enhancing behaviour, and it is important to know their health behaviour pattern when developing health interventions for these women.

2.3.2.1.2 Theory of planned behaviour
The theory of planned behaviour is a modified version of the theory of reasoned action developed by Ajzen and Fishbein (1980). The major assumption of this theory is that the highest determinant of behaviour is the person’s intention to engage in the behaviour. This intention may be in terms of the person’s readiness or willingness to perform the given behaviour (Lautenschlager & Smith, 2007; P Norman, Armitage, & Quigley, 2007). The intention is the cognitive representation of a person’s preparedness to perform a particular behaviour (Ajzen, 1988, 1991). This intention is in turn determined by the behavioural, normative and control beliefs that influence health behaviours. The behavioural belief relates to a person’s attitude towards the behaviour, which is reflected in an overall positive or negative evaluation of the behaviour. The normative belief however, is concerned with the person’s perception of social pressure from significant others to perform the behaviour while, the control belief is about the person’s perception of control over performing the behaviour (Ajzen, 1991).

The proposition of this theory is that a person’s intention can be predicted from his/her attitudes, the subjective norm of the significant others and perceived control over the behaviour (Ajzen, 1988, 1991; Lautenschlager & Smith, 2007; Norman et al., 2007). The argument that social norms are of little importance in determining people’s intentions to engage in health-related behaviour is a criticism of this theory (Godin & Kok, 1996). However, studies grounded in this model show that perceived normative expectations, particularly perceived expectations of significant others, affect health behaviour (Bissonnette & Contento, 2001; Fila & Smith, 2006). This is of relevance to this study as African culture may require West African women
seeking approval from their husbands before seeking health care (Ilika, Okonkwo, & Adogu, 2002).

2.3.2.1.3 Social cognitive theory
Social cognitive theory developed by Bandura in 1977 suggests that a number of environmental and personal factors affect an individual’s ability to adopt health-promoting actions (Bandura, 2000; Munro et al., 2007). Central to the social cognitive theory is the concept of self-efficacy (Bandura, 1997). Similar to the health belief model, social cognitive theory’s notion of self-efficacy suggests that an individual must trust his or her own ability to bring about a behavioural change. Other factors, such as positive expectations outweighing negative expectations; and high value for the outcome of the behavioural change, are also considered as important for adopting a behaviour that is health enhancing (Bandura, 1997, 2000).

The proponents of social cognitive theory argue that self-efficacy is the most important ingredient for a person to change from health damaging behaviour to health promoting behaviour (Bandura, 1997, 2004). This theory emphasises that other factors such as the importance that people put on benefits of healthy behaviour only manifest out of a person’s perception of his or her own capability. It further suggests that efforts at developing people’s self-efficacy are important in interventions for behavioural change (Bandura, 1997, 2004). Self-efficacy can be enhanced through the provision of opportunity for skill development, training or through modelling of expected health behaviour (Munro et al., 2007).

2.4 Understanding migration issues
The reasons for people’s movement and settling in another place are used to classify different types of migration (Bhugra, 2004; Chikanda, 2005; Mejia, Pizurki, & Royston, 1979; Ottosson, 2000; Socialstryrelsen, 2003; Thomas, 2006). These reasons may be referred to as either "pull" (as in the case of skilled migrants) or "push" (as in the case of refugees) factors (Bhugra, 2004; Kline, 2003; McHugh, 1984; Mejia et al., 1979). The "push" factors are
generally prevalent in the sending or donor countries, while the "pull" factors are present in the receiving countries. Both of these forces operate to bring about migration given the absence of other constraints such as legal issues (Browne, 1991; Chikanda, 2005; Peixoto, 2001; Pryce, 2000; Stockdale, 2002).

2.4.1 "Pull"-induced migration

"Pull" factors generally inspire people to choose to leave their countries of birth because they recognise better opportunities elsewhere (Browne, 1991; Chikanda, 2005; McHugh, 1984; Thomas, 2006). People who migrate as a result of the "pull" factor do not leave their cultural heritage, values and beliefs behind them. Rather, these beliefs are taken along and cherished often with the hope to return to their home countries after accomplishing their goals (Bhugra, 2004; Hultsjo & Hjelm, 2005; Ottosson, 2000; Stockdale, 2002).

A notable example of "pull"-induced migration is the movement of skilled professionals (both men and women) such as engineers, information technology experts and accountants (Buchan & Sochalski, 2004; Chikanda, 2005; Kingma, 2001; Peixoto, 2001; Pryce, 2000; Thomas, 2006). The literature suggests that professional development not attainable in the skilled professional's current job, job security, and stronger socio-political factors in the receiving countries, serve as "pull" factors for the professional's movement (Buchan & Sochalski, 2004; Chikanda, 2005; Kingma, 2001; Thomas, 2006).

Two studies on migrating nurses: Thomas (2006) in India and Chikanda (2005) in Zimbabwe explored the "pull" factors that explained these Indian and Zimbabwean nurses' migration to western countries. Findings from these studies showed that the desire to save money quickly, search for professional development and dissatisfaction with the prevailing working conditions prompted the nurses in India and Zimbabwe to migrate. Typically nurses migrate to countries like Australia, United Kingdom, Ireland and U.S.A. Nurses constitute one of the categories of skilled migrants and West African women may have similar or other reasons for migrating to Australia.
Another aspect of "pull"-induced migration is therapeutic migration. Here people migrate because of perceived climatic advantage in another country. Perceived climatic advantage may enhance the healing of certain diseases (Bryder, 1996). An example of this is the movement of Britons with tuberculosis to Australia and New Zealand between 1880 and 1914 (Bryder, 1996). However, this is not as common today as prospective migrants are assessed as being in good health.

2.4.2 "Push"-Induced migration

"Push" factors drive people to migrate because of a feeling of rejection. This migration occurs when individuals perceive that they reject their home country or when they perceive that their country rejects them (Browne, 1991; Petersen, 1958; Pryce, 2000; Wiseman & Roseman, 1979). They may lament over the circumstances in their countries of birth that make migration desirable (Kline, 2003; Robertson et al., 2006) and may welcome another opportunity to begin again in another country (Chikanda, 2005; Kingma, 2001; Kline, 2003; Robertson et al., 2006). Other "push" factors may be in the form of concern for personal safety, as in the case of countries where HIV/AIDS has significantly high prevalence (Chikanda, 2005; Kingma, 2001; Kline, 2003). People in this category may not want to return to their countries of origin, or it may not be feasible to return to their countries of birth (Browne, 1991; Chikanda, 2005). Examples of people in this situation is the relocation of displaced people after World War II (Browne, 1991; Litz & Gray, 2002) or refugees from more recent conflicts (Bhugra, 2004; Robertson et al., 2006).

Other types of "push"-induced migration include forced migration (Browne, 1991; Petersen, 1958; Wiseman & Roseman, 1979) where people are forcibly taken away as in the case of Jews in Nazi Germany (Browne, 1991). There is also impelled migration whereby people have to move to avert grievous consequences as in the case of refugees (Bhugra, 2004; Robertson et al., 2006; Socialstryrelsen, 2003; Sodergard & Ekblad, 1998).
This array of typology implies that the process of migration is heterogenous and all migrants are not likely to be motivated by the same reasons when migrating (Litz & Gray, 2002; Robertson et al., 2006; Socialstryrelsen, 2003; Sodergard & Ekblad, 1998). The literature suggests that not all migrants are likely to confront the same experience before and after migration (Bhugra, 2004; Bloch, 2006).

### 2.4.3 Gender issues in migration

Evidence suggests that certain gender issues influence the decision and the consequences of migration in both cases of "push" and "pull" migration (Curran, Shafer, Donato, & Garip, 2006; Richter, 2004; Sinke, 2006). The literature identifies the nature of gender and gender relations that pervade migration and argues that decisions about migration usually reflect societal definition of gender (Curran et al., 2006; Richter, 2004; Sinke, 2006). The social construction of the woman’s role as homemaker makes migration more difficult for a woman. Power differences within the household offer men more access and rights over resources, thereby affecting decision making about who migrates (Richter, 2004; Sinke, 2006). Curran et al (2006) argued that women do not play significant role during family discussions about the need for migration. Decisions to migrate are usually made by men and on many occasions women are not emotionally, socially and economically prepared for migration. These factors influence their experience in a new country (Richter, 2004; Sinke, 2006). Curran et al (2006) suggested that better understanding is gained about issues that relate to the level of financial support and social ties with other family members when viewed from a gendered perspective. Even though increasing numbers of female professionals migrate from developing countries to the developed world; many women migrate only to reunite with their husbands (Curran et al., 2006; Sinke, 2006). Women are seen as the more dependent family member in the migration process.

Furthermore, studies looking at immigrant employment issues have identified women as more disadvantaged than men (Gold, 2001; Read, 2004; Wall & Jose, 2004). On arrival in a new country, men are usually better positioned in the economic cycle (Read, 2004; Wall & Jose, 2004). However, the social
responsibilities of childcare make women less prepared to join the labour market as soon as they arrive in a new country. Women have limited time for networking and searching for available jobs in their new countries (Gold, 2001; Read, 2004; Wall & Jose, 2004). They experience more isolation than men and feel the impact of physical separation from their loved ones more than the men (MW Abbott et al., 2003).

Irrespective of the reasons for peoples’ movement, the literature suggests that when people migrate and settle in other places or countries they encounter other people, cultures, lifestyle, health services and new environments. These encounters may influence their health either negatively or positively (Ford & Kelly, 2005; Fuller & Ballantyne, 2000; Hsiao et al., 2006; Hultsjo & Hjelm, 2005; Marks & Worboys, 1997; Organista, Organista, & Soloff, 1998). The patterns of mobility define the conditions of the journey and their impact on health (Grondin, 2004). The legal status of immigrants often determines access to health and social services (Grondin, 2004). An immigrant with a permanent resident visa enjoys the same access to services as the citizens of a country, but this is not so for illegal immigrants and holders of other classes of visas (Grondin, 2004). This may be relevant to this study.

2.5 General health of immigrants

Historically, immigrants have been stereotyped as importers of disease and infection to their host countries (Codecasa et al., 1999; Jelinek et al., 2002; Lopez-Velez, Huerga, & Turrientes, 2003) since the nineteenth century when they were identified as ‘risk population’ in Europe and America. They were stigmatised, considered diseased and dirty, and thought to indulge in unhygienic behaviour that could spread diseases (Bryder, 1996; D. Manderson, 1997; L. Manderson, 1997).

A few Australian and international contemporary studies report that the perception of immigrants as importers of diseases is still commonplace (Codecasa et al., 1999; Jelinek et al., 2002; Leask et al., 2006). A qualitative study of 37 mothers in Australia reported that mothers’ views about infectious
disease risk posed by immigrants was the major reason for the immunisation of their children (Leask, Sheikh-Mohammed, Macintyre, Leask, & Wood, 2006). Other contemporary studies reported immigrants as importers of tuberculosis (Codecasa et al., 1999; Huerga & Lopez-Velez, 2002) and Africans as importers of Falsiparum malaria (Di Perri et al., 1994; Huerga & Lopez-Velez, 2002; Jelinek et al., 2002; Muentener, Schlagenhauf, & Steffen, 1999).

Other literature suggests that new immigrants, on average, have better health and a lower mortality rate than the local born population due to the strict health screening procedures implemented prior to arrival (Darmon & Khlat, 2001; Kelahar, Williams, & Manderson, 1999; Kwan & Ip, 2007). However, this is not the case with illegal immigrants and refugees; many of whom have significant health problems requiring specialist services. Apart from the medical tests mandated during the selection process; literature suggests that people who are physically and mentally healthy are more likely to make the decision to migrate than those with a disability or the handicapped (Acevedo-Garcia, Pan, Jun, Osypuk, & Emmons, 2005; Beiser, 2005; Franzini & Fernandez-Esquer, 2004; Gushulak, 2007).

In Australia, immigrants must satisfy the health requirements that are specified in the migration regulations before a visa is granted (Department of Immigration Multicultural and Indigenous Affairs (DIMIA), 2007). Immigrants are required to undergo medical examinations, which include an X-ray to screen for tuberculosis. The medical examinations also require that immigrants are screened for Hepatitis, HIV/AIDS and chronic conditions, such as diabetes, heart disease and arthritis. In a situation where an applicant does not meet the health requirement, the application to migrate to Australia is refused (DIMIA, 2007).

Despite the perceived health status of new immigrants, substantial evidence shows that their health advantage deteriorates after migration (Acevedo-Garcia et al., 2005; Franzini & Fernandez-Esquer, 2004; Gushulak, 2007; P. Norman et al., 2007; P. Norman, Boyle, & Rees, 2005). This may be due to
Migrants often face conflict situations between their culture’s traditional values and norms and those of the receiving country. Some African immigrant families in developed countries (J. Anderson & Doyal, 2004; Askling et al., 2005; Nwadiora, 1996) experience isolation as do a number of middle Eastern migrant women in Australia (Nahas, Hillege, & Amasheh, 1999) and Filipino women in Queensland, Australia (Bhugra, 2004; Clement, Noels, & Deneault, 2001). Migrants also feel "homesick" as revealed by a study of British immigrant women in Australia (Ward & Styles, 2005). All these experiences may affect the health of immigrants in their new countries (Bechtel et al., 2000; Darmon & Khlat, 2001; Kelahar et al., 1999).

The perception of immigrants’ health status in host countries (whether as importers of diseases or as healthier than citizens of the new countries) may depend on the typology and the sample of migrants being used may depend on the theoretical typology underpinning a study and the characteristics of the participants sampled (S. Kennedy & McDonald, 2006; Y. M. Lee, 2007; Procter, 2006; Robertson et al., 2006). A study surveying skilled migrants (Y. M. Lee, 2007) may conclude that they have better health than the local born, because of the rigorous health screening and selection process they usually undergo before migration (DIMIA, 2007). However, if refugees are selected for study, different conclusions may be drawn that they are importers of diseases to the host countries. These refugees may have arrived from holding camps through a humanitarian program with little or no prior health screening taking place prior to arrival. Nevertheless, a number of major health issues for immigrants are identified in the literature and these will be discussed in the next section.

2.5.1 Migrants’ health issues

Migration, as a discrete event does not threaten the health status of immigrants (Kennedy & McDonald, 2006; Y. M. Lee, 2007; Procter, 2006;
It is the process of migration: settling in a new environment and the reception in the destination country, that may expose the immigrants to poor health (Kennedy & McDonald, 2006; Y. M. Lee, 2007; Procter, 2006; Robertson et al., 2006). Furthermore, evidence shows that the socioeconomic status of the immigrant in their country of birth influences their experience of settling in a new country (Dalgard, Thapa, Hauff, McCubbin, & Syed, 2006; Markovic, Manderson, & Kelaher, 2002).

Literature suggests that resettlement issues confront immigrants in a new country, and these have been linked to immigrants’ risk of poor health (H. Bennett, 1997; Bhugra, 2000; George, 2002). A qualitative study of 76 newcomers to Canada and 76 service providers explored the health and social needs of African migrants (George, 2002). Using focus group discussions, findings showed a number of resettlement needs including affordable housing, unemployment, language training and information on available services, family counselling and community connections. It was further reported that linguistic and cultural differences constituted major barriers to their adaptation to the new environment (George, 2002). These findings were similar to the study of South African immigrants in New Zealand (H. Bennett, 1997), but the experience of settling in a new country for West African migrants to Australia is not known. The South African immigrants in New Zealand described the difficulty in re-establishing friendship, forming networks, and the loss of the traditional support system they were accustomed to in their country of birth. These studies reflect some of the experiences of settling in a new country. This experience and other associated anxiety have been suggested as being contributory to immigrants’ poor health (S. Kennedy & McDonald, 2006; Rantakeisu, Starrin, & Hagquist, 1999; Theodossiou, 1998).

2.5.1.1 Mental health

Mental health issues for immigrants have attracted significant attention in the literature with findings suggesting that refugees, asylum seekers and newly arrived immigrants, experience poor mental health (S. Kennedy & McDonald,
A number of qualitative and quantitative international studies have reported the poor mental health of immigrants (Bernstein, 2007; Hyun, 2001; Kozuki, Kenndy, & Hsin-Chun, 2006; Schreiber, Stern, & Wilson, 1998; Virta, Seun, & Westin, 2004). Studies have focused on Korean Americans (Bernstein, 2007; Hyun, 2001), Turkish immigrants in Norway and Sweden (Virta, Seun, & Westin, 2004), and West Indian immigrant women in Canada (Schreiber, Stern, & Wilson, 1998). Other studies include the North African immigrants in France (Al-Issa & Tousignant, 1997), Somali and Oromo refugee women in the USA (Robertson et al., 2006) and partnered Japanese immigrant women in the USA (Kozuki, Kenndy, & Hsin-Chun, 2006). All these studies suggest that immigrants feel isolated and lonely on arrival to a new country. They experience multiple losses and the struggle for survival and settlement in their new countries expose them to the risk of deteriorating mental health.

Migration has been associated with schizophrenia among immigrants in the UK (Bhugra, 2000). Psychological distress was reported for childbearing immigrant women during pregnancy and the post partum period. This was due to the absence of traditional customs that provided the needed support and social recognition to new mothers when they migrate to Western countries (Zelkowitz, 1996). Migration was associated with postpartum depression among the Middle Eastern immigrant women in Australia (Nahas et al., 1999), and depression among the older Chinese migrants in Auckland, New Zealand (M W Abbott et al., 2003).

In a New Zealand study, Abbott et al (2003) interviewed 162 Chinese immigrants, recruited through community organisations and general practitioners. This study was conducted to identify risk factors for symptoms of depression among older Chinese immigrants. Findings showed that 26% of participants either experienced symptoms of depression or were at risk of depression. Analysis of the data indicated that lower social support that is, the communal support that they were used to in their countries of birth, and difficulties in accessing health services due to language problems, increased the elderly women’s risk of depression (M W Abbott et al., 2003). The
supports that the elderly women talked about were not really the established welfare support systems that are provided in western countries. These women’s expectations were directed towards the communal support that they were used to in their countries of birth.

In Australia, a cross national study of posttraumatic stress disorder (PTSD) in 251 Dutch Australian immigrants revealed no significant association between immigration and the development of PTSD (Op den Velde et al., 2000). The Dutch Australian immigrants in the study explained that they were happy that they migrated and protected their lives from experiences of World War II. However, a number of researchers associate immigration with poor mental health (Alati, Najman, Shuttlewood, Williams, & Bor, 2003; Endrawes, O’Brien, & Wilkes, 2007; Thompson, Hartel, Manderson, Woelz-Stirling, & Kelahar, 2002). Previous immigrants’ mental health research in Australia has focused on Filipino women (Thompson, Hartel, Manderson, Woelz-Stirling, & Kelahar, 2002), refugees from East Africa (Alati, Najman, Shuttlewood, Williams, & Bor, 2003) and Egyptians of North Africa (Endrawes, O’Brien, & Wilkes, 2007). However, the association between migration and mental health for West African women is yet to be explored in the literature.

2.5.1.2 Physical health

Research has argued that the longer the length of time lived in a host country, the more the migrant’s health tends toward being similar to the patterns of that host country (Benfante, 1992; Stern & Wei, 1999; Zeeb, Razum, Blettner, & Stegmaier, 2002). Changing patterns of death and illness from cardiovascular diseases and cancers illustrate this relationship (Benfante, 1992; Zeeb et al., 2002). A quantitative study of the mortality rate by duration of stay of South Asian immigrants in England and Wales revealed that yearly increases in duration of residence were associated with increased cardiovascular disease mortality hazard (Harding, 2003). Even though the number of women in the study was not stated, Harding (2003) used a cohort of 2,272 South Asian immigrants in UK. The consistency of this pattern for West African immigrant women in Australia is not known.
Though not conclusively connected to length of stay in new countries, other studies have reported the prevalence of cardiovascular diseases within immigrant populations (Brancati et al., 2000; Burden, 1998). For example, cardiovascular diseases were reported for a few countries including Turkish and Moroccan immigrants in North West Europe (Uitewaal, Manna, Bruijnzeels, Hoes, & Thomas, 2004), the Asian Indians in Australia (Mohan, Wilkes, & Jackson, 2006) and West African immigrants in UK (Cappucio, 1997).

A number of other physical health issues for immigrants were identified in the literature. The prevalence of Type 2 diabetes mellitus was reported in studies on African Americans (Brancati et al., 2000) and Turkish and Moroccan immigrants in North West Europe (Uitewaal et al., 2004). In Australia, intestinal parasites were reported for recently arrived children from East Africa (Rice et al., 2003) and malaria was also reported for recently arrived African immigrants (Chih, Heath, & Murray, 2006). A retrospective case record analysis of 1,609 African migrants aged 16 years and over, reported malaria among these immigrants (Chih et al., 2006). Among these immigrants, the most common country of origin was Sudan while Uganda was the most common country of refuge before resettlement in Australia. Findings showed that 3.5 % of the 1609 immigrants were diagnosed with malaria. Even though this percentage may be considered small statistically, it may be a reflection of hidden health issues that African immigrants will present to health providers in Australia.

2.6 African migrant women’s health care issues

2.6.1 Human immunodeficiency virus

There is paucity of published literature on the health care issues for West African immigrant women in Australia; however, a number of studies reported health care issues for HIV positive African immigrant women in UK (Doyal & Anderson, 2005); in USA (Foley, 2005; Harawa, Bingham, Cochran, Greenland, & Cunningham, 2002) and in Spain (Holguin et al., 2003). Foley
(2005) reported the findings of a qualitative study on the perspectives of the service providers for HIV-positive Africans in U.S.A. With the use of interview methods and eight focus group discussions, the study explored the cultural and structural barriers that African women, their families and communities faced in the course of HIV prevention, diagnostic tests and treatment. Findings showed that the African women lacked understanding of the mode of transmission of HIV and were not aware of the treatment. The service providers in this study further reported that these African women experienced linguistic problems and were afraid of the American health care system (Foley, 2005). The study focused on the perspective of the service providers without considering the importance of the views of HIV-positive African women who were experiencing barriers to health care. Even though the study may suggest that HIV could be a health issue for African women, the study did not take into account the health care barriers experienced by West African migrant women.

A similar study conducted in the UK with women (n=62) from 11 African countries to explore the lived health experience of living with HIV (Doyal & Anderson, 2005). With the use of self administered questionnaire and in-depth semi-structured interviews to obtain data, findings of this descriptive study showed that the African women living with HIV in this study experienced both perceived and actual stigma. This experience then affected their access to the health care services.

2.6.2 Female genital mutilation

Female genital mutilation (FGM) is a specific health care issue for immigrant African women (Essen, Sjoberg, Gudmundsson, Ostergren, & Lindqvist, 2005; Knight, Hotchin, Bayly, & Grover, 1999; Thierfelder, Tanner, & Bodiang, 2005). Studies conducted overseas, such as Rubin (2001) in the USA; Essen et al (2005) in Sweden, and Thierfelder et al. (2005) in Switzerland, have identified female genital mutilation (FGM) as a health issue for African immigrant women in those countries.
African immigrant women who had been genitally mutilated in their countries of birth where FGM was prevalent, present to the health providers in their new countries with complications related to the procedure (Essen et al., 2005; Straus, McEwen, & Hussein, 2009; Thierfelder et al., 2005). Long term complications of the procedure such as dyspareunia, apareunia, request for re-infibulation and urinary tract infection are reported for the immigrant women with the FGM experience (Essen et al., 2005; Knight et al., 1999; Thierfelder et al., 2005).

Literature reports that FGM is a growing health issue in Western countries due to an increasing migration from countries where FGM is practiced (Knight, Hotchin, Bayly, & Grover, 1999; Ogunsiji, Wilkes, & Jackson, 2007). Knight et al., (1999) conducted an observational study of immigrant women from countries with high FGM prevalence living in Melbourne, Australia. Fifty-one immigrant women with FGM who presented to the Royal Women’s Hospital were studied. Findings confirmed the long term complications previously discussed. Though the Melbourne study was not specific to African immigrant women, they were among the 51 participants and identified as part of the cohort of immigrants in Australia from FGM endemic backgrounds. A literature review also highlighted the potential long term complications of FGM for West African immigrant women in Australia (Ogunsiji et al., 2007).

2.6.3 Domestic violence

Women’s experience of domestic violence is not peculiar to African women. Studies have reported the domestic violence experience as one of the health issues for immigrant women in their new countries (Fowler & Hill, 2004; Hampton, Oliver, & Magarian, 2003; Nash, 2005). The experience of Africans in America (Fowler & Hill, 2004; Hampton et al., 2003; Nash, 2005; Omotoso, 2004) and Ethiopian immigrant women in Israel (Kacen, 2006) portray domestic violence as a major health issue for African immigrant women.
2.7 Equity and access

Equitable access to health care is central to Australian health care policy (Gardner & Barraclough, 2004). Equity implies a measure of equality in the provision and distribution of health care services and portrays a form of equal use of health services for equal need (Heslop & Peterson, 2003; Morris, Sutton, & Gravelle, 2005). Access focuses on the ability of individuals to utilise the available health services (Aday & Anderson, 1974; Juarbe, 1995; Norris & Aiken, 2006; Penchansky & Thomas, 1981).

Despite the determination of the Australian government in providing universal health care for its multicultural population through the Medicare program, health care provision in Australia like many Western countries, has generally revealed inequity in access, and immigrants under-utilisation of available health care resources (Bhagat et al., 2002; J. Daly et al., 2002; Mahoney, Townsend, Hallebone, & Nesbitt, 2001). Equitable access to health services constitutes a key principle for the maintenance of immigrants’ health strategies and it plays an important part in their health (M. Mahoney, Townsend, Hallebone, & Nesbitt, 2001). The literature on immigrants’ health highlights equity and access when discussing issues that surround immigrants’ interaction with the health care system and health service utilisation in their new countries (Blackford & Street, 2002; Davidson et al., 2004; Morris et al., 2005; Wynaden et al., 2005).

Equity and access to health services for cultural and other minority groups is discussed in literature. Studies conducted in UK (Sword et al., 2006); USA (Durden & Hummer, 2006); Canada (Durden & Hummer, 2006) and Australia (Davidson et al., 2004; Davidson, Skull, Calache, Chesters, & Chalmers, 2007; Fuller & Ballantyne, 2000) revealed inequitable access for these minority groups.

Fuller and Ballantyne (2000) considered the settlement location of immigrants in Australia as a threat to immigrants’ access to equitable health care services. Immigrants in the rural areas are reported to have limited access to
specialist services. Explanations were offered that immigrants in the rural areas usually do not reach the critical mass that can attract the development of specialist services. As a result of this, immigrants in rural areas are at a disadvantage in the equitable provision of specialist services unlike other immigrants living in cities. Fuller and Ballantyne (2000) conducted a qualitative study on 103 health workers who have provided care for immigrants. Findings revealed that the immigrants in the rural areas underutilise country health services due to language barriers, reluctance to get involved in government bureaucracy and lack of familiarity with preventive services. Even though local people living in rural areas may experience dismay dealing with government bureaucracy; language barriers may further disadvantage immigrants in rural areas. Studies exploring immigrants’ perspectives on equity and access to health services are underreported in the literature.

2.8 Migrants’ utilisation of health services

2.8.1 Screening services

Immigrant under-utilisation of health screening services attracted the greatest attention in the literature (Harvey, 2001; L. Remennick, 2006; Shuster et al., 2009). Despite a significant amount of evidence that identifies the importance of early intervention and prevention in reducing the impact of preventable diseases, it is clear from the literature that immigrants under-utilise available screening resources in their new countries (Fenta, Hyman, & Noh, 2006; Harvey, 2001; Juon, Seung-Lee, & Klassen, 2003; McMunn, Mwanye, Paine, & Pozniak, 1998; Ogedegbe et al., 2005; Remennick, 2003).

The international literature shows that immigrants under-utilise breast cancer and cervical cancer screening services (Jirojwong & Manderson, 2001; Ogedegbe et al., 2005; Remennick, 2003; van Eijsden, van der Wal, & Bonsel, 2006). Studies conducted overseas that reported immigrant women’s under-utilisation of breast cancer screening services include that of African and Hispanic women in USA (Ogedegbe et al., 2005), Chinese Americans in USA, (Lee-Lin et al., 2007), Iranian immigrant women in Sweden (Emami &
Tishelman, 2004) and Russian immigrant women in Israel (L. I. Remennick, 2003). In the case of cervical cancer screening services, Korean-American women in USA (Juon, Seung-Lee, & Klassen, 2003) and Vietnamese American women in USA (Do et al., 2006) were also documented as under-utilising pap smear services.

In Australia, studies have confirmed that immigrants under-utilise breast cancer screening services (Jirojwong & Manderson, 2001; Kwok & Sullivan, 2006). Kwok and Sullivan (2006) conducted a qualitative study of 50 Chinese Australian women, while Jirojwong and Manderson (2001) conducted a descriptive study of 139 Thai Australian women with findings showing that these immigrant women under-utilised breast cancer screening. To date, the level of West African immigrant women’s utilisation of screening services in Australia is neglected in the literature and research endeavours.

It has been suggested that migrants’ under-utilisation of screening services may be due to lack of cancer screening knowledge (M. Lee, Lee, & Stewart, 1996; Ogedegbe et al., 2005; Tang, Solomon, & McCraken, 2000). Other suggestions include: immigrants’ perception of good health or absence of symptoms attributed to illness (Austin, Ahmad, McNally, & Stewart, 2002; Jirojwong & Manderson, 2001; Ogedegbe et al., 2005), fear of pain from cancer screening (Ogedegbe et al., 2005), and lack of clinician recommendation (F. M. Burns, Imrie, Nazroo, Johnson, & Fenton, 2007; Ogedegbe et al., 2005). Lack of language proficiency was also suggested as a reason in the case of non-Dutch speaking, non Western immigrants in the Netherlands (van Eijsden, van der Wal, & Bonsel, 2006), Mexican American women in USA (Suarez, 1994) and Thai immigrant women in Australia (Jirojwong & Manderson, 1999).

A few studies focused on West African immigrants’ utilisation of pre-travel screening services (Leonard & VanLandingham, 2001; Schilthius et al., 2007). Pre-travel screening is aimed at preventing the risk of contracting malaria, typhoid, and hepatitis. Travellers are required to seek medical care prior to travel in order to obtain vaccinations and prescriptions (Leonard &

Leonard and Van Landingham (2001) utilised focus group discussions and face-to-face interviews to obtain data from Nigerian immigrants and health providers on the immigrant pre-travel health use. The number of participants in this study is not mentioned in the literature; however, findings showed that Nigerian immigrants in USA under-utilised the preventive travel health services (Leonard & VanLandingham, 2001). These Nigerian immigrants perceived themselves to be at risk of malaria but were generally not concerned about the ramifications. They considered the acquisition of travel-related conditions as a stigma. These immigrants doubted the competence of health providers and talked about the cost of pre-travel health services. They also considered availability of vaccine and other medication as barriers to their adherence to the pre-travel health guidelines (Leonard & VanLandingham, 2001). Similar findings were reported for the West African immigrants in Sweden (Askling et al., 2005). Of 408 participants in this quantitative study, only 40% adhered to the pre-travel guidelines (Askling et al., 2005). Schilthius et al. (2007) conducted a study of 292 West African immigrants in the Netherlands and reported that these immigrants frequently utilised pre-travel services. Participants were requested to identify the reasons for their utilisation of pre-travel health services. Findings showed that these immigrants always utilised pre-travel preventive services for malaria (Schilthius et al., 2007).

2.8.2 Non-screening services

Immigrants are further noted for under-utilising mental health services despite their mental health needs in their new countries. Studies such as that of the indigenous Caribbean immigrants in USA (J. S. Jackson et al., 2007), Filipinas (people born in the Philippines) in Australia (Kelaher, Potts, &
Manderson, 2001) and Chinese immigrants in New Zealand (M W Abbott, Wong, Williams, Au, & Young, 1999) reported that these immigrants under-utilised the formal health care services in their new countries. Immigrants utilised family physicians rather than specialists for mental disorders as in the case of Ethiopians in Canada (Fenta, Hyman, & Noh, 2006). Stigma associated with mental illness was suggested in the literature as the reason for immigrants’ under-utilisation of mental health services (M W Abbott et al., 1999; J. S. Jackson et al., 2007).

Nonetheless, studies identified instances of increasing utilisation of health services (Aroian, 2002; McMunn et al., 1998; Schilthius et al., 2007; Soskolne, Auslander, & Ben-Shahar, 2006). Soskolne et al. (2006) conducted a quantitative study in Israel with the focus on 402 ageing recent and long-term immigrants from the former Soviet Union. This Israeli study, which examined the immigrants’ utilisation of medical and health social work services, found that these immigrants generally utilised more medical services than social work services. Other findings showed that recent immigrants utilised more social work services than long term immigrants (Soskolne et al., 2006).

The tendency for immigrants to utilise some of the health services in their new countries was also reported for the older Russian immigrants in USA (Aroian & Vander Wal, 2007) and for 342 randomly selected adult Ethiopian migrants with somatic disorders in Toronto, Canada (Fenta et al., 2006). With the use of the questionnaire method and health survey, the USA study of 105 Russian immigrants and 101 White non-immigrants reported that the Russian immigrants utilised considerably more health services than white non-immigrant (Aroian & Vander Wal, 2007).

A qualitative study of 118 Ugandan immigrants in London, UK also showed an effective utilisation of HIV/AIDS preventive services (McMunn, Mwanye, Paine, & Pozniak, 1998). Another study suggested that the home country experience of endemic HIV/AIDS known to the Ugandan immigrants motivated them to use HIV health service (F. M. Burns et al., 2007). Though
these studies were not exclusively about immigrant women, their findings suggest that immigrants’ perceived service needs may inform their use of certain services and underuse of others (Aroian & Vander Wal, 2007; Zunker, Rutt., & Meza, 2005).

2.9 Migrant African women utilisation of health services

Knowledge about African women’s utilisation of health services in their new countries is largely tacit. Many of the previous studies on African immigrants utilisation of health services focused on African immigrants generally as in the case of African newcomers in Canada (George, 2002), Nigerian immigrants in Houston, USA (Leonard & VanLandingham, 2001) and North African immigrants in Italy (Kirchler & Zani, 1995). In an Australian study of Sahel African women and Middle Eastern women, findings showed that these women under-utilised the health services available in Australia (Manderson & Allotey, 2003). Though some West African countries like Nigeria and Mali are within the Sahel African region, the Australian study (Manderson & Allotey, 2003) utilised women from Eritrea, Somali and Sudan. Limited studies that are exclusive to African immigrant women were found in the literature as in the case of Nigerian mothers in Italy (Moscardino, Nwobu, & Axia, 2006).

A number of studies reported that the level of acculturation associated with English proficiency explains migrant women’s under utilisation of health services. Suarez (1994) reported that Mexican migrant women in the USA with good English language skills had Papanicolaou (Pap) smears and mammography more often than those women with poor English proficiency. Harmon, Castro and Coe (1996) reported similar findings in their study on Hispanic women and health care utilisation rate. Hispanic women who were mostly Spanish speaking in the USA were least likely to receive Pap smear within the last three years. Thai migrant women in Australia also reported lack of English proficiency and ignorance about the services as factors for under utilising health care services (Jirojwong & Manderson, 1999). However, a number of efforts have been made by receiving countries, like Australia, to alleviate the difficulty of language barriers with the use of interpreters,
bilingual health workers, ethnic health workers and through other culturally specific services (Green et al., 2005; Schweitzer, Melville, Steel, & Lacherez, 2006).

The problem of immigrant women's lack of awareness of available services has also been reported in the literature (Kelaher, Potts, & Manderson, 2001; Neale, Ngeow, Skull, & Biggs, 2007; Tang et al., 2000). Ignorance was reported as the reason for the Chinese American women's under utilisation of available services in the USA (M. Lee, Lee, & Stewart, 1996; Tang, Solomon, & McCraken, 2000). The knowledge base of such services for West African women in Australia is yet to be explored.

2.10 Immigrant women’s health seeking behaviour

Health care seeking practices of immigrant women predominate studies on migrant women’s health (Have & Biji, 1999; Ivanov & Buck, 2002; Jirojwong & MacLennan, 2003; Shuster et al., 2009). Studies conducted overseas reported that Mediterranean immigrant women in Belgium utilised general practitioners (GPs) instead of obstetricians for pre-natal care (Van der Stuyft, Woodward, Armstrong, & De Muynck, 1993). A similar study of Indian immigrant women in UK also reported that these women used GPs rather than psychiatrists when seeking mental health care (Jacob, Bhugra, Lloyd, & Mann, 1998).

Brazilian women in America engaged in multiple journeys between the United States and Brazil to allow them to continue their reliance on Brazilian medical coverage and providers (Messias, 2002). They believe that the doctors in their new country do not understand their health issues. It was also reported that Thai women in Australia still adopt the health practices they utilised prior to migration despite their being in another country (Jirojwong & MacLennan, 2003). They stock up medications from their countries of origin for fear of not having access to these in their host country (Jirojwong & MacLennan, 2003).
Access behaviour of immigrant women to health care services is reportedly through the emergency room for acute episodic care and only if their sickness kept them from working (Aroian, 2002; Ivanov & Buck, 2002; Mortensen & Young, 2004). This delay in access was reported for the Hispanic women in USA (Jones, Cason, & Bond, 2002), Brazilian women in USA (Ivanov & Buck, 2002) and for Russian women in Israel (L. I. Remennick, 1999, 2003).

Often immigrant women depend on these family members and friends to restock their self-prescribed medications from time to time as in the case of Russian women in Israel (L. I. Remennick, 1999, 2003). They exchanged information, advice, transportation, instructions for preparing home remedies and also prescription drugs obtained through home and host country health care services. Jirojwong and Manderson, (2002) also reported this behaviour for Thai women in Australia. The women explained that they did not understand the referral system for health services in the host countries and as a result felt uncomfortable asking for a referral. Therefore, they delayed until they were rushed to the hospital.

2.11 Summary of the literature review and identified gaps

An overview of the relevant literature has revealed significant gaps in scholarly work. Meaning of health is subjective and varies from one individual to another and from one immigrant group to the other. The meaning of health to West African immigrant women in Australia is not documented in scholarly literature suggesting that little is known about this phenomenon. There is a relationship between people’s meaning of health, their life experiences, their perception of the health services and their health seeking behaviour. This relationship is not explored and not reported in the literature for West African immigrant women in Australia.

As immigrants’ experiences of migration and their cultural background have been shown to have a significant influence on their health seeking behaviour and utilisation of health care services in their new countries, it is important to understand West African immigrants’ cultural background. This is to enable nurses and other health care providers guide the immigrants in their health
care choices and provide appropriate care. Many studies that have investigated immigrant groups in Australia have neglected West African immigrant women.

Numerous studies on immigrants’ utilisation of health services have reported different patterns of health service utilisation. Studies conducted in Australia and overseas reveal that immigrant women under-utilise breast and cervical services. Age, length of stay in the new country, knowledge of available health resources are some of the suggested determinants of the type of service utilised by immigrants in their new countries. The pattern of health service utilisation for West African immigrant women in Australia is not documented in the literature. It is important to ascertain immigrants’ health service utilisation patterns in order to provide effective and culturally acceptable resources for immigrants, including West African women in Australia.

Many Africans consult traditional healers, they use medicinal leaves and herbs whenever they become ill. It is important to explore if the traditional notion of health has been sustained by West African immigrant women in Australia. The multicultural nature of Australia presents a challenge to the health care providers to broaden their knowledge about the underlying issues that determine immigrants’ utilisation of health services.

This study provides an opportunity to fill the gaps in the literature by exploring the meaning of health for the West African immigrants in Australia. It explores the relationship between these women’s meaning of health, their experience of migration, their perception of health services and their health seeking behaviour in Australia.
CHAPTER 3: METHODOLOGY AND METHODS

3.1 Introduction
In the previous chapter, I presented a critical review of relevant literature to this study. This chapter describes “the path” taken to explore the meaning of health for West African women in Australia as well as their migration experience and their health seeking behaviours. The underlying paradigm and research methodology as well as ethical considerations for the study are presented.

3.2 The research paradigm
The term "paradigm" refers to a set of shared beliefs and basic assumptions which guide ontological, epistemological and methodological inquiry (Crotty, 1998; Guba, 1990; Guba & Lincoln, 1989; Guba & Lincoln, 1994; Lu, Ting, Chen, & Tang, 2005). Ontological inquiry focuses on the nature of reality while epistemological questions inquire into the nature of a relationship between the researcher and the field of inquiry. Methodology on its own part is concerned with how the researcher understands what is known (Crotty, 1998; Guba, 1990; Guba & Lincoln, 1989; Lincoln & Guba, 1985). These fundamental principles of inquiry are addressed in different ways by different paradigms. The naturalistic paradigm described by Guba and Lincoln (1989), Lincoln and Guba (1985) as well as Guba and Lincoln (1989) was chosen to guide this study.

3.3 Rationale for the choice of a naturalistic inquiry.
I chose naturalistic paradigm for this research for a number of reasons. Firstly, it focuses on the complex context that underlies people's understanding and meaning of their world (Appleton & King, 1997; Denzin, 1971; Erlandson, Harris, Skipper, & Allen, 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985). Naturalistic inquiry can accommodate the underlying socio-cultural, economic and migration complexities which guide the meaning of health for West African women in Australia: Secondly, the naturalistic paradigm provides a methodological pathway informed by a sound theoretical framework (Appleton & King, 1997; Denzin, 1971; Erlandson et al., 1993;
Thirdly, this paradigm provides a rigorous qualitative research process (Guba & Lincoln, 1989; Lincoln & Guba, 1985). The naturalistic paradigm and its basic ontological, epistemological and methodological assumptions are explored below.

3.4 Naturalistic inquiry

Naturalistic inquiry, also known as the constructivist paradigm, is one of a number of paradigms that have challenged the positivist paradigm (Appleton & King, 1997; Erlandson et al., 1993; Guba, 1990; Guba & Lincoln, 1989; Lincoln & Guba, 1985). Constructivists challenge positivist assumptions of realism, dualism and experimentation. They argue that, “the positivist and the positivist paradigms are badly flawed and must be entirely replaced” by another paradigm (Guba, 1990; p.25). Proponents of naturalistic inquiry utilise the three fundamental principles of ontology, epistemology and methodology to gain an understanding of the world.

3.4.1 Ontological notion of naturalistic inquiry

The ontological principle of naturalistic inquiry assumes that individuals perceive the world based on their physical, social, political, economic and financial context (Guba & Lincoln, 1989; Lincoln & Guba, 1985; Pass, 2004; Schnelker, 2006). The ontological notion of naturalistic inquiry assumes that there are many constructions of realities that can only be studied as a whole (Lincoln & Guba, 1985; Schnelker, 2006). Naturalistic inquiry therefore argues that, rather than there being a single independent truth of a phenomenon as suggested by the positivist paradigm, there are many contextual issues which must be explored in order to unfold a subjective truth about reality (Appleton & King, 1997; Guba & Lincoln, 1989; Schnelker, 2006; Schwandt, 1994).

As a result of this assumption, naturalistic inquiry proposes that people’s subjective constructed realities cannot be subjected to “prediction and control” (Lincoln & Guba, 1985; p.37). Instead, these constructed realities can only generate deeper understanding of the world. It is therefore important to explore the convergence and divergence in West African women’s meaning of
health in terms of subjective constructed realities as it may be over-simplistic to assume that all the West African women will have the same meaning of health.

Naturalistic assumptions maintain that human knowledge is problematic and that “all human constructions are problematic” (Guba & Lincoln, 1989; p.70). Human constructions of reality are subject to modification and to change, and what may be considered, as the best construction of a phenomenon at a point in time may not be upheld at another time or it may be rejected at another time (Appleton & King, 1997; Erlandson et al., 1993; Guba & Lincoln, 1989; C. K. Russell, Gregory, Care, & Hultin, 2007). To this extent, constructivists believe that no human construction of reality can be accepted as “ultimately true” or assumed to remain constant (Guba & Lincoln, 1989; p.70). Rather, human constructions of reality are time and context bound (Appleton & King, 1997; Guba & Lincoln, 1989; Lincoln & Guba, 1985; Rowan, McCourt, Bick, & Beake, 2007).

The naturalistic assumption that meaning of health for West African women is time and context bound is relevant to this study. It is possible that these women’s perception of health when they were in Africa has been modified or changed after migrating to Australia. These women’s encounters with the Australian health care system and their migration experience may have influenced and modified their meaning of health. This study is concerned with exploring the constructions of health for migrant West African women in Australia.

3.4.2 Epistemological stand of naturalistic inquiry

Naturalistic inquiry rests on the epistemological assumption that the knower and the known are indivisible (Cleary & Freeman, 2006; Guba & Lincoln, 1989; Lincoln & Guba, 1985; Osman & Herring, 2007). Guba and Lincoln (1989) argue that all phenomena have the capacity to interact and that it is impossible to assume that the knower and the known will not influence each other. Consequently, Guba and Lincoln (1989) advise the researcher employing naturalistic methods to acknowledge those issues that can
influence the interaction between the knower and the known. Proponents of
naturalistic inquiry emphasise that no human research data can be absolutely
objective (Cleary & Freeman, 2006; Guba & Lincoln, 1989; Lincoln & Guba,
1985; Osman & Herring, 2007).

In common with other interpretive approaches, proponents of naturalistic
inquiry assume a “subjectivist position” whereby individual’s constructions of
reality are considered the premise from which meaning can be obtained
(Guba, 1990; p.26). This epistemological assumption accommodates my
positioning and the vantage point from which I am approaching this study. My
story as a West African woman in Australia is presented in chapter one.

3.4.3 Methodological viewpoint of naturalistic inquiry.
The methodology of naturalistic inquiry employs a hermeneutic and dialectic
approach (Appleton & King, 1997; Erlandson et al., 1993; Guba, 1990). The
naturalist aims at creating a sophisticated construction of people’s worlds by
assessing the diversities in people’s constructions of reality and identifying
common issues in those constructions using a hermeneutic and dialectic
methodology (Appleton & King, 1997; Erlandson et al., 1993; Guba, 1990). The
hermeneutic feature is concerned with presenting individual’s
constructions of reality as vividly as possible, while the dialectic feature
behoves the researcher to compare and contrast his or her construction and
those constructions of the individual participants in order to identify the
common grounds (Cleary & Freeman, 2006; Guba & Lincoln, 1989; Lincoln &
Guba, 1985; Osman & Herring, 2007). The focus of this endeavour is to
ensure that a rich description of the researcher-respondent interaction is
documented and available for refinement. Naturalistic inquiry does not aim to
control or predict reality (Cleary & Freeman, 2006; Guba & Lincoln, 1989;
Lincoln & Guba, 1985; J. S. Mahoney, Marfurt, daCunba, & Engebretson,
2005), rather constructions of reality emerge as a result of continuous
interaction between the researcher and the researched (Guba, 1990; Osman
& Herring, 2007). The aim of naturalistic inquiry is not to “transform the world
but to reconstruct” it (Guba, 1990; p.27).
3.5 Naturalistic methodology used for this study

The naturalistic paradigm and its ontological, epistemological and methodological assumptions predetermine how naturalistic inquiry is conducted (Appleton & King, 1997; Cleary & Freeman, 2006; Erlandson et al., 1993; Lincoln & Guba, 1985; Osman & Herring, 2007). This is reflected in the methodological pathway suggested by Lincoln and Guba (1985). Lincoln and Guba argue that, due to the naturalistic notion of multiple realities, the research focus, design, theoretical framework and the nature of the interaction between the researcher and the participants cannot be predetermined prior to the conduct of the research. Rather, the research focus, the research design and other aspects of the research process must be grounded in the data obtained in order to understand different constructions of people’s world.

Lincoln and Guba suggested 14 interwoven features of a naturalistic inquiry. These are: natural setting, use of human instrument, utilisation of tacit knowledge, use of qualitative methods, use of purposive sampling, data analysis and grounded theory, emergent design, negotiated outcome, case study, reporting mode, idiographic interpretation, tentative application, focus-determined boundaries and special criteria for trustworthiness (Lincoln & Guba, 1985; p.189-219). These features were compressed by Guba and Lincoln (1989) to explain the hermeneutic-dialectic naturalistic methodology that informed this study. Guba and Lincoln (1989) suggested that a naturalistic inquirer must satisfy the entry stipulation before conducting naturalistic inquiry and engage in the hermeneutic-dialectic process. These two core-concerns of naturalistic methodology as explained by Guba and Lincoln (1989; p.175-182) and how they were applied to this study are explored.

3.5.1 Entry stipulation

Guba and Lincoln (1989) emphasise that the constructivist must ensure that the entry expectations of natural setting, human as instrument, tacit
knowledge and qualitative methods are satisfied prior to any inquiry to be considered naturalistic.

3.5.1.1 Natural setting

Constructivists, as stated earlier, emphasise that naturalistic inquiry must be conducted in a natural setting and in consideration of the whole context that informs the content of study (Guba & Lincoln, 1989; Guba & Lincoln, 1994). By natural setting, Lincoln and Guba (1985) referred to the usual context within which the participants operate. Lincoln and Guba (1985) emphasised that “realities are wholes that cannot be understood in isolation from their context” (p.39). Due to the importance of the total context of the inquiry, the researcher’s interaction with the researched must take place within the “entity-in-context for fullest understanding” (Lincoln & Guba, 1985:p. 39). Erlandson et al (1993) explained that naturalistic inquiry relies “upon context” (p.16). It assumes that the researcher and the researched engage in a complex web of peculiar interrelationship that provides the context for the inquiry. The context “restricts and extends the applicability of the research” (Erlandson, et al 1993, p. 16). Guba and Lincoln (1989) argued that the naturalistic assumption of multiple realities demands “that the study be carried out in the same time/context frame that the inquirer seeks to understand” (p.175).

Lincoln and Guba (1985) emphasised that the research must take place within a natural setting. The importance of the natural setting was also accentuated because of the belief that the context is critical in deciding whether or not a finding may have meaning in similar contexts. Guba and Lincoln (1989) explained that using other settings would not yield the desired information for unfolding human constructions of their world. Guba and Lincoln (1988) further highlighted that in order for an inquiry to ensure “fittingness” which is one of the criterion for rigour, the study must utilise the natural setting (p.104). In addition, because of the naturalistic belief that all entities are in a state of continuous mutual modification, it was argued that all aspects of the entity could only be grasped within its natural setting (Erlandson et al., 1993; Lincoln & Guba, 1985).
3.5.1.1 Setting of this study
The setting for this study is Sydney, Australia. The first two participants were recruited through Nigerian and Ghanaian women’s associations. Further participants were introduced to me using “a snowballing technique”. In most cases participants were interviewed in the natural setting of their homes. Demographic data were collected and this provided background information through which the women’s point of reference could be understood (Table 2a & 2b).

3.5.1.2 Use of human as instrument
When engaging in naturalistic inquiry the researcher and other human beings constitute “the primary data-gathering instruments” (Guba & Lincoln, 1989; Lincoln & Guba, 1985). Lincoln and Guba (1985) advocated the use of human instruments because of their ability to adapt to different situations and their ability to identify unforeseen circumstances that may arise during the course of the inquiry. Due to the belief that the knower and the known are inseparable, they engage in the interaction. In this situation, only the human instruments can assess and identify the inherent meaning and biases in such interactions (Guba & Lincoln, 1989; Lincoln & Guba, 1985). The naturalistic paradigm assumes that multiple realities are subjective and context bound (Guba & Lincoln, 1989; Guba & Lincoln, 1994; Lincoln & Guba, 1985; Osman & Herring, 2007). Consequently, Guba and Lincoln (1989) emphasised that it is only the human instrument that is responsive, adaptable, holistic and has capacity for knowledge expansion.

3.5.1.2.1 Use of human instrument in this study
As the use of human instrument in data collection, analysis and interpretation has been identified as a major source of bias in naturalistic inquiry (Guba & Lincoln, 1989; Appleton & King, 1997; Erlandson et al, 1993), proponents of naturalistic inquiry document their pre-understanding to identify biases that may jeopardise the credibility of research findings. My personal socio-
cultural, migration and resettlement experiences inform my pre-understanding of the meaning of health. These were presented in chapter 1.

3.5.1.3 Utilisation of tacit knowledge

The use of tacit knowledge, which is the background, unspoken understanding of a phenomenon, is central to naturalistic inquiry. Proponents of this inquiry argue that the manifold construction of reality can only be understood through the utilisation of this instinctive and propositional knowledge (Gallagher, 2007; Guba & Lincoln, 1989; Lincoln & Guba, 1985; Reilly & Spratt, 2007; Rowan et al., 2007). Constructivists acknowledge tacit knowledge as legitimate and a good reflection of the values that the researcher has brought to an inquiry (Guba & Lincoln, 1989; Lincoln & Guba, 1985; Reilly & Spratt, 2007; Rowan et al., 2007). The use of tacit knowledge is based on the assumption that “we all know more than we can say” and that this background knowledge serves as the premise from which more sophisticated knowledge is obtained (Guba & Lincoln, 1989; p.176).

3.5.1.4 Use of qualitative methods

Qualitative method is the method of choice for many naturalistic enquiries. This method is able to accommodate multiple subjective world views and scholars (Appleton & King, 1997; Erlandson et al., 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985) argued that the positivist approach, with its emphasis on precise measurement and objectivity, not only fails to reveal the richness of data but also omits those subjective meanings that are not objectively observable.

While naturalistic inquiry is not anti-quantitative, proponents believe that any inquiry is value-bound. As a result, qualitative methods are considered more adaptable and more likely to identify the different influences that the value of the researcher and the paradigm used may have on the inquiry (Lincoln & Guba, 1985). The qualitative approach used in this study includes the use of interview, and non-verbal cues as data collection tools.
3.5.1.4.1 Qualitative data collection method in this study

Data were collected for this study between January and July 2006. Demographic information was obtained from the participants (see Appendix 6a) to enhance our understanding of these women’s world. A semi-structured interview technique was utilised as it allowed the participants more control over how the interview proceeded and it enabled spontaneous responses. Interviews were audio taped.

Even though qualitative interviews are similar to conversations, they need some elements of structure which may be in form of an open ended leading question (Mason, 2002). The interview commenced with one opening question “Can you please tell me your health experience since you have been living in Australia?” (Appendix 6b). Taylor (2005) argued that the aim of an interview is to gain knowledge about the world through the participants’ perspective and further stressed the importance of preserving the natural spontaneity in the exploration of the people’s lived experiences. I accomplished this by asking the women to describe fully and deeply their lived health experience as people living outside their countries of origin. During the interview, I checked responses and clarified the women’s answers by asking “Is this what you are trying to say?”; “Is this what you mean by saying…?”; “Did I hear you say…?” The women readily responded to probing by either agreeing or elaborating their responses.

The duration of interviews was one to two hours. The day, time and venue for the interview were at the discretion of the women. Twenty women preferred to have the interview in their home between 10 am and 2 pm on their designated days off from work. One woman preferred to have her interview at a university library between 6 pm and 8 pm after her day’s work. A journal of non-verbal cues and gestures was maintained (see Appendix 1 for the introduction of these women). Transcription of the audio taped interviews was conducted immediately after each interview.

According to Taylor (2005), participants may consciously or unconsciously exclude some of their painful and confidential experiences. A safe, secure
and trusting environment can reduce this tendency during the interview phase, thus enhancing the quality of the data. In order to provide such an ideal environment, participants of this study nominated where the interview was conducted.

The main aim of naturalistic inquiry is to explicate other peoples’ experience and to have a deeper understanding of the meaning of it in the context of the whole of human experiences (Appleton & King, 1997; Erlandson et al., 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985). In this study, this was achieved as all the women talked about their meaning of health and their lived health experience in Australia.

3.5.2 Guba and Lincoln’s hermeneutic-dialectic.
Guba and Lincoln (1989) explained the process involved in hermeneutic-dialectic methodology. According to Guba and Lincoln (1989) “it is hermeneutic because it is interpretive in character, and dialectic because it represents a comparison and contrast of divergent views with a view to achieving a higher level synthesis of them all” (p.148). To achieve the level of hermeneutic-dialectic that is required in naturalistic inquiry, Guba and Lincoln (1989) suggested a continuous interaction of all the views in a pattern that is “cycling and recycling until consensus (or non-consensus) emerges” (p.177). The suggested elements were: selection of participants; continuous interplay of data collection and data analysis; grounding findings within the respondents’ constructions and emergent design.

3.5.2.1 Selection of participants
Guba and Lincoln (1989) emphasised the importance of determining the selection criteria that participants need to meet (Guba & Lincoln, 1989; Lincoln & Guba, 1985). For the purpose of the current study, selection criteria were used to enhance the collection of relevant data. The sampling and recruitment techniques that were influenced by these criteria are presented in the following section.
3.5.2.1.1 Sampling technique in this study
The preferred sampling method for naturalistic inquiry is purposive sampling (Erlandson et al., 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985). In purposive sampling, the researchers purposefully select the participants who will best contribute to the information needs of the study (D. F. Polit & Beck, 2006; Schneider & Elliot, 2007). Purposive sampling enables the researcher to identify the convergence and divergence in the participants’ constructions of their world (Erlandson et al., 1993; Lincoln & Guba, 1985). Proponents of naturalistic inquiry also consider purposive sampling as having the potential to maximise researchers’ ability to develop theory grounded in “local conditions, local mutual shaping and local values” (Lincoln & Guba, 1985; p.40). In order to achieve this, I used two key informants and a snowballing technique.

3.5.2.1.2 Sample size
A purposive sample of 21 West African born women engaged in open-ended audio taped interviews. This number of participants is congruent with qualitative research, where sample sizes are usually small due to the large volume of verbal data that must be analysed (N. Burns & Grove, 2009; D. Jackson & Borbasi, 2008). It was found that no new themes emerged after 18 interviews so an extra three were conducted to confirm this.

3.5.2.1.3 Recruitment of participants in this study.
Guba and Lincoln (1989) suggest that participants must be willing to participate in the study and must be old enough to articulate their constructions of reality. The inclusion criteria for this study were: that the participants were women; 18 years and over; currently residing in Australia and willing to participate in the interview.

According to Guba and Lincoln (1989), the initial step in accessing the participants for naturalistic inquiry is to select “an initial respondent, for any convenient or salient reason” (p.151). The first two women were accessed through the Nigerian and Ghanaian women associations in Australia. These countries of origin were selected because they are the most represented
West African countries in Australia and English was the common language spoken by both researcher and participants.

Subsequent participants were accessed using “a snowballing technique” with one person leading to other potential interviewees (Guba & Lincoln, 1989; D. Jackson, Daly, & Chang, 2003; Lincoln & Guba, 1985; L. Richards & Morse, 2007). This technique has some limitations, as the sample may result in the bias of some migrant networks over others (Jacobsen & Landau, 2003). However, this method has been used for similar studies where culturally and linguistically diverse background participants were required (Kihato, 2007). An introduction to the women who participated in this study is presented in Tables 2a and 2b below and in Appendix 1.

3.5.2.2 Continuous interplay of data collection and data analysis

Guba and Lincoln (1989) suggested that the researcher focuses on a general question to explore the research objective when interviewing the first respondent. The responses will become baseline data and will assist in refining successive interviews and will “become part of the agenda in all subsequent data collection” (Guba & Lincoln, 1989; p.178).

I commenced the interviews with an open-ended question about the meaning of health for West African women in Australia (see data collection method above). The salient points in the responses of the first woman interviewed were noted and this assisted me in subsequent interviews. Subsequent interviews were not compared with the responses given by the first woman interviewed rather the convergence and divergence in all the women’s responses was identified.

3.5.2.2.1 Data analysis in this study and emerging themes

Transcription and analysis were attended immediately after the conclusion of each interview. Transcripts were initially read to gain a general understanding of the content of the interviews. After this, each transcript was re-read to identify and highlight important words, sentences and phrases. Qualitative
research computer software, QSR NUDIST Vivo 2.0 (1999) was used to assist in sorting the data to select and highlight significant phrases. Relevant phrases and statements were then put into categories to arrive at the emerging themes. I was mindful that there are numerous views of the world as purported by naturalistic inquiry (Guba & Lincoln 1985, p41). The inquiry is a product of the whole.

Table 2a
Demographic information: Age, country of origin, marital status, number of children, age range of children and length of stay in Australia.

<table>
<thead>
<tr>
<th>Names</th>
<th>Age of the women</th>
<th>Country of origin</th>
<th>Marital status</th>
<th>No. of children</th>
<th>Age range of children</th>
<th>Length of stay in Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ammah</td>
<td>26-30 yrs</td>
<td>Ghana</td>
<td>Married</td>
<td>2</td>
<td>5mths-3 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Anna</td>
<td>41-45 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>4</td>
<td>4-22 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Maureen</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>2</td>
<td>8-10 years</td>
<td>11 years and over</td>
</tr>
<tr>
<td>Sola</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>3</td>
<td>10-14 years</td>
<td>11 years and over</td>
</tr>
<tr>
<td>Sandra</td>
<td>31-35 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>2</td>
<td>2-7 years</td>
<td>0-5 years</td>
</tr>
<tr>
<td>Rita</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>4</td>
<td>3-12 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Agnes</td>
<td>46-50 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>3</td>
<td>10-25 years</td>
<td>11 years and over</td>
</tr>
<tr>
<td>Titi</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>4</td>
<td>8-14 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Kinder</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>4</td>
<td>6-14 years</td>
<td>11 years and over</td>
</tr>
<tr>
<td>Jenny</td>
<td>41-45 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>6</td>
<td>10-25 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Joy</td>
<td>41-45 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>3</td>
<td>6-21 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Matilda</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>1</td>
<td>7 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Onome</td>
<td>&lt;=25 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>1</td>
<td>2 years</td>
<td>0-5 years</td>
</tr>
<tr>
<td>Emma</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>3</td>
<td>1-10 years</td>
<td>11 years and above</td>
</tr>
<tr>
<td>Henrietta</td>
<td>41-45 yrs</td>
<td>Ghana</td>
<td>Married</td>
<td>4</td>
<td>17-29 years</td>
<td>0-5 years</td>
</tr>
<tr>
<td>Stella</td>
<td>31-35 yrs</td>
<td>Ghana</td>
<td>Married</td>
<td>None</td>
<td>N/A</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Michelle</td>
<td>26-30 yrs</td>
<td>Ghana</td>
<td>Married</td>
<td>3</td>
<td>3-7 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Precious</td>
<td>41-45 yrs</td>
<td>Ghana</td>
<td>Married</td>
<td>5</td>
<td>17-30 years</td>
<td>11 years and over</td>
</tr>
<tr>
<td>Rosemary</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>7</td>
<td>1-18 years</td>
<td>6-10 years</td>
</tr>
<tr>
<td>Oluwatosin</td>
<td>36-40 yrs</td>
<td>Nigeria</td>
<td>Married</td>
<td>2</td>
<td>6-10 years</td>
<td>0-5 years</td>
</tr>
<tr>
<td>Warris</td>
<td>&lt;=25 yrs</td>
<td>Ghana</td>
<td>Married</td>
<td>None</td>
<td>N/A</td>
<td>11 years and over</td>
</tr>
</tbody>
</table>
Table 2b.
Demographic information: Educational level prior to migration, occupation before migration and occupation since migration to Australia.

<table>
<thead>
<tr>
<th>Names</th>
<th>Educational level prior to migration</th>
<th>Occupation before migration to Australia</th>
<th>Occupation since migration to Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ammah</td>
<td>Pre-tertiary</td>
<td>Home-duties</td>
<td>Assistant in nursing/ Home-making</td>
</tr>
<tr>
<td>Anna</td>
<td>Pre-tertiary</td>
<td>Engineer</td>
<td>Assistant in nursing</td>
</tr>
<tr>
<td>Maureen</td>
<td>Post-tertiary</td>
<td>Student</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Sola</td>
<td>Post-tertiary</td>
<td>Chemical Engineer</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Sandra</td>
<td>Post-tertiary</td>
<td>Pharmacist</td>
<td>Undergraduate nursing student</td>
</tr>
<tr>
<td>Rita</td>
<td>Post-tertiary</td>
<td>Executive Secretary</td>
<td>Enrolled nurse</td>
</tr>
<tr>
<td>Agnes</td>
<td>Post-tertiary education</td>
<td>Teacher</td>
<td>Enrolled nurse</td>
</tr>
<tr>
<td>Titi</td>
<td>Post-tertiary education</td>
<td>Computer Programmer</td>
<td>Health education officer</td>
</tr>
<tr>
<td>Kinder</td>
<td>Post-tertiary education</td>
<td>Microbiologist</td>
<td>Microbiologist</td>
</tr>
<tr>
<td>Jenny</td>
<td>Post-tertiary education</td>
<td>Teacher</td>
<td>Assistant in nursing</td>
</tr>
<tr>
<td>Joy</td>
<td>Post-tertiary education</td>
<td>Banker</td>
<td>Assistant in nursing</td>
</tr>
<tr>
<td>Matilda</td>
<td>Tertiary</td>
<td>Pharmacist</td>
<td>Customer service</td>
</tr>
<tr>
<td>Onome</td>
<td>Tertiary</td>
<td>Student</td>
<td>Administrative officer</td>
</tr>
<tr>
<td>Emma</td>
<td>Post-tertiary education</td>
<td>Teacher</td>
<td>Account clerk</td>
</tr>
<tr>
<td>Henrietta</td>
<td>Post-tertiary education</td>
<td>Nurse/Midwife</td>
<td>Registered nurse/midwife</td>
</tr>
<tr>
<td>Stella</td>
<td>Pre-tertiary education</td>
<td>Student</td>
<td>Assistant in nursing</td>
</tr>
<tr>
<td>Michelle</td>
<td>Pre-tertiary education</td>
<td>Student</td>
<td>Assistant in nursing</td>
</tr>
<tr>
<td>Precious</td>
<td>Post-tertiary education</td>
<td>Nurse</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Rosemary</td>
<td>Pre-tertiary education</td>
<td>Trader</td>
<td>Home duties</td>
</tr>
<tr>
<td>Oluwatosin</td>
<td>Post-tertiary education</td>
<td>Industrial Chemist</td>
<td>Industrial Chemist</td>
</tr>
<tr>
<td>Warris</td>
<td>Post-tertiary education</td>
<td>Student</td>
<td>Registered nurse</td>
</tr>
</tbody>
</table>

A review of all transcripts of interviews and original audiotapes were attended simultaneously and repeatedly. I telephoned the women to reconfirm some of
their responses, to ensure that what they said was what I transcribed and to preserve the integrity of the data. I documented my general impressions of the interviews in a journal to record on-going reflections of the research process. A recurring theme of these reflections was “What is the meaning of this experience on these women’s health?”

Non-verbal cues and gestures recorded in the journal during the interviews were revisited regularly to ensure accuracy of context in the interpretation of the data. The crucial words, ideas and meanings derived from all the women and the individual stories (the parts) were then related and traced back (to the whole) in the remaining part of the study to illuminate the meaning shared by all these women in the form of emerging themes.

Table 3
Emerging major themes, minor themes and sub-themes

<table>
<thead>
<tr>
<th>Major theme</th>
<th>Minor theme</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being healthy</td>
<td>Defining health</td>
<td>-Having mental wellbeing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Being wealthy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Being stable in the physical body</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Suffering in silence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Suffering as normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Smiling to hide suffering</td>
</tr>
<tr>
<td></td>
<td>Being overworked</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being health conscious</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suffering and smiling</td>
<td></td>
</tr>
<tr>
<td>Being Spiritual</td>
<td>Having inner conviction of a sacred being</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being in Christian communities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Believing in folkloric and spiritual</td>
<td></td>
</tr>
<tr>
<td></td>
<td>forces</td>
<td></td>
</tr>
<tr>
<td>Being a migrant</td>
<td>Being lonely and isolated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beginning again</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being alienated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mothering in a new context</td>
<td></td>
</tr>
<tr>
<td>Encountering the health care system</td>
<td>Not in our orientation</td>
<td>-Being a different system</td>
</tr>
<tr>
<td></td>
<td>Exploring health service encounter</td>
<td>-Wanting to use alternatives</td>
</tr>
<tr>
<td></td>
<td>Reduced expectation</td>
<td>-Wanting curative health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Experiencing health care provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Experiencing health care provided</td>
</tr>
</tbody>
</table>
In order to show the process of extracting significant words, phrases and statements, some excerpts of a thematic reflection from the original conversation with Maureen and Rita (pseudonyms), are presented as examples in Appendix 2. These statements are shown in bold type for easier identification.

Maureen and Rita’s conversations illustrate in more detail the process used. Significant statements were categorised, collapsed (see Appendix 3) and identified the following categories: (1) Concept of health (2) Community life (3) World of difference (4) Low self esteem (5) Challenged to raise self-esteem (6) Spirituality (7) Encounter with the health care system (8) Absence of sickness (9) All round state (10) Loneliness/isolation (11) Self-appraised (12) Facing challenge (13) Belief about disease causation (14) Efficacy of prayer (15) Orientation (16) Under-utilisation of health services. Finally, a hierarchical representation of a major theme, minor theme and sub-theme were developed from all the women’s stories (Table 3 above).

3.6 Special criteria for ensuring trustworthiness or rigour.
Naturalistic inquiry like other qualitative paradigms is criticised that it is not rigorous, precise, exact, uses small samples and thereby ungeneralisable (Guba & Lincoln, 1989; T. Koch, 1994, 1998, 2006; Lincoln & Guba, 1985). Traditionally, the need to ensure the validity and reliability of any research endeavour resides in the natural sciences (Borbasi, Hengstberger-Sims, & Jackson, 2008; N. Burns & Grove, 2009; Walters, 1995). While it is important for quantitative method to be precise and exact in order to achieve refinement and perfection, qualitative research derives its strength by aiming for a full interpretation of life experiences to achieve its exactness and precision (van Manen, 1997).

In order to ensure a rigorous effort while conducting qualitative research, Guba and Lincoln (1989) suggested credibility, dependability, transferability and confirmability as central to rigour in qualitative research because these criteria determine the level of trustworthiness of the research (N. Burns & Grove, 2009; D. Jackson et al., 2003; T. Koch, 1994; D. F. Polit & Beck, 2006;
Streubert & Carpenter, 1995). Credibility and dependability are considered as criteria for determining the quality of qualitative data and transferability as criterion for determining the level at which the research findings can be transferred to other settings and groups (D. F. Polit & Beck, 2006; D. F. Polit & Hungler, 1995). Koch (1994) likened credibility to internal validity, and transferability to external validity, while dependability was likened to reliability. Even though there are continuing contributions from researchers on the content and criteria that must be used in evaluating qualitative research, they all acknowledge the need for rigour for the research to add to knowledge.

3.6.1 Achieving credibility in this study
In achieving credibility in a naturalistic inquiry, Lincoln and Guba (1985) suggested the need for the researcher to ensure that the findings are believable and that the findings are confirmed to be true by the participants. A number of other authors have highlighted various ways to achieve credibility in qualitative research (D. Jackson & Borbasi, 2008; D. Jackson et al., 2003; T. Koch, 1994; D. F. Polit & Beck, 2006). According to Koch (1994), self awareness is an essential ingredient for achieving credibility in qualitative research. Koch (1994) suggested that a way of accomplishing this is to keep a field journal, which enables a detailed record of relationships and personal reflections. A journal of relationships and personal reflection was maintained, record of gestures and body language was kept and every process involved in the research presented. Jackson, Daly and Chang (2003) also cited three examples of how credibility may be achieved in qualitative research. These examples include sending analysed data to the participants to verify that the analysis was true to their experience and sending a hard copy of the interview transcript to the participants to clarify that the transcript really reflects their experience. Another example includes attending a follow-up interview with the participants in order to clarify or corroborate what the participants said in the first interview. As part of data collection procedures, a copy of the interview transcript was sent to the interviewee. The interviewee was asked to read the transcript of the interview to ensure that what was transcribed was exactly what they wanted to say. All the women corroborated the transcripts.
and offered more comments however, no new data was identified from the follow-up telephone call.

Another suggestion for achieving credibility in a qualitative research is peer debriefing (D. F. Polit & Beck, 2006). The purpose of peer debriefing is to explore different components of an inquiry that the researcher might have considered as well as other areas that the researcher may need to consider. Peer debriefing provides opportunity for the researcher to engage with thought provoking questions posed by colleagues in the same profession or experts in the phenomenon of interest. Ongoing discussions with my supervisors and other higher degree research students assisted in refining my thoughts about this inquiry. I have presented findings from my study at School and College colloquia as well as during national and international conferences. Questions and feedbacks during these presentations enabled me to explore all possibilities about this inquiry.

3.6.2 Confirmability in this study
Confirmability refers to the way in which the data was interpreted. Sandelowski (1994) states that the participants moods, thoughts and feelings are represented in quotes. I used direct quotes from the transcripts to illustrate the emerging themes and sub-themes. Quotes from the transcripts were carefully checked to ensure valid interpretation of the women’s meaning. Direct quotes from interviews that informed the women’s understanding of their meaning of health are presented in chapters 4 and 5. This process minimised the possibility of the undue influence of my pre-understanding.

3.6.3 Achieving transferability in this study
Transferability refers to the extent to which research findings are applicable to other situations. Lincoln and Guba (1985) argued that because the subjective constructions of people’s reality are central to naturalistic inquiry generalisation is not the focus of this method. Lincoln and Guba (1985) explained that setting effect, history effect and selection effect threaten generalisation. Guba and Lincoln (1989) however, recommended that in order to achieve transferability, the researcher must provide a vivid
description of the context in which the study was conducted. Transferability in this study is achieved through the detailed description of approaches taken, concepts generated and the description of the women in their setting (see appendix 1). I presented a vivid description of the women’s context when introducing the women that participated in this study (see appendix 1).

3.6.4 Achieving dependability in this study
Dependability refers to how the researcher is able to carry the reader along in understanding the outcome of the research (T. Koch, 1994). Dependability in this study was achieved by explaining every process involved in the research. Justification for the choice of method and methodology was provided; the path taken in accessing the women in this study was stated and decision trails in unfolding the thematic analysis presented.

3.7 Limitations of the method
A number of limitations have been associated with naturalistic inquiry. The use of human beings as a research instrument has been criticised. Human beings though intelligent and sensitive are criticised to be fallible (D. Polit, Beck, & Hungler, 2001). The subjective nature of naturalistic inquiry and the use of small sample size have also been criticised. The critics argue that the subjective nature renders naturalistic inquiry unverifiable and the small sample size renders it ungeneralisable (D. Polit et al., 2001). However, it is only the human instrument that can utilise the complex web of the participants’ context to produce an understanding of reality.

However, in response to this criticism, it is expected that researchers utilising naturalistic inquiry present their pre-understanding and reveal any identified biases that may affect the credibility of the research findings (Guba & Lincoln, 1989; Lincoln & Guba, 1985). My pre-understanding is presented in chapter 1 under my story as a West African woman in Australia.

3.8 Ethical considerations
Consideration of ethical issues is an acclaimed aspect of nursing research, theory and practice (Hawley, 1997). The University of Western Sydney
Human Research and Ethics Committee approved the conduct of this study (see appendix 8). The notion of ethics centres around right and wrong; duty and moral accountability (Hawley, 1997). Four ethical principles discussed by Hawley (1997): autonomy, beneficence, non-maleficence and justice, and how they inform this study are presented below.

### 3.8.1 Ethical principle of autonomy and this study

The principle of autonomy states that individuals have the right to make decisions about their life as long as the consequence of this decision does not infringe on another person’s autonomy (Hawley, 1997). Autonomy suggests that adults and individuals that are mentally able to make decisions have the right to accept or refuse participation in a study. It suggests that individuals have the right to access adequate information that can guide their decision-making. According to the principle of autonomy, individuals must not be confined, forced or disadvantaged for exercising their right.

The women, who participated in this study, were all 18 years of age and over and capable of giving informed consent. Prior to the commencement of the interviews, these women were provided with information sheet (Appendix 4) and participant consent form (Appendix 5). The information sheet explained requirements of participation in the study and potential participants were encouraged to seek clarification of any issue that was not clear to them. The women were assured that they were not compelled to participate in this study, and that failure to do so would not affect them in any way. Additionally they were informed that they were free to withdraw from participation at any stage without any adverse repercussion. After reading and understanding the requirements of participation, these women signed the consent form.

### 3.8.2 The principle of beneficence and this study.

The principle of beneficence implies doing or promoting good (Hawley, 1997; Huycke & All, 2000). It suggests that the health provider ensures that the care provided is in the best interest of the consumer. This study was conducted in anticipation of promoting the good and wellbeing of West African immigrant women in Australia. These women were among the recent immigrants whose
construction of health may not be understood by health providers in Australia. Understanding these women’s meaning of health has the potential for improving the health care provided to them.

3.8.3 The principle of non-maleficence and this study

The ethical principle of non-maleficence may be defined as “above all, do not harm” (Hawley, 1997; p.26). This principle advocates that the health researcher or health provider refrains from doing anything harmful or anything that can expose the participant or the patient to the risk of harm. The issues concerning confidentiality and anonymity are usually identified when discussing non-maleficence.

Whilst anonymity is not possible with face-to-face interviews, for the purpose of conducting interviews and follow-up procedures only the researcher had access to the identities of all participants thus enhancing confidentiality. Additionally, each participant chose a pseudonym, which further promotes confidentiality when disseminating findings of this study. The women were informed that the transcripts would be kept locked in a filing cabinet in a secured office at the University for the duration of the study and for five years after the completion of the study. After this time, they will be shredded and all computer files of the study will be destroyed. It was not anticipated that the interview would create any physical hardship or harm for these women. However, it was anticipated that they may become distressed while relating sensitive and painful information about their lived health experience in country different from that in which they were born. O’Brien (2003) suggested that “conversations that explore the subjective meaning of a situation may stimulate self reflection; reappraisal and self disclosure and this may be distressing for individuals” (p.116). The women were provided with a contact list of free counselling services in case of any distress while relaying sensitive and painful information about their health experience in Australia (see Appendix 7).
3.8.4 The principle of justice

Justice means that individuals are treated equally without subordination or discrimination based on socioeconomic status, race, religion, gender or education (Hawley, 1997). It implies providing equal opportunities for individuals to achieve their goals or accomplish a task. Justice means fairness and in abiding with this principle, researchers are advised to be cognisant of their obligation to the participants by sharing knowledge obtained during the researcher-participant encounter.

In this study, all the women were given equal opportunity to suggest the time and place most convenient for them to participate in the audio taped interview. They were also given equal opportunity to talk about their meaning of health until they had nothing more to say. All the women that were referred to me and willing to participate were given an equal opportunity to participate in this study. It is possible that some women who could have participated in this study were not recruited.

3.9 Summary

This chapter has situated this study in the constructivist paradigm. Relevant aspects of (Lincoln & Guba, 1985) work were presented. The methodological guidelines used in naturalistic inquiry and how it relates to this study were explained. The decision trail that culminated in identifying emerging themes was enumerated. The next chapter presents the first part of the findings on the meaning of health to West African women in Australia.
CHAPTER 4
MEANING OF HEALTH FOR WEST AFRICAN WOMEN IN AUSTRALIA: BEING HEALTHY AND BEING SPIRITUAL

4.1 Introduction
The naturalistic philosophical and methodological underpinnings of this research were outlined in the last chapter. Four major themes were identified: “being healthy”, “being spiritual”, “being a migrant” and “encountering the health care system” (See table 3). In this chapter, two of the four themes: “being healthy” and “being spiritual” will be examined. The women explained what it means for them to be healthy and what spirituality means to their health. Below, the women's notion of being healthy and the way they connected their spirituality to their health is investigated.

4.2 Being healthy
Table 4: Being Healthy

<table>
<thead>
<tr>
<th>Major theme</th>
<th>Minor themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being healthy</td>
<td>• Defining health</td>
<td>- Having mental well-being</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Being wealthy</td>
</tr>
<tr>
<td></td>
<td>• Being overworked</td>
<td>- Being stable in the physical body</td>
</tr>
<tr>
<td></td>
<td>• Being health conscious</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Suffering and smiling</td>
<td>-Suffering in silence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Suffering as normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Smiling to hide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suffering</td>
</tr>
</tbody>
</table>

The notion of "being healthy" was very strongly represented in all the interviews. The women interviewed provided their definitions of health to describe the meaning that health had for them. While most of the women
explained their health in terms of physiological health, they emphasised that a sound understanding of their health could not be understood from the physiological aspect alone. They explained what it meant to them to be conscious of their health. The women emphasised that it was from their experience of overworking, their domestic violence experience of suffering and smiling and their migration experience that a good understanding of their meaning of health could be obtained. The dynamic nature of the meaning of health was also revealed in the women’s conversations as they talked about their notion of a healthy woman’s body. This created the sub-theme - "being health conscious".

4.2.1 Defining health

4.2.1.1 Having mental wellbeing

All the participants explored various areas of their experiences and emphasised that health means mental wellbeing. Mental wellbeing for these women is a state of emotional stability whereby a person has a sense of belonging, experiences high self-esteem and feels worthy of competing for available jobs with other professionals. However, they used their experience of low self-esteem and inability to provide for their needs to describe themselves as unhealthy.

Nineteen women considered their search for employment over a period of years as an enormous struggle. They believed these experiences reduced their self-esteem as individuals and that it made them feel unworthy of competing with other professionals here in Australia. The women stated that they felt distorted in their thought patterns and were ‘depressed’ on many occasions. These women described their feelings of depression; they spoke about their experience of feeling unfulfilled and considered themselves failures for not being able to achieve what they sought to accomplish. They used many words such as feeling sad and unworthy to explain their depressive experiences.
Eighteen women perceived that something was wrong with them as individuals. They explained that their inability to obtain employment when they wanted to work, and in the position or profession of their choice, suggested to them that they were not capable of competing adequately with health professionals in Australia. They experienced feelings of sadness, self-pity, and became withdrawn, feeling they had wasted the years they spent studying in their countries of birth. Feeling alienated and being isolated from family members troubled them, and according to Stella:

“Depression means anxiety, when you are worried... You panic a lot, I mean little things trigger you and you want to cry. This is because a lot of things have been built up and you are ready to explode at any time” (Stella).

Nineteen of the participants emphasised that they felt stressed most of the time. Managing family life, studying and performing jobs that were physically demanding meant stress for most of them. Fifteen of the women had been dependent on paid household help and family members in their countries of birth, while nine out of these fifteen women even had personal chauffeurs. This background made learning to live independently in Australia stressful for them.

“I am someone by nature who is not used to hard life working so hard physically. I was working mentally back home in my country I was in my office doing paper work, light job and things like that but on getting here I was doing physical work, lifting, lifting people, cleaning,... Ah! that was really stressful being my nature I wasn't brought up that way so it was stressful for me” (Sandra).

Many things competed for these women’s time. They needed to get to their places of work on time, as well as organise other aspects of their lives. Sixteen women explained that they were charged extra fees whenever they were late in picking up their children from child care centres because they attended lectures and had school assignments. There was little time for them to rest. They became impatient with their children and husbands.
“Stress is when you are tired, physically, emotionally you are anxious you are not only tired physically but you are also worrying about how I’m going to be able to go to work tomorrow, how am I going to be able to get up and do the dishes or how am I going to be able to iron the children’s clothes, how am I going to put those washing in the washing machine and in fact endless worries borne out of tiredness. Sometimes I’m on my bed and I can’t even sleep why? It’s because I’m thinking ahead about what I have to do the next day. That I have to cook and do some other things. I keep thinking about how I’m I going to go about the tasks ahead” (Rita).

Nineteen women considered their experiences of tiredness as affecting their emotional health. They considered the absence of extended family members who could provide assistance as responsible for this tiredness. All the women with this experience talked about how they often became emotional whenever they compared their past social networking experiences in their countries of birth with that of Australia. These participants emphasised that they often act out this emotion on their immediate family members here in Australia, especially the children. The women explained that overwork and its associated tiredness further affected the affection that they wanted to give to their children.

“So many times, it’s only natural that when you are tired and stressed you are prone to be irritable, nervous, anxious and all these negative emotions you are very impatient and touchy. So when the kids want to come around and maybe spend time with you, they want to snuggle they want to cuddle mummy, they want mummy to show some affections but mummy is dead tired, too tired to even care” (Rita).

4.2.1.2 Being wealthy

Eighteen women explained that health means wealth to them. They explained literally that health avails people the opportunity to accomplish their goals. Sixteen of these women stated that only healthy people can think about and follow up on business ventures that can create more wealth. However, when one is unhealthy every other thing becomes secondary. All of them acknowledged that illness is expensive due to the cost of treatment and sick days off from work. They explained that health provides an opportunity
for people to reach their goals in wealth creation and in fulfilling other life aspirations.

The women related their experience as poor new arrivals to equate health with financial wealth. They considered their initial experience as one of suffering because they could not afford what they needed. On arrival to Australia, fifteen of these women could not afford independent accommodation and therefore had to stay in shared accommodation with friends. As a result of their financial difficulties, they were often unable to adequately feed their families. These experiences indicate that the women see money as an integral ingredient in maintaining their health.

“…health is wealth. …the health that I can talk about is wealth; it covers every aspect of life” (Oluwatosin).

However, seventeen women perceived their initial experience of poverty as an opportunity to enhance their potential. Their experiences compelled them to look for work. They needed money to care for their children and pay their bills as acknowledged in Sola’s conversation:

“I can say it’s a blessing for me to come here (Australia) because it has helped me to develop and be independent” (Sola).

4.2.1.3 Being stable in the physical body

Health, to these West African women, means equilibrium in the various parts of the body. They emphasised the importance of a balance in the physical body in their attempt to define health. Twenty women explained that they required a stable physical body to perform daily activities. Most of these women stated that they participated in a number of indoor and outdoor activities and considered themselves healthy when they were able to perform these activities. These West African women described health as physical wellbeing. They emphasised that health is having a strong body free from physical pain. Joy and Anna described what health meant to them:
“Health is a well being of a person, strong in the bones, all alert,...” (Joy).

In the same vein Anna said:

“...when your body is not feeling any pain. If your body is okay and you are not feeling anything, it means you are healthy” (Anna).

In addition to psychological wellbeing, these West African women were preoccupied with identifying symptoms of body weakness, discomfort and diseases, and intervention was not initiated in the absence of these symptoms. Their notion of health means that any illness that does not make them uncomfortable does not require health seeking. Utilising preventive health services in the absence of symptoms was considered a waste of time. As discussed in the biomedical model, these women emphasised the body as a system of body parts that must maintain its status quo and a disturbance in this state of equilibrium means taking action to return it back to its normal state. Disturbance in the status quo means disease or sickness to these women. They respond to pain by seeking pain relief. However, the provision of analgesia may simply provide temporary relief of a disease process without paying attention to other socio-cultural factors that might have triggered the disease.

Health also means the absence of disease in the physical body for eighteen of these women. They explained that they had frequent experiences of malaria fever from mosquito bites when they were in Africa. The malaria fever made these women very ill on many occasions and they relied on medical attention and traditional herbs. The women explained that they had not had malaria fever since their arrival in Australia. As a result of this context, health means absence of malaria fever and other types of illness. According to Precious:

“It (health) is a state of being well, ...without any sickness” (Precious).

In the same manner, Warris explained what health means to her:
“Health to me is not to be sick. If I am not sick, I feel healthy, the moment I am not sick, I am healthy. I can be bombarded with problems and I don’t consider it as sick” (Warris).

A state of instability in these women’s physiological status threatens their strength and ability to perform physical activities. The women were saddled with many responsibilities for which vigour and vitality were required. They identified areas of overwork that suggest health as a focus on the ability of the body to attend to daily activities. The women’s roles as mothers of school-aged children, wives to their husbands, and the expectations from their places of work, demanded physical fitness.

### 4.2.2 Being Overworked

The women narrated their experience of being overworked at home and at work, which made them physically tired. Unlike their experiences in Africa where they had support from their extended families, the women had to attend to every aspect of their lives without the assistance they were used to. They observed that in contrast to their lives in Africa, they frequently became fatigued in Australia. Oluwatosin spoke of her experience:

“…in Nigeria I didn’t experience so many of those days where I get so much tired or so much weak physically. But here in Australia I see myself getting tired more often than I was used to in Nigeria, because there is just too much to do and it has just got to be done” (Oluwatosin).

Henrietta described experiencing exhaustion and continuous complaints of body aches:

“…a lot of people and they are also busy, they go to work, they come home its like busy, busy, everybody is complaining, they are tired, they are in pain” (Henrietta).

Michelle, a mother of three young children below the age of seven years described the recurring domestic chores that women in Australia do without
any assistance. Attending to these chores alone without easy access to relatives or assistance from their husbands made the women overworked.

“Yes, always tired because they (African women) do everything and a lot. Only the same woman will have to do shopping, you have to do your washing and pack them up, you have to clean up, clean the children’s mess, and at the same time you have to sit with the children to help them with their school work, it is very hard” (Michelle).

Twenty women spoke about their experiences as African women in that their husbands were not traditionally expected to assist with house chores. This experience may be typical of patriarchal societies irrespective of the part of the world. However, the women identified this experience as problematic for them considering that they are now living in one of the Western countries where women may be more aware of their rights. Most of them expressed their feelings about their husbands being insensitive to the overwhelming load of work:

“We African women have problem in this area (lack of assistance with house chores from husbands) because the African men are not helpful at all at home (here in Australia). They don’t do anything at all, especially if you have children, you’ve got a lot to do all the time and that is why I think the women are tired all the time. They (husbands) don’t help, they don’t do anything, they just come home, eat, put TV on, sit down every time of the day. And you have to wash, you have to clean and at the same time you’ve got a little child that you must change nappy for. You have to bath them, clean them up, you have to put them to bed, it is too much, I am really tired and I am not happy at it in this aspect of marriage at all” (Michelle).

The women considered their experience of overwork at home using their African context as a framework. Sixteen women explained that their husbands liked homemade meals that they had become accustomed to in Africa and refused to eat out in restaurants or partake of take-away food. These women’s husbands also did not like left-over food or their food being micro waved. While one may argue that homemade meals are healthier for the family, preparing fresh homemade meals everyday, in addition to their
paid work for the family’s financial benefit, meant overwork and no leisure
time for these women, resulting in frequent fatigue. For many of these
women, the expectation of cooking fresh food everyday was not considered a
problem when they were in Africa, but the context of their living outside the
reach of extended family assistance made this expectation problematic.

Nonetheless, seven women identified some areas where their husbands
rendered assistance at home. One of the women, Sola, who works on
weekends, explained that her husband attends to the three children while she
goes to work and takes them to their sporting activities. Oluwatosin also
stated that her husband renders assistance whenever he observed that she
(Oluwatosin) was too exhausted to continue to attend the house chores. Sola
however cautioned that African men do not take up the commitment to
continually render assistance at home. She said that although her husband
may take the children out for activities, this cannot be expected all the time.
According to her:

“But as for daddy, it’s only when they (children) see daddy and
he may even say sorry I don’t have the time, I can’t go
anywhere. I have to rest” (Sola).

This experience of overwork at home informed the women’s suggestion that
health means having the physical energy to drop off and pick up the children
from school. It means physical ability and strength to attend to their
household chores without assistance from their husbands. Health means
physical ability to meet the needs of the family and according to Emma:

“…health is something that keeps you going” (Emma).

The women stated that they were not only overworked at home, they were
also overworked with extra work shifts in order to support their extended
family members in Africa, to pay bills and mortgages. Apart from the
challenges of settling in a new country, these women were taking up the
lifestyle of their new country; in addition to their commitment to their countries
of birth. All the women spoke about the importance they attached to
rendering financial and material assistance to their parents and other family members in Africa. Nineteen women stated that this financial commitment to family members in Africa propelled them to do extra work. They explained that the cultural idea about family in Africa was that of reciprocity. The children were expected to take care of their parents when they grow old because the parents looked after them as children when they were young. The children (wherever they were) were expected to provide for their aging parents. Joy talked about what was expected of her:

“It (supporting extended family members) is compulsory because that is also what I said earlier when I said ‘we take care of ourselves’ even financially. Take for example, myself I left my mother behind, I left my father behind and they are all elderly people. I left my cousin, my brothers, my sisters and all these people depended on me when I was back home, so I have to continue to support them from here, that’s just the problem” (Joy).

Jenny used the word ‘abandon’ to describe her failure to remit money to her elderly parents in Africa.

“…you can’t just abandon your parents like that, you have to understand that they stopped working and they are old so you can’t just leave them to go hungry, so when you work here you have to send some money back to them to feed themselves” (Jenny).

Seventeen women (especially those whose parents were not living in Australia) explained that culturally speaking, they were expected to be physically available for their elderly parents to assist them with all areas of daily living. They regarded sending money to their parents as a way of compensating for their lack of physical presence. With the absence of a state support system in Africa such as Centrelink, the women emphasised that their responsibility of providing financial support to their parents must be met even if it meant overworking themselves. Health therefore was also considered by these women as the absence of any constraint in terms of sickness that may hinder them from meeting their responsibilities.
Three women, who had their parents in Australia, also stated that there were expectations from aunties, uncles and cousins in Africa to send money to them. They explained that all family members were expected to care for any family member that was in need. Warris, who came to Australia when she was 9 years old and had been in Australia for 16 years identified the underlying health promoting perspective that propelled the women to strive to support the extended family members in Africa. She stated that sending money home means happiness, fulfilment and success for these women. She mentioned one of the traditional beliefs that made supporting extended family members compulsory for the women.

“...you can’t say you won’t do it (support other family members) because you just have to. Sending money home means fulfilment and satisfaction; it is a sign of feeling of success to them. Our belief system is that as a traveller, the one who goes and turns his neck to look back home is a successful person. So, let’s say if you come to Australia and you just worry about the children you have in Australia, your aunties and cousins will disregard you and you will be treated as an outcast in the family” (Warris).

Warris cited an example to emphasise her point:

“There is one that came here to study for his medical degree. The mother sold her properties and everybody in the family gave him money to be able to travel to Australia. But when he finished and stayed here working, he didn’t send money to anybody at home. He was not giving money to the wife’s family; he abandoned everybody. Unfortunately, he died here, but when he died his family rejected him. They didn’t want him buried in the family compound amongst other family members and that is a big insult in our tradition. In our tradition, when you die your family should welcome your body back, unless your wife and children begged for the family’s indulgence to be buried somewhere else. But in this case the family didn’t want the body, he was rejected” (Warris).

The women emphasised the pressure that payment of bills placed on them to overwork. Thirteen of them described their experiences of either doing overtime work or doing two jobs in order to keep up to date with their bills. According to Precious, the pressure to pay her bills did not allow her time to
stay at home to rest or relax. She described how she had to go from place to place working in order to pay the bills.

“There are always a lot of bills around to pay and so you have to run around to make ends meet…” (Precious).

The story Stella told was similar. She reiterated that there was no other means of paying the bills other than overworking herself.

“There, body aches but still you have to work very hard otherwise you can’t pay bills” (Stella).

Payment of the mortgage was another reason the women were overworked. Nineteen women were living in their own homes and they were mostly first home buyers in Australia. The West African women in this study placed a lot of value on owning their properties. They came to Australia with this orientation and they overworked themselves to pay their mortgages in order to own their own properties in the future.

Eighteen women stated that health means ability to sleep, eat and relax at home whenever they want without the pressure to overwork. They identified the impact that working too much was having on their health, physically, socially, emotionally and spiritually.

“It (overworking) has a lot of impact on your health because you don’t even have time to look after yourself, you don’t have time to take proper care of yourself because you are busy,…working here and there and a lot of things like that” (Rosemary).

All the women who considered health as the ability to sleep, eat and relax identified alteration in their sleeping and eating patterns. They explained that they go to bed as late as midnight and wake up as early as 4.30 am everyday. They could not remember the last time they had an afternoon rest. Ten women emphasised that they had to wake up in the middle of the night to do some housework before their children woke up. Seventeen women stated that they were not able to follow a specific eating pattern as they were always
preoccupied with finishing their housework before eating. Twelve women spoke about their experience of disrupted sleeping patterns which has implications for their mental health. One of the women, Rita narrated her experience:

“...these days I have realised that I become fatigued easily and this is happening a little too frequently. I also sometimes find it difficult to sleep, like I will be in bed for sometime before I fall asleep and even when I fall asleep the sleep may be broken. I may wake up again and not go back to sleep for some hours. [...] As regards eating, there are days, I don’t eat. Not because I don’t want to eat but by the time I finish with dropping the kids, do the grocery shopping pay bills and going back to cook may be I have skipped 1 or 2 meals. Really this is no exaggeration” (Rita).

Emma however, had a somewhat different notion of health from most of the women. She considered a healthy person as someone who is reflective and able to consider the implications of his or her actions. Emma considered a healthy person as someone that would not overwork herself or do double shifts. Even though eight women came to join their husbands in Australia, seven of these husbands did not have well paying jobs. Also, four of these women came with children that needed to go to school and demanded other things that would put pressure on the family’s income. Ten women came with their husbands and had their children trying to settle in Australia. However, Emma’s husband had been in Australia for a number of years, had a well paying job, was living in his own house and had settled into the Australian lifestyle before going back to Nigeria to marry her. Emma gave birth to her children in Australia and she did not have to worry about paying for independent accommodation like most of the other participants. Emma worked only two days a week and she could not comprehend why people should overwork. She said:

“A healthy person to me is someone that can use his/her brain before you do anything. You think that anyone that is healthy is someone that is living? I keep saying it that you cannot be healthy if you have to do double shifts, you cannot be healthy if you have to work on Saturdays. You may put powder on your face and look beautiful but inward you may be dying. So a
Nevertheless, the stories of most of the women were that of overwork. They acknowledged that overwork affected their health in Australia but the need to meet the financial demands compelled them to overwork. It is evident that health means more than physical wellness to these women; rather it cuts across their social, emotional, psychological and spiritual life. The women’s conversations revealed that health means many things to them.

4.2.3 Being health conscious

The West African women in this study articulated that their perception of a healthy woman’s body was changing as a result of their migration. According to them, in Africa weight gain is encouraged but in Australia women are encouraged to be slim. Most of the women referred to the importance of weight gain in Africa as this was considered a sign of affluence. They stated that married women in Africa were expected to gain some weight after marriage. According to Sandra:

“That is the norm back home, people want to add weight rather than lose weight, they look for things to eat or do that will make them put on weight, that is a sign of good living. People expect that after some years that a woman has been married, she has to add weight in order for them to appreciate that the husband is taking very good care of her. That means there is enough food to eat at home” (Sandra).

However, being in Australia and having been exposed to media images of “healthy women’s bodies” in the Western context, the women’s perception of their body was changing. As stated by Warris:

“When I came here (Australia), I found it very ironic because when I was watching TV, the images they were showing on the TV as an ideal image of a woman were very skinny” (Warris).

These women were now considering themselves as more health conscious in Australia. Anna emphasised that she was not happy with the way she was
gaining weight in Australia but this was contrary to the way she would have felt if she were still in Africa.

“When I came to Australia I think my weight was maybe 52 kg or something but now I’m increasing so I don’t really feel good about that. I want to bring that weight back to how it was before so I’m trying my best to do this without joining any fitness centre because I don’t have that much money to go and spend. I know I can do it myself” (Anna).

The women acknowledged that in Australia they were more health conscious and that more emphasis was now placed on a healthy lifestyle. They identified some of the different lifestyle practices that they have adopted in Australia. Seventeen women observed that there were opportunities for more balanced diets in Australia. They explained that they had more fruit and vegetables with their meals.

Apart from the efforts of the women to eat a balanced diet, their participation in weight-watching programs was also discussed. Seven women eagerly identified the benefits they derived in going to the gymnasium. Sola articulated:

“But with the exercise issue from my own perspective, one thing it deals with body image and at the same time internally it helps your system as well. At least it keeps the joints… it also relates to good body image” (Sola).

The women appreciated that their lives in Africa included informal ways of exercising, such as walking long distances to visit friends or for shopping, pounding yams, and fetching water from wells or brooks. However when they migrated to Australia, these activities became unnecessary and irrelevant; therefore a formal exercise regime was required in order to remain healthy. This posed yet another challenge for them, as they were unaccustomed to setting aside time especially for exercise.
4.2.4 Suffering and smiling

Eighteen women explained that being healthy means freedom from the suffering of domestic violence. The women used the phrase ‘suffering and smiling’ to describe their domestic violence experience. They argued that they were used to the informal network of extended family members as mediators in situations of domestic violence in Africa. With the absence of these extended family members in Australia, there was a vacuum created for most of the women in this study. The women faced the challenging decision of whether to keep their experience of spousal abuse to themselves or report it to formal law enforcement agencies.

4.2.4.1 Suffering in silence

Although the West African born women in this study are now in a Western country that publicly denounces domestic violence, sixteen of them perceived that they were still constrained by socio-cultural factors that hindered them from reporting their domestic violence experience. Oluwatosin emphatically stated that African women are not expected to report their husbands.

“(With) domestic violence there is a constituted authority (African culture) that you just don’t go there broadcasting to the police or telling anybody who cares to listen” (Oluwatosin).

Eighteen women identified issues that surrounded their reluctance to report their domestic violence experience. These women perceived that the consequences of reporting the abuse would be severe. They feared that the police would arrest their husbands, thereby leaving them to be sole carers of their children in a foreign land. This fear ensured the continued silence of these women regarding their experience of domestic violence. However, the conversation of nine women suggested that the reluctance to report their domestic violence experience might be due to the level of most of the women’s integration into the Western culture. While all the women believed that domestic violence should be discouraged, those with more exposure to Western ideas argued that domestic violence experiences should be openly
reported and actively discouraged. One of these women, talked about her experience:

“There was a time I did feel helpless and I felt like leaving my husband because it seems as if I was getting a lot of encouragement from a few Australian friends that I met here. They were telling me that if I leave him, the government will take care of you, you will get a lot of government support, lot of money and so on…” (Titi).

Joy also predicted that as many West African women integrate into the Western culture, many experiences of domestic violence would be reported. According to her,

“The way out is far, but we are getting there. Why I said that is that the women are now getting their freedom gradually because by the time you have a friend that is an Australian, you will be able to share your mind with her. And that Australian friend or lady will be able to tell you the way and will take you to where the problem (domestic violence experience) can be solved…” (Joy).

4.2.4.2 Suffering as normal

Eleven women’s stories revealed that they did not consider most of their experiences as violence. This is because they perceived it to be generally acceptable. Maureen for instance said:

“All these agencies will not bring you together rather; it will even make it worse. Why do you need to go and report to them or seek their help when you know it’s not going to help ‘matter’… because it (domestic violence) is acceptable, no one sees anything wrong with it” (Maureen).

Most of these women (n=19) were aware of the social stigma that may accompany reporting their abusive husbands. As West African women who reported their domestic violence experiences were generally accused of not making their marriages work, these women refrained from disclosing such violence to avoid being alienated by their community.
I observed that many of the women shook their heads when describing their experience of domestic violence. I asked these women why they were shaking their heads. They explained that they used this non-verbal cue to demonstrate their frustration with domestic violence. They reflected that the acceptance of their subservient position is deeply rooted in African culture. The West African women in this study valued their community approval and avoided actions that may deviate from societal norms. These sociocultural constraints meant that these West African born women outwardly presented as happy and smiling whilst inwardly they were suffering due to domestic violence.

Seventeen women explained that they suffer various patterns of domestic violence in silence. They acknowledged that they had quite a number of difficult experiences in their intimate relationship with their husbands. They cited their experiences of financial manipulation, emotional manipulation, being silenced during family discussions, verbal abuse and bullying. The women stated that their experiences were not only or necessarily of physical beating but that their husbands took absolute control of the family’s finances, and controlled all other aspects of their lives. Titi identified verbal abuse and described the pattern that some African men tend to take in progressing from financial manipulation to emotional manipulation of their wives:

“...the first area of control that an African man will try to take charge is the finance, once they are in control of the finance, they believe that they can make every other person dance to their tunes, everyone else will be happy when they choose to be happy and everybody has to be sad when they are sad” (Titi).

Most of these women (n=17) spoke about the enormity of their domestic violence experience. They explained that their husbands screamed, bullied, attacked and ignored them and had no respect for them. They articulated that they suffered subordination in silence. Their husbands reminded them on many occasions that as the men in the house they had the right to dominate family decisions. The women emphasised that they had to take instructions irrespective of whether it was appropriate or not. They had no control over
their lives. Even when the women were tired, they had to cook for their husbands and satisfy their sexual desires. Considering that eight came to Australia as part of family reunion, their experience of domestic violence also took the form of threats. Seventeen women reflected that as their husbands were the primary visa holders they used this fact to intimidate and coerce their wives. The coercion was noted in Joy’s conversation that the husband would say:

“...I brought you here so you don’t have any right to me, whatever I say is what you are going to obey, that is African men for you” (Joy).

A number of the women (n=15) described the role of the woman in marriage from an African perspective. This pre-understanding influenced their thinking even in Australia. The women were expected to accept whatever experience they had in marriage as part of married life. This explained why these women stayed in abusive relationships. This was apparent in the exchange with Maureen:

“...with Africans once you are married, it’s for good, you have to make it work at all cost” (Maureen).

These West African women considered their social ranking as an important issue in understanding their domestic violence experience. The women were aware of the gender roles and expectations that structure African people’s lives. The women stated that quite a number of things that were not tolerated for women were justified for men, for example, certain aspects of traditional African culture validate men having more than one wife or having concubines outside the home as identified by Matilda:

“...African men think they are not supposed to be confined to one woman, so therefore they go around, they sleep around. [...] The women are expected to take it and I mean it is accepted” (Matilda).
4.2.4.3 Smiling to hide suffering

Eighteen women confessed that they smiled on many occasions to cover up their suffering of domestic violence. They considered domestic violence as an issue that must remain in the private domain. Maureen talked about how African women laughed, smiled and used pretence to deal with the suffering of domestic violence.

“For example if your husband has just beaten you mercilessly and someone knocks at your door, you pretend as if you are the sweetest couple in the whole world “ (Maureen).

Joy presented her observation that many women only put on superficial smiles to cover their experiences of domestic violence. They hide their suffering:

“African women are just smiling but they are suffering inside and I am telling you that a lot of African women have all the reason to divorce but for one way or the other, they can’t” (Joy).

In this section West African women’s constructs of their health were explored through their definitions of health. The women’s context and their experiences informed the meaning and perception of their health. The next section considered the interconnection between the women’s health and their spirituality.

4.3 Being spiritual

Table 5: Being spiritual

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Further explanations of the meaning of health for West African women in Australia and the interconnection between their health and spirituality were
revealed through the theme "being spiritual". For these West African women the immigration process was accompanied by many changes in their lives. They described how settling in a foreign country caused significant economic, emotional and physical strain for all the members of the family.

Seventeen women emphasised that as immigrants, health means holism. They explained that health goes beyond equilibrium in the parts of the body; it also means equilibrium socially, mentally, spiritually and emotionally. These women presented a holistic notion of health. Thirteen women considered themselves unhealthy when any aspect of their lives, be it social, mental or emotional was affected. To these women, an argument with somebody or any strain in relationship threatens their health. Many of them considered social disconnection as a health risk and anything that disturbs their mental status means illness. Stories of some of the women revealed that health means coherence in all aspects of their lives.

"...it (health) has to be all-round state of mental, physical, spiritual and emotional well-being not just the absence of illness" (Maureen).

"To me, health is well-being, physically, mentally, emotionally not just feeling well in the body. The emotion should be alright, mentally one is able to think straight and one is not stressed out emotionally and even spiritually too" (Rita).

These West African women all remembered the migration experience and they articulated spirituality as an important source of encouragement and strength. They emphasised that spirituality was the major resource for their health. The women talked about their strong belief in the existence of a sacred being and they spoke about the impact of being in a Christian community on their health. As African women, they spoke about issues that they perceived as causing diseases, through their belief in folkloric and spiritual forces.
4.3.1 Having inner conviction of a sacred being

All the women in this study expressed their inner conviction in the existence of a sacred being. They all believed that something higher and more powerful existed beyond the physical and material world. They explained that the belief in a sacred being sustained them during the difficult times they experienced settling into a new country. Sixteen women stated that they sold their belongings and property to finance their migration to Australia. They left their paid jobs, friends and the environment they were familiar with in Africa. On coming to Australia, they were not familiar with the people, the environment, the food and the culture. With the loss of all that they valued in Africa, they considered God as their "all in all" in Australia. They acknowledged that they could have died in the midst of their negative experiences but that their being alive is due to the protection of a sacred being. Joy referred to this sacred being as God, and linked God to every aspect of her survival...

"God is everything to me, He is the Supreme Being, in all my life, He is everything to me. I don’t know where to start to tell you what God is. God is the most Supreme Being and we must all give glory to Him because it is by His own grace that we are still living. It is by His grace that you can come here and sit down to interview me, it is by His grace that we breathe and do everything so God is everything in all my life.” (Joy).

Eighteen women reflected on how they wrote many job applications, attended many interviews with no success. They remembered the frequent negative feedback following job interviews. They described the temptation to give up the search for work and explained that they could have gone back to Africa as a result of the frustration and disappointment. They emphasised their inner conviction that it was a sacred being that was directing and encouraging them not to give up. The women considered the sacred being as God, who they viewed as their creator and their maker. Stella emphasised her connectedness to this sacred being as the only condition for her being well.

"God is the Omnipotent. He is the creator of heaven and earth. ...I know there is somebody there looking after me."
...most of the time I ask God for direction. Whatever I face I pray first because I know the strength of God has to come upon it before it is okay with me. I consult my maker first before I do anything. I pray that the Spirit of God should prevail” (Stella).

During the conversation with Rosemary she stated her conviction that a specific influence was responsible for everything in existence and that this influence was God:

"...everything around us came into existence from a particular force and we believe God himself is the one behind everything" (Rosemary).

Nineteen women reiterated that the essence of their survival in a new country was due to this spiritual connectedness. According to Oluwatosin, her being spiritual explained the joy and tranquillity that she enjoyed.

"...but I am convinced as an individual of this spiritual being that gives me the joy that keeps my mind in the perfect state. What I mean in the perfect state, I mean the state that it is void of worry, it is void of anxiety, it is void of fear" (Oluwatosin).

The response of Ammah to the impact of being spiritual on her emotional health was similar to that of Oluwatosin. She reiterated that her faith in the spiritual being gives her happiness in every aspect of her life.

"Oh, faith gives me more happiness. If any thing comes on my way, I always say that I have faith in God, and I believe in Him and my heart will be full of joy" (Ammah).

Twenty women spoke about the importance of their inner conviction of the existence of a sacred being. The women however emphasised that their personal inner conviction of the importance of a sacred being did not influence their professional practice. Considering that more than half of the women were working in the health related sector, they explained that their professional practice was guided by their professional code of conduct and

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their employers’ requirements. The registered nurses among the women explained that they followed best practice procedures and referred patients to relevant allied health services as required. Eighteen women nevertheless explained that their cultural background and their personal belief about a sacred being permeated their personal decisions when they became sick.

“My belief in God is a personal thing and it is not imposed on my patients. As a registered nurse, I give medication to my patients as ordered by the doctors. However, this does not mean that I depend on medications when I become sick” (Maureen).

“For example, there are clinical guidelines and manuals that I follow in caring for my patients. My professional expectation is different from my belief. As a Christian, when I am sick or troubled, I call on God” (Sola).

All the women in this study were Christians. This may be a reflection of the dominant religion of the West African women in Australia or it may be more of the sampling bias. Being Christians, the women talked about their trust in the Christian god (God) to heal. They made reference to their belief in this God as the one that held final authority over their health. They described how they were sustained through their belief in this God. The women’s trust in their Christian God to heal different types of health related problems was clearly identified in the women’s conversation. They presented God as their healer. Stella posited that:

“… as Christians we believe God is our healer” (Stella).

In the same vein, Onome explained that:

“I think God is the Supreme Being and the place he takes in the process of healing is that if you believe in him, he will just heal you instantly because my belief is that he created us, so being our creator he knows what we go through” (Onome).

The women did not only talk about their trust in God to heal, they also spoke about how their belief in God had sustained them. They considered their
belief in God as their source of inspiration in Australia. They discussed at length their experience of starting their lives over again in a different environment explaining that they found this very difficult and challenging. The women talked about how they were sustained through the strain of migration. In the words of Rita, her believing in God was her life-wire.

"But in it (experience of migration) all as a Christian I really thank God. I don't know how I could have felt the impact mentally, physically in this country if it wasn't for my Christian faith. And I am telling you that is the truth, it is my faith in God and this has been my life-wire" (Rita)

Titi also narrated the experience of living in a new country and acknowledged that her belief in God was the only fuel that kept her going.

"I believe that over these period of years it was a big struggle but I believe it has reduced my self esteem as an individual and it made me feel that I was not worthy of competing with other professionals here ...When I was going through all these experiences, the only thing that sustained me was my faith in God" (Titi).

Nineteen women talked about their medical experience and the resourcefulness of their belief in God. Five of these women were either registered nurses, pharmacist or microbiologist in Africa. Fifteen women that had been working in the health care sector since arriving in Australia were working in other capacities such as schoolteachers, bankers, computer analysts and accountants in Africa. They only received their training as registered nurses, enrolled nurses or assistant in nursing when they came to Australia. The need for these women to change their career pathway may be a reflection of the work available to migrants when they arrive in Australia. This may also be due to the urgency for these women to find a means of livelihood when they arrived in Australia.

One of the women who was a chemical engineer in Africa but now a registered nurse, Sola, spoke about her experience. She stated that her belief in God has sustained her through the anxiety of carrying her first
pregnancy, which was complicated by a diagnosis of gestational diabetes. She had her first pregnancy soon after she arrived in Australia and had not gone to the university in Australia to obtain her Bachelor of Nursing degree at this time. Having her first experience of pregnancy in a new country without an immediate family network of support and advice was worrying for Sola. She stated that she had never heard of this condition before and could not imagine how serious it could be. She stated that her faith in God was the only source of strength.

“I didn’t have any clue about gestational diabetes…I was feeling very scared because it was like a taboo to me,… it was really something serious because they said if they have not discovered that something negative could have happened to the baby. I kept praying about it seriously, it really affected me initially, because I kept thinking, worried but after a while I summoned the courage that it’s only God that can fix whatever problem that may be there. And God really intervened” (Sola).

Fifteen women irrespective of being health care workers in Australia confessed that certain medical terms they encountered created some anxiety and fear in their minds. They reflected that they were not used to hearing complex medical terminology from their medical doctors in Africa. They explained that each time they presented to their doctors in Africa, the doctors assessed them to determine what was wrong and the doctors initiated treatment without telling them “the big scary words”. However, the women stated that doctors in Australia used diagnostic terminology which the women considered fearful on many occasions. They explained that their Christian beliefs strengthened them in overcoming their fear. Ammah and Sola explained that medical diagnostic terminology generated fear and anxiety that they only overcame through their Christian belief.

“If you don’t believe in your God and you get any of these sicknesses, all the time you will be thinking about it. The person will be thinking all the time. So if you don’t have God and you don’t put your faith in Him, you will be living in absolute fear with big names that doctors use” (Ammah).

While discussing her diagnosis of gestational diabetes Sola emphasised that:
“...even back home we have the traditional clinics or whatever they call them and people go there for treatment and check ups, but we didn’t know all these but coming to Australia.... They started calling different things with different names... I believe spiritually that God is above anything and I still hold on to that faith and it’s really working for me and also in my family” (Sola).

During the course of the conversations with the women, the influence that their Christian beliefs had on their health behaviour was evident. They engaged in private activities such as praying, meditation and Church attendance. The women’s initial action when they fell sick was to pray, they took tablets only when they felt led by the spirit, claiming that Jesus was their doctor.

The women’s Christian beliefs influenced their level of compliance with biomedical advice. The women relied on the direction of the divine being rather than biomedical intervention. While talking about taking prescribed medication when she was pregnant, Ammah stated:

"When I put the medicine in my palm, I looked at them in my palm, it was a lot of them, I think about five of them on the spot, then I put them down. I looked at them again and put them down, I did like that for about three or so times, I can then feel in my spirit that something was telling me not to take the medications and I didn’t” (Ammah).

The women’s strong Christian beliefs also influenced their utilisation of biomedical health resources. While volunteering an explanation for her under-utilisation of Western health resources in Australia, Joy identified these women’s individual faith in God.

"God is a great healer and that’s why when we ask that question about some people believing in and some people not believing in this entire pap-smear thing. (Beating her chest to show her conviction) If you have faith that you won’t participate because you believe that God is there for you surely you can’t have it because God is the great healer. If
you have any sickness and you believe that God is going to heal you, he will but it is an individual thing" (Joy).

The women’s conversation indicated a subjective definition of health. They suggested that peoples’ use of alternative health methods may explain their level of willingness to uptake preventative Western health services. Matilda’s story illustrates the influence of the women’s spirituality on their utilisation of other health care services in Australia. She stated that she would rather tell God the problem she had with her husband than consult a professional marriage counsellor or psychologist

“...when I have problems with my husband I just go to my room and cry and tell God about it because He knows how to fix it. ...that (consulting marriage counsellor or psychologist) is the last thing on my mind, I can never go and seek their (marriage counsellor or psychologist) counsel. To be honest, I will like to say that I thank God for my experience in life, in my exposure to the bible and to be honest if there is anything I personally think there is nothing that the psychologists are going to tell me that is not in the bible” (Matilda).

Titi similarly found her Christian faith and practice to be most valuable health resource when she was experiencing domestic problems.

There was a time I did feel very helpless and I felt like leaving my husband, ...but I resisted that temptation... In all situations that I found myself, I just kept on holding on to the word of God (Titi).

Onome also did not seek professional advice when she was experiencing psychological problems. She related her experience of not able to find a job in her profession and how this affected her mental health. Praying and studying the bible constituted a significant resource that she tapped into for her healing.

"No, I did not go to a counselor because I don’t believe in that because I for one I studied guidance and counseling psychology, so I tried to deal with it especially with prayers because I don’t believe in counseling may be because I studied guidance and counseling. I don’t believe that it will be
easy for anybody to counsel me, so I just pray, the only way I helped myself was by praying and reading the Bible” (Onome).

The women’s Christian belief also influenced at what point they accessed health resources. For these women accessing biomedical health resources was a last resort. Oluwatosin described her course of action in a typical situation.

"I will first of all pray, then use that (herbs) for dysentery before going to see the GP (General practitioner)" (Oluwatosin).

The women stated that there were situations when they experienced headache, stomach ache or simple cuts and might not access health care facilities at all. From Onome’s point of view,

"But if I feel any headache or pain, all I do is just to pray and that has always been solving my problems. I can confirm that it has been working for me” (Onome).

4.3.2 Being in Christian communities
The women in this study explained what it meant to them and to their health to be part of a Christian community. Even though all the women were Christians, they belonged to different denominations and their churches were located in different parts of Sydney. Six women were Catholics, three were Anglicans, five were Baptists and seven women were Pentecostals. These women considered themselves as belonging to the body of Christ and community of Christians. According to these women, going to church and meeting other members of their various churches meant going to a place of timely support, encouragement and counselling in different experiences of life. They considered the Christian community as an avenue for resolving certain women’s health issues. Being in the midst of fellow Christians according to Oluwatosin could help in resolving health issues like domestic violence

“You have the church community if the woman is a Christian we have Clergyman that can actually come in prayerfully with
the wisdom of God to help resolve such cases (Domestic violence experience)” (Oluwatosin).

Nineteen women described attending church as an activity where they could meet other Christians of different cultural, socio-economic and professional backgrounds but feel connected through Christ. Most of the women who had experienced racism and financial hardship obtained emotional and material support from church. While the loss of supportive family/kinship relationships poses one of the major challenges of migration, seventeen women considered being in the midst of other Christians as a great opportunity to access Godly counsel. According to Rita, the Church members provided timely support and encouragement in a new country.

“Yes, I do prefer the informal network of Christian friends because of the advantages attached to it. The first one is the accessibility, they are easily accessible, I don’t need to book any appointment. All I need to do is just phone them. Also, as I said these are people that I trust that will give me good counsel. They will not give me counsel that will escalate my problems but counsel that will be based on the word of God which is supposed to be a final authority on every aspect of human life” (Rita).

The Christian communities were also regarded as an alternative to biomedical resources. Many women explained that belonging to a Church was an opportunity to harness corporate prayer. They considered Church meetings as avenues where Christian confidants can be sought and found, and thereby tensions associated with sickness could be relieved.

“You go to the pastor and your pastor will pray for you. You can even confide in your Christian sister to pray for you and you can join hands to pray together” (Ammah).

The women in this study perceived being a member of a Christian community as a source of support for living outside their countries of birth. For these women, not only did living outside their countries of birth mean being outside the reach of close family members, it also meant they needed to look for new friends and acquaintances for social and spiritual support.
4.3.3 Believing in folkloric and spiritual forces

In addition to these women’s belief in a sacred being, 18 of them confirmed their inner conviction of the existence of other spiritual forces like witches, wizards, evil eyes enemies and spells. The women in this category believed that spiritual forces had the ability to negatively influence peoples’ health. They believed that the witches, wizards, evil eyes, enemies and spells emanate from the devil and that they can cause all kinds of disease. They reconciled the two disparate stances of believing in God and believing in folkloric forces by explaining that their God protects them from contracting diseases. They believed that the sacred being is their shield and fortress against any illness from the devil. As observed on many occasions throughout the interviews, specific distinctions were not made between each of the forces. Even though the women believe these forces exist, they believe that these forces cannot harm them as Christians. Furthermore, even if they experience an illness they trust their Christian God can heal them. The women’s belief that spiritual forces can cause certain diseases is illustrated by Stella’s story.

"I know there are evil forces around us. I believe things do happen. ... as Christians we believe there are demons, we believe that there are spiritual wickedness in high places and that is why you have to know the God you serve and hold on to him...” (Stella).

Ten women discussed that it was possible for evil forces to terminate people’s lives. They explained that they had seen people dying mysteriously and that they could not think of any physiological explanation for those deaths. One of the women, Agnes, narrated an incident she witnessed when she was in Africa. A man died in an airport on his way to London. Agnes argued that she did not believe the man died a natural death. She explained that the man refused to repay an amount of money he owed and that the person he owed money to cursed him. Agnes explained that she believed the man’s death was due to the curse.
The women also discussed their belief that some people were supernatural beings in human form. The devil has planned evil things for these beings to undertake. According to Agnes:

"There are people that just go along with the flow but physically people look at them as if they are persons but inwardly they are dead, they (evil forces) have killed them" (Agnes).

Twelve women expressed their belief in the ability of evil forces to cause disease or other terrible things irrespective of where one was living. They believed that it is possible for witches and wizards who are enraged with an individual for any reason to afflict such individuals with illness even when living in Australia. The women explained that even though they are living in Australia, they still have their lineage in Africa and that they remained connected to this lineage.

"...but I believe that people with the African race still have that spiritual connections, these are forces that are actually responsible for circumstances in peoples’ lives. Somehow it is still possible even when you are here for those forces to come but with prayer God will help..." (Rosemary).

Rosemary described the experience of one of her African friends living in Australia. She explained that her friend had difficulty with conception despite medical treatment. She stated that if the problem was gynaecological, the medical intervention would have solved the problem. However, the persistent difficulty in the face of medical intervention reinforced her belief that evil forces could cause terrible experience irrespective of one’s location.

"Actually, I have seen about one or two cases, one was from barrenness and she said that she has not been able to have a child even upon all the medical treatment that she has received, she then concluded that it must be from spiritual forces from families back home in Africa" (Rosemary)

Seventeen women believed that there are "good eyes" and that there are "evil eyes". They contended that "good eyes" bring about favour, mercy and life
successes. According to the women, "evil eyes" can cause diseases. They believed that when "evil eyes" are on an individual it will be difficult to live a healthy life. Michelle pointed out:

"...African people believe that some diseases are caused by evil eyes, or people that don't like you" (Michelle).

The women also related a belief that when an individual engages in activities that are out of character, then such a person is under the influence of spells. One of the women, Henrietta, cited an example of a situation that may depict the influence of spells. Traditionally, African men consider household chores as the sole responsibility of women.

"...So if your husband comes out to help, then they will say the woman has probably cast a spell on the man and the husband is now doing everything for the woman" (Henrietta).

The women reiterated that their belief in the existence of spiritual forces sometimes influenced their health seeking behaviour. Onome stressed that when Africans believed that witches caused a sickness they sought help from witch doctors.

"The only one I know is that if the sickness is very strong and they can’t find answer like when somebody is not responding to treatment. Maybe they have done series of tests in hospital and they cannot even find the cause or anything wrong with the patient, I think they believe that it is a spiritual thing and it has to be treated spiritually" (Onome).

As well as their belief in the spiritual forces the women also spoke about their folkloric belief. Agnes talked about the African folkloric belief that pregnant women should not disclose their due date of delivery.

"...we believe that it is not good for people to know when you are having a baby, they don’t like people to know and you have to keep it a secret from people apart from your parents, your husband and probably very close sisters staying with you. This is because they believe that if you tell people, on
Agnes also narrated the African folkloric belief about using local herbs in enhancing opening of the cervix at delivery.

“No, it (local herb) is not meant to make people feel better, it is just a belief that it will help keep the pregnancy and make the woman deliver the baby safely, they believe that if this is done that the woman’s cervix will open properly during childbirth. Some people don’t believe in it and they don’t do it, but some people do it religiously. They believe that it will help drive away any evil that might have been plotted against the woman” (Agnes).

Even though the women believed that spiritual forces caused some diseases, they also believed they were immune to such diseases. The women believed that the protection from their Christian God was sufficient for them. They believed that their Christian God could protect them from the evil activities of witches, wizards, curses and spells. These participants also believed that even if they become sick, the sacred being was able to provide the buffer so that they would not die from the sickness. The women believed that as Christians they have been washed with the blood of Jesus. They explained that their praying to God, their participation in sacraments and Holy Communion meant that they were covered with the blood of Jesus. According to Oluwatosin the insurance she had was the blood of Jesus.

“I know that for the Christians we believe […] that some sicknesses come not just naturally, they come from the devil …and if you have the coverage, the insurance that covers you with the blood of Jesus you probably will not be attacked with any of such sicknesses” (Oluwatosin).

4.4 Summary
In this chapter, two of the four major themes: “being healthy” and, “being spiritual” describing the meaning of health for West African women in Australia were examined. The meaning of health for these women was perceptive and diverse. Some of the women perceived health from a physical point of view, while most of them considered health to be more than a
physiological notion. The women explained the resourcefulness of spirituality in relation to their health. The next chapter examines the two remaining themes: “being a migrant” and “encountering the health care system”
CHAPTER 5
MEANING OF HEALTH AND HEALTH SEEKING BEHAVIOUR: BEING A MIGRANT AND ENCOUNTERING THE HEALTH CARE SYSTEM

5.1 Introduction
Chapter four explored two of the four major themes identified: “being healthy” and “being spiritual”. In this chapter, the remaining two major themes: “being a migrant” and “encountering the health care system” are examined. Through these remaining themes, the influence of the women’s meaning of health on their health seeking behaviour is explored.

5.2 Being a migrant
Table 6: Being a migrant

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All the women in this study described the experience of being a migrant during the course of the interviews. They reported that they were born in West Africa and that they migrated to Australia for economic reasons and family reunion. The women reflected on the fact that their African background placed a great deal of importance on the extended family. They were used to being part of a close knit community of family members, friends and neighbours. Household chores, happy moments, celebrations and social activities were shared within this community setting. For most of the women, the experience of being a migrant was like being thrown into a pool without any idea of knowing how to swim.

These West African women found many differences between the life style and cultural mores they encountered in Australia and those of their countries of
They described their experience of starting new professional careers. Fifteen women could not find employment in their trained professions and so chose to retrain in other fields. Other women (n=7) were compelled to have their qualifications reassessed despite this step being taken in their countries of birth prior to migration approval.

Sixteen women spoke about their experience of verbal and attitudinal discrimination. Among the women in this category, seven of them described how they were told to go back to their countries of origin. Six women also spoke about how they were reprimanded at work for the same mistake for which other colleagues (born in Australia) were not reprimanded.

Almost all the women (n=19) described what mothering in a new environment meant to them. They explained that in Africa, it is disrespectful for children to refer to their parents or their friends’ parents by their given names. Eighteen women expressed their surprise whenever their children’s friends referred to them by their given names. The custom in West Africa is that people are not expected to address, or refer to, those who are older or higher in status by their first name. In Australia, these women observed people calling their bosses and elderly people by their given names. The women could not imagine the shame that would be placed on them as mothers if their children go to Africa for holiday and refer to adults by their first names. According to these women, it would mean that they had failed in training and in disciplining of their children. These experiences were incorporated in the sub-themes that emerged in the text relating to "being a migrant". These sub-themes were: "being lonely and isolated", "beginning again", "being alienated and mothering in a new context".

5.2.1 Being lonely and isolated
The experience of loneliness and isolation was a sub-theme that the women interviewed identified as characteristic of their migration experience. This experience is better understood in the context of the communal way of life these women practised in their countries of birth. All the women explained that in Africa, family members relied on one another for support,
encouragement and advice. They shared both joyous and trying moments together. They stated that they knew their neighbours so well that they could freely go to their houses to ask about their welfare, and to ask for many types of assistance. They recalled that they needed no prior notification or appointment whenever they wanted to see their extended family members, friends or neighbours. These women were then looking forward to having the same kind of experience here in Australia. Agnes talked about her experience of not having anybody to talk to:

"…in the Western world; (in this case Australia) where you are all by yourself, nobody to talk to, not even your neighbours. I didn’t like the lifestyle…" (Agnes).

Maureen also shared her experience during the conversation:

"…you see even your next door neighbour and you try to say hello and they turn their face away or you smile to them no response…” (Maureen).

Nine women explained that the need to notify their neighbours before visiting them was different to what they were used to, and that this meant loneliness. Rita, talked about her experience:

"I have been to neighbour’s house and it’s either they are not home or they are busy attending to something else. They will just tell you that they are sorry; they cannot have you around or something like that. …I just feel lonely" (Rita).

Eighteen participants came to Australia directly from their countries of birth where they were used to the company of friends and neighbours. They explained that in Africa, if they did not see their neighbours for one or two days they could go and enquire about their welfare. They considered not associating closely with their neighbours here in Australia as abnormal, by describing it as lonely and isolating. The women not only considered knowing their neighbours as important, they also identified not finding people to talk to and confide in as an issue that bothered them. They were used to different
levels of associations and interactions. One’s next-door neighbour was the closest person to talk to and with whom to exchange greetings.

Sixteen women considered the difficulty in establishing friendships as isolating and explained that opportunities for making friends were limited in the new country. They presented the picture of the difference by frequent comparison of Australia to their home country. Titi specifically described the difficulty she had in making friends:

“I mean that compared with Nigeria, some of the available networks of friends from church and everywhere and family support was not here. I discovered that to make friends here was totally impossible. I lived in a suburb where there are a lot of white Australians around and I tried to make friends with them but I kept on receiving a sort of non-verbal push away, so I just found out that I couldn’t mix up with the women” (Titi).

Not finding friends and neighbours to assist with household chores was isolating and lonely for seventeen women. Henrietta described the experience as a confining one. Friends were too busy to assist with child minding and vice versa.

“Like when I had my children back home (in Africa), my neighbours were there anytime I went to work, they were there looking after them until I came back which is totally different from here. Here, even though there are friends around but they are also working so you can’t just tell them that they should stop work and come and support you here” (Henrietta).

Most of the women (n=14) who had been in Australia for less than ten years; stated that lack of intimacy with their neighbours meant loneliness for them. One of these women, Oluwatosin, cited an example of the lack of closeness that she experienced in Australia.

“If I were in my country, I would be able to get a helping hand at such moment (whenever she had a lot to do). But here it is not so. I know that I cannot easily go to my neighbour and say, please can you come over and help me to do the dishes, it is not possible” (Oluwatosin).
However, nine women revealed that their experience of loneliness and isolation was not in absolute terms. They explained that not all the women had the same experience in establishing friendships and connecting with their neighbours when they came to Australia. These few women described their experience of feeling welcomed and receiving assistance from people they had not known previously. Kinder explained that:

"When I came (to Australia) I had a good reception from people even those I didn't know.... They showed us love and hospitality and it has been wonderful, but I need to add here that this is not general, some people found it very hard and rough but for me, I think my initial experiences were okay" (Kinder)

Joy also talked about her initial experience

"Really when I came in with my family, they (Australians) welcomed us and we were well received" (Joy).

Two of the women who felt welcomed when they came to Australia explained that the elderly people in their neighbourhood were friendlier than the younger ones. They emphasised that the elderly people paid more attention and enquired about how these West African women were adapting to the Australian environment. These women recalled that they had not known their neighbours previously and had not made many friends in Australia. They explained that the greetings from few people around gave them a sense of belonging and made them happy. These women characterised the greetings they received from the elderly people as a warm reception. According to Joy:

"...like my first experience when I came in, you see all these elderly women, they greet you they say hello to you, they ask you when have you been in Australia and you tell them you are just coming in and they say welcome. They try to give you joy and things like that. [...] But the younger ones look at you like as if an animal has come..." (Joy).
Sixteen women expressed their loneliness and isolation with the absence of family members who served as confidants in their new country.

"Back home we have extended family network to the extent that if you have anything bothering your mind, there are those family members around to call. They are there they share their experience with you, they keep the discussion secret and they won't laugh at you" (Anna).

In Australia, Sandra had to combine her university studies with managing the home. Her husband could not assist at home because he worked hard to support the family. Sandra emphasised that the experience of being without any assistance when she had miscarriages meant isolation.

"There is a gap as a result of not being in my country of birth, because when I first came to Australia, I had two miscarriages and when I was having those threatening miscarriages, I am sure if I was in my country, I would have discussed it with my parents or with my aunt and other people that can support me that are women that have passed through that experience before. They would have been able to advise me on what to do and how to handle the situation, but here there is nobody and I didn’t know anything about such issue. That gap is there and it’s affecting me …" (Sandra).

Living in a country as a migrant means facing change and adapting to a new way of life. This was evident in Michelle’s experience. Michelle did have her extended family in Australia, but discovered that her parents were not as available to help her with household chores. Michelle’s parents have embraced a Western lifestyle. In Africa, when parents, and mothers especially, have married children they considered their paid employment as secondary. Those mothers in Africa willingly took time off work to babysit their grandchildren as this was considered their primary responsibility in assisting their married children. According to Michelle:

"It is still different from back home because here they (Michelle’s parents) have got their own things to do, they have to pay their mortgage so they have to go to work, they are not always home because they are working too. It is still different from Africa, for example back home my mother will be home
and I can take the children to her for anytime I want, may be for a week or two weeks or whatever, but here she has to work to pay for her mortgage and things like that, it’s very hard, even though my father and mother are here, it doesn’t really help” (Michelle).

5.2.2 Beginning again
The women’s conversations contained the recurring sub-theme of how they had to begin their lives all over again in a new country. They recounted a sense of loss of everything they had achieved when they were in their countries of birth, and all that they had accumulated in terms of material wealth prior to coming to Australia. These women vividly described the ordeal of searching for gainful employment. They believed that, Australian employers did not acknowledge their qualifications or their previous work experience. It is possible that the type of professional skill that these West African women possessed, and the demand for those skills in Australia, determined the willingness of employers to employ these women in Australia. Nineteen women who talked about the ordeal of searching for employment stated that their lack of local experience in Australia and any other Western country greatly hindered their employment opportunities.

According to Sandra:

“They (Australian employers) believe we are not from advanced countries or may be they believe that we are not capable of doing their jobs here…” (Sandra).

All the women, excepting Warris, who came to Australia when she was 9 years old, narrated how they had to start their lives from scratch. Seven women had their qualifications reassessed, 12 women had to start new careers and all of them had to adapt to a different lifestyle in Australia. Eight women started work in Australia in a lower position than that they had occupied in Africa. For example, Oluwatosin held a managerial position in a company in Africa but had to work as a subordinate in Australia. Sixteen women described their experience of learning new skills and attending more training when they came to Australia. According to Joy,
"Before we (Joy and her husband) migrated we were told from the assessment that our certificates were up to the Australian standard, so we started. ... we got here and we thought that we were going to get jobs in the same field we were back in Africa but it wasn’t so” (Joy).

Oluwatosin also spoke about her experience of having her credentials reassessed in Australia

"When we (Oluwatosin and her husband) were in Nigeria, we were told that our qualifications were being assessed, during the course of processing our application for migration. But we discovered that when we came we actually had to go through the Department of Education or something there is a particular board, I can’t really remember, NOOSR (National office of overseas skills recognition) I think, so we had to go through them to assess our applications again and see whether that is actually acceptable to the Australian standard” (Oluwatosin).

Seventeen women had to enrol in further studies in order to comply with Australian industry requirements even though they thought they had finished schooling in their countries of birth. Sandra emphasised that:

"The decision to go back to school was a very hard one to take. To now go to school for another three years, I didn’t plan for that, I didn’t bargain for that when I left my country. Having to start all over again was a very, very tough decision" (Sandra).

Rita painted a picture of struggling to recapture what she perceived had been lost. She was a University graduate, working as a qualified executive secretary prior to migration to Australia. She explained that her immediate family owned a well furnished home where they were living; had a good car and her children were attending private schools. However, her experience was different when she came to Australia.

"When I was in Nigeria we had established ourselves but leaving Nigeria we have to sell off all our possession. On coming to Australia we have to start from the scratch, build up again. I will be 40 this year if I was in Nigeria I don’t know but
definitely I wouldn’t be struggling starting University all over again, that wouldn’t be the case” (Rita).

Eighteen women particularly those who had post-tertiary educational qualifications reflected on the number of years spent on education and training in their countries of birth and considered it time wasted, as they were no longer relevant to the careers they pursued in Australia. Some considered going back to their countries of origin. However the social implication of returning without accomplishing what they planned to achieve constrained them to endure their circumstances.

5.2.3 Being alienated
Migration meant alienation for most of the women in this study. They narrated their experiences of living as aliens and they had no difficulty in illustrating specific situations. The women described occasions when they were treated as "not belonging" at work and in other areas of their daily lives. They stated that they were referred to as "strangers" They spoke about how they were deprived of job opportunities and they believed that this experience was due to their being migrants from Africa. They explained that they experienced negative verbal and non-verbal comments from people, which nourished their feeling of alienation.

“There was a particular patient at the […] hospital that came to me in a four bedded room and told me, “you this black girl, what are you doing in Australia” and I said I am working and that I am a permanent resident in this country. He went further by saying, “what do you eat in your country, do you have food? Do you have cloth? You must be very lucky to be in Australia” (Rita).

Onome illustrated how she was verbally attacked in a shopping centre carpark. She recounted that she was trying to park her car in one of two adjoining parking spaces when a man drove in front of her and parked occupying the two spaces. Onome explained that she told the man that he was occupying the two spaces but he was reluctant to park properly. After a while, he grudgingly moved his car into one space. However, Onome recounted that:
"...after parking my car and I was trying to bring out my baby’s pram, the man came down to me and said “you black bitch, go back to Africa” (Onome).

Sola also described her experiences at work:

"Actually, it got to a stage that I started feeling a bit uncomfortable when I go to work because I hate all these stereotypes kind of things. Sometimes they say people don’t want to work with you. They don’t want to work with you…!! Initially I didn’t really take it serious but with time it was really getting to me and it was really affecting me" (Sola)

Eighteen women talked about remaining in the same positions at work for many years without promotion. Ten of them enumerated situations where junior colleagues had been entrusted with greater responsibilities and eight women mentioned situations where they were made to report to somebody junior to them. They interpreted their experiences to mean that they were being discriminated against because they were "strangers". Kinder described one of the occasions where she applied for a higher position but was rejected for reasons she considered not tenable;

"...and another occasion also I applied for another team leader position. And when I forwarded all my resume and my degree one of the bosses called me and said Kinder, “it’s nice to discover that you have all these experiences and all these qualifications but sorry we cannot give you this position because we don’t want to set you up to fall”. I cannot understand what this means and I get more confused but all I could say to it is that it’s all discrimination and racial problem" (Kinder).

Comments and experiences such as these suggest that these women felt alienated in their new country. Eight women, however, spoke about feelings of belonging and cited instances where their "difference" was invisible. According to Emma’s experience:

"It’s (living in Australia) great in the sense that even though I am from a very far away place, when I am in the midst of
Australians I don’t feel that I am an African, because my children are the only blacks in the school they go to and they are really enjoying it, they socialise very well. I have actually met an Australian who is my next-door neighbour. This lady when I moved in here about ten years ago was always greeting us hello, hello and she came over to me and said I won’t mind to take your children as my grand children here and I will be their grand mother in Australia and since that time my children call her grandma. Grandma is always here more than five times a week and my children always go there to play with her. When I was having my baby she was the one who stood by me in the hospital, when I was going to the hospital she was going with me every appointment and if any appointment day is not convenient for her she will tell the midwife to change it because she has got another appointment that day. We started together since I started going to the hospital, she always go with me for every appointment, all the x-ray, blood tests and everything she was always there and when I was having my baby she was there with me and she is my mother. I am really happy being here, I was thinking I came a long way and when I came here I met people who made me feel otherwise. I don’t realise that I am black when I am in their midst, no I never have any problem being here” (Emma).

5.2.4 Mothering in a new context
Nineteen women were mothers. To these women their resettlement experience meant a whole new perspective of mothering. They discussed their experience of caring for children in an Australian environment as physically exhausting, financially expensive and emotionally draining. The culture and the values that inform their notions of mothering were at odds with Western practices and so this created tension and confusion. The women explored their experiences of being confronted with ideas which conflicted with their own.

Some women stated that health care during pregnancy was different in Australia compared to West Africa. Emma shared her experience of pregnancy in a new environment.

"My expectation is that when you are pregnant back home in Africa and you go to the hospital, they give you tablets to be using but when I went to the hospital here, the doctor just
checked me and told me to go home, they didn’t give me anything. I then told my husband that back in Africa they normally give you all the tablets but they haven’t given me anything here, my husband said may be you don’t need it because if you need it they will give you, I was really surprised at this. I was also expecting the hospital to give me a list of items to buy in preparation for the baby to be born because that is also the practice in Africa but they didn’t give me any either. When I had my baby in the hospital they didn’t give me any tablet either, it is a completely different system entirely” (Emma).

These women’s expectation of care during pregnancy in their new country was informed by their understanding of pregnancy care in their countries of birth. In Africa, women are given iron tablets and folic acid routinely during their pregnancy. But in Australia, twelve women stated that they were not routinely given these medications. They stated that this experience was strange to them and that it created some anxiety for them. Most of the women (n=20) migrated to Australia as adults. Twelve of them had given birth to children in their countries of origin, and those who had not had children in Africa had seen family members taking these medications during pregnancy. They believed this practice as crucial for good pregnancy and delivery outcomes.

Participant mothers (n=19) talked about their childcare experience in a new context. The women that had children prior to coming to Australia had a basis for comparison. Those who started their families in Australia also referred to the input of extended family members regarding the care of children. In their countries of origin, the availability of grandmothers, sisters, aunties and uncles while the mother went to work or had an outing, reduced or eliminated the cost of childcare. However, once in Australia, the women had to search for baby sitters and bear the cost.

"For instance when I had my first son in Nigeria, I didn’t pay anything for day care, my people were very happy to look after my children for me, if I wasn’t there on time to pick my children up from school, my mum will be there to pick them up. Even if my mum is not there, my sister will be there to pick them up and I don’t pay for all those things, if I want to go out,
I just have to tell my mum look after the children and that is it. But here, all the time I have to look for baby sitter, look for day care centre to put my children and/or lock them up inside. We are not brought up like that, sometimes it’s frustrating and I am not used to that” (Agnes).

The West African women in this study recalled their lives in Africa where they did not have to work harder to pay for baby sitters, or wake up earlier to ensure that the children were taken to day-care centres before going to work on weekdays. They reflected on times when staying up late at night to finish household chores, or pack children’s lunches were not necessary because there were extended family members assisting with child care. They reported that their experience in Australia had implications for their leisure time, as they needed to work harder to meet up the demands of having children.

Nine women who were mothers of teenage children described their experience of mothering to be physically and emotionally demanding. Dealing with adolescents and their youthful exuberance in an environment that in itself was alien to them, was problematic. In Africa, there are no clear definitions of developmental stages. One is either a child or an adult and it is generally accepted that a child lives at home until marriage. The experience of these mothers in Australia was that their teenagers emphasised that they (the teenagers) could leave home as soon as they were 18 years old. This was traumatic for these mothers who had not been brought up in this way in Africa. Mothering teenagers in an environment where children were more empowered, in many ways challenged the mothering roles of the women in this study. The women identified a number of constraints that they considered hindrances to their mothering roles. According to Precious:

"Over here, the children have got more freedom than back in Ghana or back in Africa, so because of that it is a bit harder for mothers to bring up the children in the ways that we were brought up back at home. The system gives more freedom to the children and sometime it becomes a bit of problem to the parents because at the end of the day, the children might say if I am not getting this from my mother, the system will give it to me and that may make them to rebel. It is a bit of a worry
to some of the families that are not born here to raise up the children" (Precious).

Even though Ammah’s children were less than five years of age, she took the time to illustrate some of the experiences of her African friends here in Australia. She stated that these mothers cried frequently. These mothers acknowledged that they were mothering in a different environment and that they would not have condoned certain behaviour from their teenagers in their home countries.

"...everything, what is going on, so here I can say that young girls are very free than African girls (living in Africa)... I think that most of their parents, most of them to me find it very difficult to talk to their children and I think most of them too they’re afraid if they say don’t do it the child will pack her things and leave the house so they don’t say it. But back home you yourself will know, our mother will deal with you" (Ammah).

The nine women described occasions where their teenagers have argued with them and threatened to report them to the police during discipline or when they (teenagers) were not allowed to go out at certain times of the day. The women stated that they (the women) never argued with their own parents when they were in Africa. They explained that they did not threaten their parents when they were growing up. These women emphasised that their children knew all the emergency numbers and that they threatened to call the police in order to escape punishment when misbehaving at home. The mothers explained that they could not say anything because they did not want to incur the wrath of the government of their new country. The women felt that they did not have full control over the lives and behaviour of their children and they found this unsatisfactory.

"...but here there is no authority because when you talk to them too much they may call the police for you and they may question you why you have to do that for your own child. Many times, it is very disappointing when you bring children here" (Agnes).
The women were afraid of failure in their mothering responsibility. Having teenage children who did not question their mothers’ authority meant accomplishment for these women. Most of these mothers looked forward to their children following their advice and instructions and remaining in the family home until they got married. For these children to behave outside what these women considered as culturally and socially acceptable in an African context meant they had failed as mothers.

Agnes told me of her personal experience during our informal chatting after the audio taped conversation. She said she cried frequently when her two sons moved out of home. According to Agnes her sons moved out of home when they were 20 and 18 years respectively. She could not see the need for her sons to go and rent a house when the big family house was there for all of them to share. She emphasised that her sons would not have moved out at these ages if they were all living in Africa. Pondering on the sons' level of persistence, Agnes said:

"...though these children saw how unhappy I was, they were still determined to leave home..." (Agnes).

Living in a new country brings migrants into contact with its health care system. The women’s experiences with the Australian health care system are described under the next theme, "encountering the health care system".
5.3 Encountering the health care system

Table 7: Encountering the health care system

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5.3.1 *Not in our orientation*

The women in this study used the minor theme "*not in our orientation*" to explore their reasons for under-utilising the Western health resources in Australia. They emphasised that certain aspects of health care in Australia were different to their orientation. Even though fourteen women were working within the Australian health care system, these women argued that their professional expectation at work did not hinder them from utilising alternative health care when they became sick. They reemphasised that they followed the expected procedures and complied with the professional code of conduct when caring for their patients. However, the women described their health behaviour when they became sick as individuals.

Twenty women stated that they preferred to use alternative methods and explained that it was not in their orientation to access the Western health service as their initial line of action whenever they became sick. They wanted access to health providers from their own cultural background and articulated that they leaned towards curative rather than preventive medicine. Within this
minor theme, the women spoke about: "being a different system", "wanting to use alternatives" and "wanting curative health".

5.3.1.1 Being a different system

Nineteen women admitted that their socio-cultural background and life experiences as West Africans were different to Australians. This, according to the women, could be responsible for their under-utilisation of the health services provided in Australia. They cited specific examples of the aspects of health care provision that were different to the ones they were used to. These women stated that counselling services in Africa contrasted greatly with counsellors in Australia, who offered no direct solutions or suggestions. For instance, Henrietta recounted that:

“Counselling system here is very different from back home. You know back home they will make it clear to you that you are at fault but here it is different and because the counselling system is a bit different here people don’t want to use the counselling system here too, it’s totally different” (Henrietta).

Maureen used her personal experience to show how her perceived difference in the system negatively influenced her willingness to comply with specialist’s referrals. While this could reveal a lack of insight, it could also be a reflection of her socio-cultural background. She related an incident that occurred at work that she considered disturbing and traumatic. She visited her general practitioner who realised that she was quite disturbed and referred her to a psychiatrist. However, according to her:

"Though, I was disturbed by certain experiences. I can’t imagine why they are sending me to a psychiatrist, because back at home in Africa only mad people are referred to a psychiatrist“ (Maureen).

Eighteen women were used to delaying presentation at health centres and hospitals in their countries of birth.
"Back in Nigeria, you hardly go to the hospital except that you are dying. So I think people still carry that kind of attitude over here that they delay seeking attention" (Sola).

All of the women argued that the social and health support networks provided in Australia were different to what they were familiar with. They were used to their traditional communal network of support and considered the formal networking in Australia as irrelevant to them.

"Australia has some sort of social support services… that is not the kind of support that we were brought up with. We are talking of the close family kind of support, may be the extended family, parents, brothers, sisters, aunts etc being there for us when we need them especially when we have emotional problems or health problems" (Sandra).

Thirteen women stated that they were used to self-medication from their countries of birth and it was not common to obtain a doctors' prescription each time they became ill.

"In Nigeria, …people would just go on self medication and they prescribe a drug for themselves and they take the drug because they have experienced that before or because the doctor has prescribed such a medicine for them before” (Oluwatosin).

"…it is not every time that I have problem that I have to go and see the doctor" (Anna).

All the women considered the system to be different to what they were used to from their countries of birth. According to most of the women (n=17), in Australia, emphasis is placed on doctor's prescriptions and early intervention. They however argued that only in cases of serious sickness did they need to present to health care providers.

"…but here everything is medication and you have to go to the hospital …unless something is really serious may be you have some accident or something is very serious …you can’t just go over to the hospital“ (Michelle).
5.3.1.2 Wanting to use alternatives

Most of the women’s (n=20) pre-migration practice and use of alternative methods of health care in their countries of birth influenced their under utilisation of Western health care services in Australia. They had preconceptions regarding the severity of various illnesses and perceived that only serious illness needed hospital treatment. Their initial course of action whenever they became ill was to source for herbs and rely on their spiritual point of reference. According to Sola:

"We (Africans) use the local traditional herbs, so going to medical centre or the hospital is for major health problems" (Sola).

All the women in this study were Christians and most of them (n=16) emphasised that it was their usual practice to rely on their Christian God to heal. This had implications for their willingness to utilise the available western health care services in Australia.

"…more importantly their spirituality of prayers. They (African women) will pray and first trust in God before they begin to approach the hospital" (Titi).

Seventeen women explained that their utilisation of alternative health care was not due to lack of hospitals and other Western health care services. They explained that most of them have grown up to believe in the efficacy of herbs and leaves in healing. The women explained that they have seen traditional healers back in Africa who have put herbs and leaves together for sick people to eat or drink. They reported that these sick people became well after taking the herbs. Eleven women stated that when they were sick they became well after using herbs and leaves on many occasions.

"…all I used was the herbs, got the leaves, cooked it and used it, that’s it" (Joy).

Eighteen women emphasised that many Africans believed in the use of herbs and leaves whenever they became ill. They explained that when they were in
Africa they had family members who fostered the use of herbs, leaves and different types of concoctions. Matilda explained that these grandparents always offered her and her siblings these herbs whenever they became ill. She emphasised that this level of exposure to the use of herbs and leaves made her to believe in the efficacy of herbs. She explained that her grandmother came prepared with different kinds of leaves and herbs whenever she came to visit them in Africa.

"...my grand mother used to visit us and whenever we have malaria she will prepare all these herbs for us and actually I think she used to come prepared with boxes of those herbs, all she needed to do was to cook them and give you to drink and you will be fine, they work very well, when you take it you don’t need to take chloroquine at all or any western medicine for that matter. Up till now, my grand mother is till using all those herbs and they work effectively for her" (Matilda).

Furthermore, 14 women explained that the cost of seeking Western health care in Africa made them to utilise alternatives that were less expensive. There were hospitals in Africa but Western health care was expensive. The women explained that whenever they became sick in Africa, they would try any remedy that would make them feel better without incurring hospital bills. They emphasised that it cost them a lot more if they needed a hospital bed. Considering the poverty level in most African countries, people tried all avenues to avoid expensive hospitalisation.

" I think that is one of the reasons because some people when they don’t have money to go to the hospital, they prefer to go to the traditional doctors as we call them and they will pluck some leaves and mix it for you" (Jenny),

Nineteen women stated that they used mainstream Western health care, as a last resort. They explained that when the alternative methods failed they resorted to the use of Western health care. They stated that it is only when the alternative methods could not make them well when they became ill, that they needed something else. It was at this point that they accessed Western health care.
“Sometimes they (alternative methods) work, but if they fail to work then people will resort to consulting the western health care system” (Rita).

Fifteen women explained that even though they were not aware of herbs that may be available in Australia and that Medicare covered most of their health care needs, they still preferred alternative remedies because of their belief in them. They explained that Medicare does not cover all the cost of specialists’ consultation. They stated that their belief system and experience determined the line of action whenever they became ill. The women stated that they use prayer in Australia.

“I think it all depends on your belief at the end of the day. If you have had your grand mother taught your mother …you discover that she will just cook those herbs straight before you think of anything else” (Matilda).

The women emphasised that people will mostly believe what they have seen, felt or touched even though they read about it. These women have seen people use alternative remedies, they have used them and they believe in their efficacy. The women argued that it is difficult to change from what they believe in, but that it is only when what they believe in does not work that they consider other resources

“I don’t think people will change easily, if you grow up with the belief that when you have headache, all you have to do is to pray, then that’s what you are going to be doing or if I have a headache, I think I should just have a rest, that’s what you are going to be doing. I don’t think that they are going to change because there is a new doctor in town but I think if you are very sick and you try what you know and it doesn’t seem to be working, then you may be quick to change because you are still sick” (Matilda).

5.3.1.3 Wanting curative health

All the women in this study stated that the utilisation of preventive health services “is not in their orientation”. Most of them migrated to Australia as
adults and had not observed their parents and grandparents utilise preventive health services. It was strange to them to hear of various preventive measures needed to stay healthy. Sandra confessed that:

"I don’t even know anything about mammogram… My mother, my grand parents, my aunt, my sisters and most people I know around, don’t do it “(Sandra).

The women’s perception of preventive health care was that of searching the body for diseases that were not actually there. They considered it abnormal to seek help when their activities of daily living had not been compromised with illness.

"Yes, we don’t go about looking for what is not there, until it comes by itself, I know that may be too late, but until it’s making us really sick…” (Maureen).

Seventeen women believed that they would feel the pain and experience certain symptoms if there was any malignant disease in any part of their body. This assumption may reveal their socio-cultural background and it may also reveal their limited professional experience as health care workers. They explained that it was a waste of time and resources to seek preventive health care and that they preferred to take presenting symptoms to health providers. They further stated that it was not in their orientation to anticipate life-threatening diseases or prevent them. Most of them considered other areas of their lives like economic survival as more important than paying attention to preventive health practice. They were less preoccupied by the possibility of becoming ill with any of the chronic diseases.

“The African women… do not anticipate any of the chronic diseases. An African woman does not live everyday in fear that she might have cancer” (Kinder).

Eleven women, who confessed that they had never had any preventative health care screening, emphasised that they had no reason to fear having any of the chronic diseases. The women explained that they did not have a family
history of cancer and any of the chronic diseases. They also explained that there was no emphasis on participating in routine check up or screening when they were in West Africa. Eight women reported that they had a pap smear and mammography when their general practitioners encouraged them. They however confessed that they only had this health screening once because they disliked the experience of exposing the parts of their body that they considered private and personal.

Regarding health screening for cervical cancer, the women explained that as African married women and possibly due to their FGM experience, it was humiliating to expose their vagina in anticipation of finding diseases. They also described their experience of mammography as traumatic. The few women (n=8) who had attended mammography reported that the trauma that their breast was subjected to, could lead to the development of breast problems. The women explained that only promiscuous women expose those parts of the body that women consider as private and personal for the sake of health screening. This explanation may be due to the women’s cultural or religious beliefs. The women stressed that they held on to their personal health belief even though they provided adequate information and made referrals for their patients when the doctors suggested preventative screenings.

5.3.2 Exploring health care experiences.

The West African women in this study described their experience with the Australian health care system by considering the positive and negative aspects of the experience. Even though most of the women were working in the Australian health care system, they described their experience from the perspective of health care consumers. Eleven women gave detailed accounts of their experience with Australian health care providers and the quality of health care provided. Most of these women identified aspects of their care and encounters with the health care system that they considered satisfactory. They balanced these, acknowledging aspects of their care that fell below their expectations. The women described their experience through two sub-
themes: “experiencing health care providers” and “experiencing health care provided”.

5.3.2.1 Experiencing the service providers

5.3.2.1.1 Positive aspects

The women interviewed identified the support, care and friendly attention they received as positive aspects of their experience with health service providers in Australia. They considered the friendly care, information and kindness received from the service providers as welcoming and helpful in contrast to the difficulties they experienced as migrants. Rosemary describes an encounter with her doctor that made her happy with the health service providers in Australia.

“I have sought help from the doctors and they are supportive, they give advice on how to avoid the circumstances (skin breakdown) and how to take care of your skin” (Rosemary).

Michelle also highly commended the attention and care received in the hospital after having caesarean section.

“When I had my first baby, I did caesarean and I was in the hospital for five days and that was very good, the time I was there, the girls will come and attend to me very well. Back then, I had very nice and good service so I have nothing to complain about, even the physiotherapist will come to help you to go for a walk” (Michelle).

Oluwatosin spoke of the friendly health care providers that attended to her in an emergency department:

“...on getting there (emergency department) some of the personnel I met there attended to me in a way that was friendly. They told me that I had to stay over the night for this doctor to see me the second day and to examine me and to do a series of tests to certify that this was the case and this was not the case just to at least satisfy their curiosity. I was placed on the bed, one of the nurses came around to ask me some questions and some of the people around me took down answers” (Oluwatosin)
The women’s conversations did not only focus on their positive experience with the Australian health care system; they also spoke about those dissatisfying aspects of their encounters.

5.3.2.1.2 Negative aspects.

The women’s encounters with the Australian health care system were not all positive. They also talked about the attitudes of some health care workers and described their dissatisfaction with the workers’ preoccupation with routine leaving limited time for provider-client relationship. One of the women, Titi, spoke about her experience:

“One thing I will say is that the way the health care system is structured here is such that no matter what the patient tells the professional, the professional usually does not listen to what the patient has to say in terms of the care of that person’s body” (Titi).

Agnes cited a specific experience when she took her daughter to a public hospital. Agnes' daughter was experiencing an asthma attack and Agnes attempted to inform the triage nurse of the seriousness of the attack. Agnes related that the triage nurse did not respond to her but continued with her work until she forced her way in to see the doctors. She added:

“They (health providers) need to listen to people and attend to them, even though the nurse came back to me to apologise but I told her that if anything bad has happened, sorry won’t fix it and that I would have certainly sued her and the hospital” (Agnes).

Rosemary talked about her experience when a doctor attempted to avoid answering her questions. She felt that this health provider did not welcome her efforts to be involved in her own care.

“Sometimes you may have the ability to stand out to speak out; you might be shut down too… Sometimes I went to the doctor and said I have a problem and I tried to be inquisitive and the doctor shut me down and avoided my questions. Things like that can easily put you down” (Rosemary).
Sola's experience with one of the nurses in a postnatal ward mirrored these sentiments:

"I rang, I pressed the buzzer all the time that please I’m in pain I’m dying please help. Occasionally she (the midwife) just said I’m coming I have so many things to do and she didn’t come by. She was not even willing to do anything, even though I was crying my head off. When I pressed the buzzer, she came in quickly to cancel it and went out again" (Sola).

The negative experiences related by these women may not be peculiar to them, as other Anglo-Celtic or migrants from other parts of the world may have this experience. However, their acknowledgement of their social identity as migrants that is living outside their countries of birth made them interpret the experience as discouraging and unpleasant. Some of the women had their first child in Australia. They had no previous postnatal experience and they considered it insensitive for the health providers to disregard their call for pain-relief. Most of the women explained that they were assured during the antenatal classes that the nurses were available to provide all the support they needed. Not obtaining this support made the encounter disappointing for them.

In addition, the women talked of medical personnel raising their voices and being rude generally. In Africa, it is common for nurses and other medical professionals to talk roughly and rudely to patients. However while these women would accept health professionals' rudeness as normal in Africa, they considered this poor treatment in Australia.

5.3.2.2 Experiencing the service provided

5.3.2.2.1 Positive aspects
All the women were satisfied with Medicare and other aspects of the health care services provided in Australia. They acknowledged that the level of health care services provided in Australia is more advanced than that available in West Africa. They were satisfied with the diagnostic services they had used and the prompt attention they received from ambulance services.
All these women commended the Medicare scheme for alleviating the financial burden in health seeking. In Africa, people pay for health care services, consequently people consider the cost before seeking health care services. People from low socio economic backgrounds delay seeking health care interventions. The best hospital facilities are largely patronised by the affluent. Coming to a country where a universal health care scheme is available to all legal residents made these women happy. Joy specifically commended the Australian government for Medicare assistance:

“… they (Australian government) did a very good job by giving health assistance to the people in the country, it is very good and I really praise the government for that. For health care whenever I take my children to the hospital, they just ask you, do you have your Medicare card, that is it, and I really praise them for that” (Joy).

Seventeen women discussed their satisfaction with the various health services available through the health care system. One of the women acknowledged that the health service in Australia enabled her to access timely ophthalmic care. Following her arrival in Australia, Matilda did not bother to access ophthalmic services until she was informed that she could obtain this service regularly under Medicare. Matilda confessed that if she had to pay for these services she would not have had the check up. Matilda was working two days a week, her husband was the only one with a full-time job and they had a mortgage to pay. They had a son attending school and Matilda had parents and family members in Africa relying on her to send money. Despite the seriousness of her eye condition, various financial commitments would not have enabled her to pay for an eye check up

“… my eyes are not able to resist normal pressure I think it’s glaucoma and because of health care system here, somebody told me that you can do eye check up every three years and I just did that. I think if not for the system, I do not think I will just go for some kind of eye check up” (Matilda).
Nineteen women spoke about the quantity and quality of the health care equipments available in Australia. They acknowledged that modern technological equipments that they did not see or use in Africa were used for diagnostic test and other aspects of health care in Australia. These participants remembered how they had to pay for most of the medications in Africa whenever they had to go to the hospital or whenever they accompanied a family member to the hospital. All the women in this study lived in Sydney where most of the modern equipments were available. They remembered that only a few laboratories had modern equipments in their countries of birth. People had to travel to those few places and had to pay exorbitant charges whenever they needed laboratory tests. Working in the health care system here in Australia and having had opportunity of visiting the hospital here in Australia enabled the women to appreciate the Australian health care system.

"… there are a lot of equipments also to detect certain things which ordinary machine can’t detect which also makes it good. There are a lot of drugs available in the system, there are a lot of doctors available that you can utilise and you don’t have to pay all these huge amounts of money to access the system unlike in Africa" (Henrietta).

Ten women expressed their satisfaction with the ambulance services they have used in Australia. They explained that the ambulance service was prompt in attending to their needs when they became ill. In these women’s countries of birth the telephone network was unreliable. Unlike in Australia, it was difficult to contact the ambulance services by telephone. It could take a number of hours before an ambulance responded to an emergency call. For these women, the prompt attention from the ambulance services in Australia was commendable.

"Overall, I will say the health care provision in Australia is really excellent … The few times that I have passed out in the house my husband has had to call the ambulance and they came within the hour and they attended to me and it was just good. Believe me I have used them at least three or four times with this reflux pass out thing in the house. So in all I would say that the health care system in Australia is good and
I cannot even compare it with back home in Africa. It is really good” (Titi).

Stella reflected on when her husband was sick and she needed to take him to the hospital.

"When my husband was sick not too long ago they (ambulance services) were very quick to respond. I called the ambulance and the ambulance came promptly, we took my husband to the hospital and they took good care of him. Even in emergency, he received very good attention. There was no problem at all it was very good” (Stella).

Even though most of the services that the women utilised were satisfying, they provided insights into their negative experience with the service provided.

5.3.2.2.2 Negative aspects
Fifteen women identified health services that did not meet their expectations. Most of these women focussed on their experience with emergency services and expressed their dissatisfaction with the care they received. They discussed their experience of long hours of waiting before receiving medical intervention, even in emergency situations. They stated that they were not happy with the delay in initiating intervention when they or their families became sick. While narrating her experiences Jenny described her encounter.

"Terrible, because sometimes you go there (emergency department) and it is not good. For example, there was a time my son was sick and we took him to the hospital in the emergency department, we were there for more than eight hours and the child was crying. He cried and cried and nothing was done. Again there was another time I took my daughter to the hospital as well, she was in pain and she was crying but there was no one to attend to us, it was the same emergency department again” (Jenny.)

Kinder also reflects:
"... the emergency system in the hospitals here in Australia is nothing to write home about. In fact, they shouldn’t be called emergency again, they should be changed to “delay-ancy” instead. I have had this horrible experience where you take a child who is very ill in your hands and you end up spending eight hours. The emergency system here is very poor, you go there and before they do anything, they will let you know that you are in for a long wait" (Kinder).

The rate at which actual interventions were delayed when the women presented to the hospital were strongly identified in their conversation as below their satisfaction. Henrietta emphasised that the delay in attending to her grandson who had a cough resulted in other complications.

"I remember my grandson had a cough and I know what the child went through when he was born so I instructed my daughter to take the child to the hospital, which she did and she was told to allow the child to build his immunity… This child that was said to build his immunity ended up being hospitalised for days even to the extent of nearly going into surgery because he ended up having collection of fluids in the lungs, he ended up having all these complications that you can name" (Henrietta).

This experience may not be peculiar to them alone as there are a number of studies that explore the dissatisfaction of patients with the service they received from the emergency departments. The experience of the women here may not relate to the triage not wanting to attend to them because they were migrants as stated by some of the women. Many other things may be responsible; it is possible that the triage nurse was attending to other patients at that particular point in time. However, most of the women in this study considered it as a slight or as deliberate because of their uptake of the social identity of a migrant and their notion of considering themselves as outsiders.

Apart from the women’s exploration of the health service they received in Australia, ‘reduced expectation’ was also very strong in the women’s conversation. Within their story about their encounter with the health care system, the women described what prompted them to lose confidence in western health care system generally.
5.3.3 Reduced Expectation

Seventeen women spoke about reduced expectation in the health care system of developed countries. Prior to these women’s migration to Australia, they had a very high expectation for the Australian health care system. They believed that the health care system in Australia, being one of the developed countries would have solution to all their health care needs. They explained that when they were in Africa they knew a number of rich people who had travelled to developed countries for medical attention. Even though most of these women are health care workers, interview content reflected their perspective as health care consumers. They believed that health care providers had adequate training and expertise to solve their health problems. These women deemed that health providers in the developed countries were capable of identifying different health problems within a short period of time. They believed that modern equipment and high level technology was available in the developed countries. The women trusted that every aspect of the health care system in Australia was reliable. They thought that all their health problems would be solved in Australia.

“We (Africans) have always had a very high expectation for what we call the “white man’s medicine”... I started to think that I am here (Australia) and they have everything, whatever my problem is they can solve it” (Maureen).

Seventeen of the women believed that the doctors in developed countries could not give conflicting diagnoses. They did not anticipate the need to doubt the medical judgment of the doctors in the developed countries. However, the women explained that certain experiences related to their health care made them lose the confidence they had prior to migration to Australia.

Some of the women related their experience of misdiagnosis. They reported their experience of having to repeat diagnostic tests. These participants spoke about seeking second opinions before making decisions about their health care. Anna described her experience of conflicting diagnoses. She explained that when she became ill, her general practitioner diagnosed her as
having fibroids after conducting a number of tests. She stated that she was referred to a specialist doctor who initially suggested surgical intervention. However, the specialist later told Anna that the ultrasound revealed no indication of fibroids.

“...did all those test and later she (the GP) said oh you've got fibroid. I said fibroid? She then sent me to a specialist. The specialist said we have to do a little operation... then the specialist said I can’t find anything wrong, I can’t see anything. I said what do you mean? I came here to remove the fibroid” (Anna).

When these women were in their countries of birth, they were used to trusting medical doctors’ opinions. Doctors are considered as custodians of knowledge in Africa. Back in Africa, people believe that the doctor is always right and you would not doubt their opinions or recommendations. Consequently, most African women are not used to dictating what they want, how they want it or even how they are feeling simply because they assumed that the doctors know everything. The women were not used to seeking a second opinion about their health care. However, the women’s experiences reduced their level of confidence in some of these doctors and prompted Anna to seek second opinion:

“Can you imagine that? Then I had to make another decision to go and see another GP. I went there we did the same processing and he said there is nothing there that I don’t have fibroid. She couldn't even see anything related to fibroid” (Anna).

The women appreciated the diagnostic tests recommended by general practitioners and specialists to inform any diagnosis. However, the number of visits to specialists and the associated cost impacted on the confidence the women had in these doctors. They expected that doctors would make a diagnosis after conducting a series of tests. The women explained that on most occasions doctors did not offer a diagnosis and this resulted in a reduced expectation in these doctors.
"I remember recently I was having something on my lips and I went to the doctor, they did all the tests and I even requested some more tests to be done, they did everything but they couldn’t find anything, the GP referred me to the specialist, they did all the scans and everything but they still couldn’t find anything. So this raises some questions of whether they really know what they are doing because at times they find it really hard to diagnose" (Henrietta).

The reluctance of Rosemary’s doctor to identify ailments from diagnostic tests made her doubt the doctor’s knowledge.

"I went to a doctor and said I have done the test, I have done an X-ray I want you to tell me what is in that X-ray the doctor said okay there is no problem but I will just refer you to another doctor. If you want to refer me to another doctor from your own point of view what have you seen…? It took my pressing forward and even almost becoming sarcastic before getting an answer to my question. If it is because the doctor doesn’t know I don’t know but I didn’t get any answer at the time I asked unless I had to ask and ask again" (Rosemary).

These women were not used to being sent to specialists in private practice who charged per visit. They were used to a health system where both the general practitioner and specialists were hospital based. Given these women’s financial difficulty as recent migrants to Australia, they applauded Medicare. Unlike when they were in Africa, they assumed that they would not incur any cost for their health care in Australia. However, they did not understand the referral system in Australia and the cost of specialists’ services reduced the women’s confidence. The women made reference to the specialists who do not bulk-bill and whose services are not fully covered by Medicare but the patient had to pay on each visit. They perceived that the specialists abuse the system. The women believed that the specialists requested further consultation for their financial interest.

"It is like they don’t really know what they are doing exactly. Unlike back home, those old doctors will just look at you and they tell you what the problem is and that is what it is. But I think here because of the way the health system is set up they have the time to look here, look there and everywhere before they will look at the main thing. I think it is because of
The stereotypic attitudes of some health care workers also reduced these women’s confidence. Most of the women acknowledged that female genital mutilation (FGM) or circumcision is a major health issue for African women living in the developed countries. They explained that currently, there is a campaign to eradicate FGM in their countries of birth. However, given that most of these women were adults when they migrated to Australia, they might have experienced FGM. They expressed their support to make FGM illegal in Australia and they actively support the global campaign against the practice. However, the women expressed their dissatisfaction with the stereotype from the health providers especially during childbirth:

“…for African women… there is already a stereotype…” (Titi).

Some of these women (n=13) access the health care as consumers, for obstetric and gynaecological care. Due to their experience with the health providers they doubted health care workers’ knowledge of FGM and their understanding of victims' subjective experience of this practice. The women in the study emphasised that victims of FGM did not circumcise themselves, but they bear the short and long term effects of the practice. They explained that the associated embarrassment and shame make it difficult for these victims to discuss their experience with their midwives and gynaecologists. Several of them were aware of the effect of FGM on women during childbirth. They were however uncertain of the quality of health care they received during this childbirth. These women explained that they believed many Australian health providers might not be familiar with FGM. The women stated that they expected health care providers to provide enabling environment for African women to talk about their FGM experience, being victims of this illegal practice. According to one of the women, Kinder:

"I know that a very high percentage of African women have been genitally mutilated. They (Australian health care workers) should in the process of questioning, find out from them if they went through such process (genital mutilation)
and if they found out they should be able to do something to help them to have safe deliveries and probably reduce complications” (Kinder).

The women talked about their experience of losing confidence in the ability of Western health care workers in caring for African women’s health care issues like FGM. This experience may be peculiar to these women and other women that may come from cultural backgrounds where FGM is prevalent. However these women’s notion of being different may explain their concern.

5.4 Summary
This chapter has presented the second part of the findings on the meaning of health to West African women in Australia. The women’s stories revealed that their experiences as immigrant women have influenced their perception of their health care encounter in Australia and so their meaning of health. The women’s stories also revealed that their meaning of health has significant influence on their health seeking behaviour in Australia. The next chapter will discuss the findings of this study in the light of contemporary literature.
CHAPTER 6: DISCUSSION

6.1 Introduction

Chapter five focused on the remaining two major emerging themes: “being a migrant” and “encountering the health care system.” This chapter ties the findings to the research questions that the study aimed to focus on. It presents the meaning of health to West African women and explores how this meaning determine their health seeking behaviour. Also discussed, using contemporary literature to illuminate key issues, are how these women’s health seeking behaviours are influenced by their migration experiences and personal encounters with the health care providers.

The West African immigrant women who participated in this study were first generation migrant women from Ghana and Nigeria currently living in Australia. These women spoke about their meaning of health. They explained their understanding of the meaning of health and how this interacts with their personal experiences of migration, culture and expectations of health care services. The participants’ stories revealed the influence of strong belief in mystical forces, gender and a biomedical understanding of health. The subjective and dynamic nature of the meaning of health were also reflected in the women’s stories.

6.2 Understanding the meaning of health for West African women in Australia.

In understanding the concept of ‘meaning’ Heidegger suggested that it “is that from which something is understandable as the thing it is” (M. King, 1964, p. 6). ‘Meaning’ in essence is what makes the understanding of a thing attainable. Our understanding of the meaning of health for West African immigrant women in Australia is made attainable by their explanations of health. The West African women in this study spoke about their meaning of health and attempted to put health into perspective similar to previous efforts that focused on conceptualising health (Levin & Browner, 2004; B. Taylor, 2001). However, previous studies that aimed at understanding people’s
health have neglected the specifics of the meaning of health for recent immigrants in Australia including West African women. The explanations of the women in this study demonstrated that the meaning of health is subjective, it is dynamic and that their meaning of health is influenced by a combination of world views. The participants’ stories added to the body of knowledge by revealing the trio influences of biomedical, mystical beliefs and being women on African immigrant women’s meaning of health in their new countries.

6.2.1 Subjective nature of health
Each individual's subjective experiences determine their meaning of health. The women’s stories revealed that there is no universal meaning of health; rather it is what individuals consider it to be and this is based on their experiences. The diverse definitions that the women provided in describing health added credence to a subjective understanding of the meaning of health. This is congruent with arguments presented in previous research, that maintain that the meaning of health stems from personal experience and varies among individuals (Chan et al., 2006; Rodrigues, Watanabe, & Derntl, 2006; Weerasinghe & Mitchell, 2007).

When analysed, the data revealed an array of understandings of the meaning of health suggesting a subjective nature of the meaning of health. Some of the participants considered themselves healthy despite having an illness, as long as they remained ambulant and able to attend to their daily activities. To them, being sick meant being bedridden, to lack appetite, experience physical signs and symptoms of pain and subsequent admission to hospital. They explained that as long as they could eat and go to work, they believed that they were healthy.

Some participants described health as the ability to rest and sleep without being continually overworked. However, the financial commitments these women had, meant they were consistently under pressure to work long hours. This added to their initial experiences of poverty after arriving in Australia.
caused some of the women to consider wealth as a measure of health. Although implied, a financial interpretation of health, is not overtly considered in previous definitions of health (for example definitions by Levin & Browner, 2004; B. Taylor, 2001; World Health Organisation (WHO), 1946). A number of the women argued that one must be able to participate in social activities and gatherings to be healthy. This broad notion of health for West African women supports the all-encompassing nature of the concept of health as described in previous literature (Concha et al., 2003; Levin & Browner, 2004).

6.2.2 Dynamic nature of health

In addition to the women’s subjective understandings of health, the data reflected that the individual’s meaning of health is dynamic and context bound. The women’s stories suggested that living outside their countries of birth influenced and even changed their meaning of health. Some of the women’s stories revealed a re-evaluation and modification of their meaning of health due to the process of acculturation. Acculturation has been used to explain the changes in thinking and behaviour that take place as people from one ethno-cultural background are immersed in another over an extended period of time (Berry, 1997). Acculturation theory proposes that even though cultural beliefs and values are passed from one generation to another, individuals change as a result of prolonged interactions with others from different cultures (Arends-Toth & Van de Vijver, 2003). Although West African women have considered domestic violence as a normal part of marital life when they were in Africa, this perception is increasingly changing as they interact with people from other cultural backgrounds in Australia.

Assimilation is one of the ways through which acculturation can manifest (Arends-Toth & Van de Vijver, 2003). In assimilation migrants prefer to adapt to the culture of the dominant group more than the migrants’ culture. Living in a different environment and being exposed to a Western society, where domestic violence is openly discouraged, made some West African women to prefer Australian zero tolerance to domestic violence. As a result of this, these women re-evaluate and modify their previous beliefs regarding the
normality and unavoidability of domestic violence. This aspect of the women’s conversations is a cogent example that people’s perception of their world are in a state of continuous modification (Erlandson et al., 1993; Lincoln & Guba, 1985).

It can be suggested that due to their acculturation, some of the women considered their experience of domestic violence as unacceptable. It is very likely that if these women were living in Africa they would still have acknowledged domestic violence as a normal practice, a view congruent with the traditional experience of women in Botswana (Boonzaier & De La Rey, 2003; Maundeni, 2002). However, being in a western country, having new friends and acculturation has enabled some of the participants to modify their understanding of domestic violence. This interpretation reflects an assumption of Social Cognitive Theory that certain environmental factors affect an individual’s ability to adopt behavioural changes (Bandura, 2000; Munro et al., 2007).

Thus by living in a new environment, making new friends from other continents of the world and through different media images, West African women re-assessed their previous notion of domestic violence. This interpretation of the data is consistent with previously discussed literature that advocates that individuals change as a result of interactions with others from different cultures (Arends-Toth & Van de Vijver, 2003).

The importance of context became vivid in the women’s understanding of health. Context is the ‘where’ of an experience which determines the meaning that is proffered for such experience (Heidegger, 1962, p. 141). The participants’ stories revealed that living in Australia prompted a re-evaluation of their traditional concept of a healthy woman’s body. There is a widely held belief in Africa that a healthy woman is a fat woman. Married women are particularly expected to put on more weight as a sign of wealth and to prove that they are well cared for by their husbands. For many people in Africa, to be fat is a sign of good living. “Back in Nigeria, when you have a big buttocks
and as a married woman you are expected to look a bit chubby so the fatter you are the richer they think you are” (Sola).

This traditional notion that wealth is associated with the size of the body can be considered as one reason that women in the African context did not allocate time to routine physical activities. However, on migration to Australia, some of the women spoke about losing weight “when I came to Australia I think my weight was maybe 52 kg or something but now I’m increasing so I don’t really feel good about that…” (Anna). Due to their exposure to the Australian cultural context, certain aspects of the women’s lifestyle, daily routines and health seeking behaviour have been modified. This is consistent with the ontological assumption of naturalistic inquiry that suggests people are not static in their perception of the world but perceive it differently based on their context (Lincoln & Guba, 1985; Guba & Lincoln, 1989; Schnelker, 2006; Pass, 2004). This is in the sense that some of my participants now have the western perception that increased weight is not healthy.

For some of the women the notion of keeping fit has become part of their health beliefs. Some of them spoke about their efforts at keeping fit and reducing body weight. They spoke about their participation in physical activities such as walking and utilisation of exercise equipments. Similar to a study conducted by Becker, Fay, Gilman and Striegel-Moore (2007) of 115 Fijian girls who reported that acculturation had a strong influence on the perception of body shape; West African women’s context as well as acculturation influenced their notion of a healthy woman’s body in Australia. This is the first time that West African immigrant women’s re-evaluation of their understanding of a healthy woman’s body is documented in Australia.

6.3 Influences of biomedical ideas, belief in higher mystical forces and being women on West African women’s meaning of health.

6.3.1 Biomedical influences

Previous literature suggests that individual’s meaning of health is influenced by multiple and changing world-views (Aina, 2004; Bardin, 2002; Kheong,
2003; K. M. King, 2000). This also extends to the meaning of health for West African women. While the meaning of health for the participants in this study revealed their biomedical notions of health emphasising the state of the physical body (B. O. Abiodun, 2005; Bardin, 2002; Han & Ballis, 2007; Pereira et al., 2007); most of the women reported that for them the meaning of health extended beyond physiological and the associated pathological features of health described in previous literature (Aina, 2004; Bardin, 2002; Kheong, 2003; K. M. King, 2000). These West African women argued that additionally their belief in mystical forces and their social position as women significantly impacted on their meaning of health, factors also explored by other researchers (Boneham & Sixsmith, 2006; Koenig, 2004; Rippentrop, Altmaier, Chen, Found, & Keffala, 2005).

Congruent with the biomedical assumptions (Ivanitz, 2000; Morgan et al., 1993; Tetrick, 2002), health is primarily the absence of illness or disease to the participants in this study. However, biomedical notions of health were more prominent in some of the women’s narratives compared to others. This was particularly so where participants were health care workers or receiving training as health care providers. It is likely that the dominant biomedical ideas emphasised in health care provider training would have modified the existing understandings of these women’s meaning of health thus modifying their beliefs, as discussed in existing literature (B. O. Abiodun, 2005; Bardin, 2002; Bell, 2000; Hummelvoll & da Silva, 1994).

Influenced by biomedical ideas (B. O. Abiodun, 2005; Bardin, 2002; L. Bennett & Duke, 1995; Han & Ballis, 2007; Kheong, 2003), the primary concern of some of the participants is the physiological disease process which emphasises curing diseases through scientific management of symptoms. The pervasiveness of a biomedical influence on the meaning of health amongst these West African women may be explained through a combination of their historical and socio-cultural factors that have formed their worldviews. Both Ghana and Nigeria are former British colonies. It may be suggested that the biomedical influence on these women’s meaning of health is influenced by an interaction of African interpretations of Western health
culture formed in colonial times, traditional beliefs and contemporary Australian health culture. That the women are educated at a tertiary level and predominantly in health care can also be considered as one of the reasons for this result.

As a result of the biomedical perspective, the women in this study waited for physical symptoms of pain, weakness and discomfort before perceiving themselves as unhealthy. Health means equilibrium in the various parts of the body for these women and they emphasised the need for the physical manifestation of illness before seeking help. This conceptualisation of health and ill health is consistent with that reported by Abiodun, (2005); Bardin, (2002); Han and Ballis, (2007) Pereira et al. (2007). Also congruent with the biomedical model (B. O. Abiodun, 2005; Bardin, 2002; Han & Ballis, 2007), the participants emphasised the body as a system of body parts that must maintain its status quo.

### 6.3.2 Belief in higher mystical forces

Belief in higher mystical forces was a powerful aspect of these West African women’s meaning of health. This significant cultural framework supporting traditional African belief systems is not always included in people’s explanations of their health. Understanding these women’s meaning of health in terms of their belief in higher mystical forces was revealed through "spirituality". Spirituality is commonly used interchangeably with religion (Cotton, Zebracki, Rosenthal, Tsevat, & Drotar, 2006; Tanyi, 2002) but literature suggests that the two concepts are different (Boero et al., 2005; Tanyi, 2002). Spirituality involves human’s search for meaning in life (Boero et al., 2005; Tanyi, 2002) but religion focuses on an organised entity with rituals and practices about a higher power or God (Tanyi, 2002). For the participants, "spirituality" is culturally shaped on the traditional African belief in the existence of two interwoven and inseparable yet distinguishable worlds of the spirits and humans (Ademuwagun, 1978; Aworeni, 1998; Gbadegesin, 1991). Even though there is a paucity of academic literature exploring the nature and influence of traditional African belief, existing works reveal that this
belief acknowledges the universal order of the "Sacred Being", smaller gods or divinities and then human beings (Ademuwagun, 1978; Aworeni, 1998; Gbadegesin, 1991). The traditional African belief system recognises a multiplicity of spirits serving different purposes in maintaining the stability of various bodily organs and the way that humans relate to the spiritual forces determines their health and well-being (Aworeni, 1998).

While religion and spirituality can mean different things to different people, spirituality can be enmeshed in religion for others (McSherry & Cash, 2004; Tanyi, 2002). For the women in this study, spirituality was related to religion. The connection between spirituality and the women’s notion of health revealed a dichotomy between Christianity and folkloric forces. Being Christians, the women referred to their Christian God as the “Sacred Being”. They emphasised that something higher and more powerful exists beyond the physical and material world. These women put the “Sacred Being” into context in explaining their health.

It is important to note the difficulty in disentangling what “God” meant to these women as they made several references to this “God” using different concepts such as “Supreme God”, “Sacred Being” and “Supreme Being”. Most of the women’s stories revealed a fusion in the sense that it was not clear whether these women were referring to “The Sacred Being” of the traditional African belief or their Christian God or both or none. However, irrespective of the terms used it could be deduced that these women were referring to a Being or power higher than themselves.

The women acknowledged that the “Sacred Being” sustained them during the difficult period of settling in a new country. These findings mirror those of Endrawes et al., (2007) who reported on the experiences of Egyptian families in Australia in caring for their family members with mental illness. The West African women explained that they could have died in the midst of their negative experiences, but their survival was due to the protection of the “Sacred Being”. They referred to this Sacred Being as “God”, and linked “God” to every aspect of their health and survival.
Consistent with the findings of Koenig, (2004) and Rippentrop et. al. (2005) who linked spirituality to better mental health and greater wellbeing, these West African women’s connectedness with the “Sacred Being” shaped their mental wellbeing. This was particularly so for those women who experienced low self-esteem in the course of searching for appropriate employment that meets up with their educational achievements. These women blamed themselves for migrating to Australia when they reflected on the rewarding jobs they left behind. However, they considered spirituality as a protective factor against negative health outcomes (Cotton et al., 2006; Ritt-Olson et al., 2004). Congruent with previous studies, spirituality enhanced these women’s health perception and their quality of life (Boero et al., 2005; Koenig, 2004; Potter & Zanszniewski, 2000; Rippentrop et al., 2005).

West African women’s connection with the “Sacred Being” gave meaning to their lives. The women described their spirituality as their ‘life-wire, comfort and joy’. This reflects literature that suggests spirituality contributes to the feeling of health in the sense of human completeness and stability; it provides the will to live, believe and faith (Robert, Lawrence, & Duggal, 2001; Ross, 1995). The importance of spirituality to people’s meaning of health has been documented among migrants (Endrawes et al., 2007) and non-migrants (Krupski et al., 2006). It has been documented in Australia (Endrawes et al., 2007) and overseas (Koffman, Morgan, Edmonds, Speck, & Higginson, 2008) as well as the acutely ill (Harold, Koenig, & George, 2004) and chronically ill (Koffman et al., 2008). The significant role that spirituality plays in people’s health was also reported among Muslim-American immigrant women (Abuzahra, 2004).

Influenced by traditional African belief, these West African women also emphasised their folkloric belief in the existence of spiritual forces and the ability of these forces to cause illness. This reflects literature that reports the influence of people’s cultural beliefs on their meaning of health (Kwok & Sullivan, 2006; Lynam et al., 2007; Spector, 2000). However, for the first time
this study has provided a picture specific to West African belief systems and how strongly this impacts on these women’s meaning of health.

In the face of their Christian beliefs, these women believed that forces such as witches, wizards, spell and evil eyes are responsible for illness. This view has been identified by previous literature that reported on causes of diseases from traditional African perspective (Asamoah-Gyadu, 2007; Westerlund, 2006). According to Westerlund (2006), traditional African beliefs argue that diseases can be caused by various means that is supra-human means, social/human mode due to witches, curses and spells and; through natural causes. The supra-human and social/human causes are blamed on mystical forces. Further, when ordinary problems cannot be solved despite different types of interventions, they are also considered to be caused by mystical forces (Asamoah-Gyadu, 2007). The women in this study believed that the witches, wizards, evil eyes enemies and spells emanate from the devil. This phenomena was also reported by Richards (2002) who found Cameroonian women linked the cause of their infertility to witches, wizards and evil eyes. Though most of the women participating in this study had resided in Australia for more than three years, the traditional African culture nevertheless strongly influences their understanding of illness causation.

Age at the time of migration was a significant factor in the influence of African cultural belief for my participants. This is because it enhances our understanding of the extent to which these women held on to their African cultural beliefs despite the fact that majority of them have been in Australia for more than six years. This influence was particularly observed from the story of those women who migrated to Australia as adults. These women who were born in Africa and spent their childhood there have internalised traditional African cultural beliefs through a process of socialisation. These beliefs are passed on to these women by their parents and significant others and become part of their thinking. Irrespective of physical environment, socialisation which is the social process of passing on of values, norms, morals and beliefs systems from generation to generation occurs (Barr & Neville, 2008). This is revealed in the story of one of the women who
migrated to Australia as a child. This participant also believed in evil eyes, witches and wizards. This illustrates the significant role of parental socialisation in passing on of values, norms, mores and beliefs from one generation to the other (Barr & Neville, 2008).

The West African women in this study attempted to reconcile the two disparate stances of believing in Christian God and believing in folkloric forces by explaining that their “God” protected them from contracting diseases. Consistent with previous assertions that spirituality is a protective factor against negative health outcomes (Cotton et al., 2006; Ritt-Olson et al., 2004), the women believed that “God” is their shield and fortress against any illness from the devil. They made reference to their belief in this “God” as the one that has the final authority on their health. There was a fusion of their reference to “God” in the sense that it was not clear whether these women were referring to the Sacred Being of African traditional philosophy, or to their Christian God. This has not been exposed in prior literature.

6.3.3 Being a woman

Being a woman was a significant theme in the meaning of health for the participants in this study. Social constructions identify women’s roles as mothers and carers (Fraser, 2008; Teman, 2008). Participants considered themselves as products of this gendered social construction of being women. The women in this study spoke about their roles as mothers and spouses, with the emphasis that their traditional role of caring for the family affects their health and influences their meaning of health. Traditional African gender roles relegate women to domestic duties (Babou, 2009). An ideal African woman is one who is able to adequately manage the family daily expenses, hospitable as well as attend to domestic chores such as cooking, cleaning and educating the children (Babou, 2009). The participants in this study indicated that fulfilling their caring roles put a lot of pressure on their health that they had limited time for rest and leisure. They had inadequate time to eat and they worried over the enormous responsibility of caring for their husbands and children in Australia. They indicated that good health is ability
to care for and provide for the needs of their nuclear and extended family members. The women stated that the demand on them to do the cleaning, washing, shopping, cooking and caring is informed by traditional African gendered role expectation.

Studies focusing on gender roles have reported that the strong adherence to a traditional feminine gender role is related to poor coping in women when compared with a more modern flexible gender role expectation (Hoffman & Kloska, 1995; Lindstrom, 1999; McCall & Struthers, 1994). The women in this study predominantly clung to the traditional feminine gender roles. Congruent with a study of older women in a U.K study (Boneham & Sixsmith, 2006), West African women in this study felt that the responsibility for their own everyday matters, those of their husbands and children lay in their hands. They acknowledged themselves as the primary carers in their roles as mothers and spouses.

The gendered social construction of these participants as African women legitimises their “suffer and smile” experience of domestic violence within this framework. This was also found to be the case for African women in America (Fowler & Hill, 2004; Hampton et al., 2003; Nash, 2005; Omotoso, 2004) and Ethiopian immigrant women in Israel (Kacen, 2006). The women in this study explained that their experience of domestic violence was informed by their gendered social status. Describing their experience as “suffering and smiling”, most of the married women spoke about their experience of financial and emotional manipulation.

Contrary to modern Western thinking, most of the women in this study perceived domestic violence as a normal and expected experience within marriage. Even though violence against women takes place across all geographical regions and among all societies irrespective of their complexity, modern Western cultures, including the Australian, do not consider it appropriate (Michalski, 2004; Stanko, 2006). The West African immigrant women in Australia who migrated as adults witnessed domestic violence towards their mothers while in Africa. These women also received premarital
counselling emphasising their subservient position with in the family unit and to their husbands. Thus, their meaning of health had been substantially gendered.

The perpetrators of this violence were these women’s husbands. This supports the vast literature that reported intimate partners as major perpetrators of domestic violence (Campbell et al., 2002; Naved, Azim, Bhuiya, & Persson, 2004; Oyediran & Isiugo-Abanihe, 2005). The women explained that their husbands silenced them during family discussions, used verbal abuse, screamed, bullied, attacked, ignored and had no respect for them. Traditional African cultural definition of gender roles reinforces female subordination to men (Babou, 2009). Most of the women in this study explained that the traditional African cultural expectation of female subservience is responsible for their suffering. This traditional African gender role in Botswana also makes it acceptable for women to be abused by their husbands if they ignore their household chores, are rude to their husbands or behave in a morally unacceptable manner (Boonzaier & De La Rey, 2003; Maundeni, 2002).

The gendered explanation of health emphasises that patriarchy permeates every aspect of people’s lives and influences people’s definition of health (Horsfall, 1994; K. S. Johnson et al., 2005; McCool et al., 2004). The women participating in this study perceived that their traditional African patriarchal background reinforced their acceptance of suffering from domestic violence. They emphasised that they suffered the violence in silence and they smiled to hide the suffering. These women stated that they smiled on many occasions to cover up their suffering of domestic violence.

Domestic violence is associated with poorer general health status (Campbell et al., 2002; Campbell & Soeken, 1999; Coker, Smith, Bethea, King, & McKeown, 2000; Fehringer & Hindin, 2009); higher risk for suicidal behaviour (Kaslow et al., 1998) and increased chronic health problems (Lown & Vega, 2001; Tolman & Rosen, 2001). Although, these West African women did not link their domestic violence experience to a particular health issue, as they
spoke about their unhappiness with domestic violence experience, their stories implied a deterioration of their mental health.

6.4 Meaning of health as a determinant of West African women’s health seeking behaviour

Studies on health seeking behaviour explore people’s behaviour towards their health, which is reflected in their interaction with the health care system (Khan & Pillay, 2003; MacKian, 2003). Influenced by biomedical notions of health, West African women do not initiate health seeking in the absence of physical symptoms of pain and discomfort (Weiner & Martin, 2008). These West African women believed that an illness that does not make them uncomfortable does not necessitate health seeking behaviour. This reflects previous findings that reported that the presence of physical symptoms was a significant determining factor in people’s health seeking behaviour (Morin, LeBlanc, Daley, Gregoire, & Merette, 2006). Thus, the women considered accessing preventative health care services a waste of time.

It is important to note that these West African women underutilised screening services. They voiced the opinion that attending health screening can be considered as looking for health problems that are not there. While it is the first time this belief has been recorded for West African women in Australia, this attitude has been reported in studies of women from other cultures. Most of the young women in Warshawsky-Livne, Cwkel, Pliskin and Avgar’s (2005) Israeli study considered visiting a doctor as “looking for trouble”. This is unlike the middle-aged Israeli women in the same study that considered regular health checks as crucial for their peace of mind and early detection of potential health problems.

In this study, the women’s attitude towards preventative health services especially cervical cancer screening could be due to their FGM experience. FGM is a deeply rooted traditional practice in many African countries and has been reported a major health issue for immigrants from these African countries (Momoh, 2004; Straus et al., 2009; Thierfelder et al., 2005). Considering the ages of the women who participated in this study, it is very
likely that majority of these women have had some form of FGM before migration to Australia. Previous literature revealed that age at FGM ranges from early childhood to 29 years (Dare et al., 2004). The majority of these women migrated to Australia as adults and Mandara (2004) prospective clinical survey of 500 women reported that FGM was still broadly practiced in Nigeria. Even though none of these women openly identified themselves as having had FGM, previous studies conducted on African women in Ghana (Odoi, Brody, & Elkins, 1997) and Nigeria (Mandara, 2004; Nkwo & Onah, 2001; Obi, 2004) reported that an average of 35% of their participants had FGM. The women’s inability to identify themselves as having FGM may be due to shame (Baron & Denmark, 2006) and low self esteem (Osinowo & Taiwo, 2003) that have been previously reported for women with FGM experience.

The possibility of associating the invasiveness and pain experienced during screening procedures with the trauma of FGM may explain the participants’ underrepresentation in screening services. Some of the women who have participated in health screening complained about the pain and discomfort experienced during these procedures. FGM procedures are described as brutal and traumatic for the victims and it is documented that these victims suffer a psychological sequelae of posttraumatic stress disorder (Momoh, 2004; Penna, Fallani, Fambrini, Zipoli, & Marchioni, 2002).

Furthermore, these women’s unwillingness to participate in screening services may be due to embarrassment and shame (Baron & Denmark, 2006; Horowitz & Jackson, 1997; Straus et al., 2009) and their inability to receive adequate gynaecologic screening examinations (E. Kelly & Hillard, 2005) which have been previously reported for women with FGM experience. FGM involves an excision of parts of female genitalia (Baron & Denmark, 2006; Momoh, 2004) and perhaps due to difference majority of the participants underutilised preventive services in Australia.

The African cultural belief that FGM is practiced to ‘protect’ females from promiscuity (Nkwo & Onah, 2001) and the social expectations for women to
be discrete, modest and chaste (Gilligan, 1982) may explain these women’s perception that promiscuous women participate in cervical screening. Traditionally, girls are socialised in Africa to maintain their virginity until they get married and they are expected to consider their genitalia as private which must not be touched except by their husbands (Abidogun, 2007). The emotional discomfort of subjecting their genitalia to screening may explain these women’s negative connotation of screening services.

The attitudes of the women participating in this study towards accessing health care services mirrored those of the Brazilian women living in the USA in Ivanov and Buck’s, (2002) study. Similar to the Brazilian women in USA, the women in this study delayed access to Western health care services until they became very sick. The women in this study gave an explanation that they needed to experience physical symptoms of pain and discomfort that could not be treated by traditional methods before justifying the need for accessing health care services. Congruent with other studies that report the access behaviour of immigrant women to health care services such as (Aroian, 2002; Ivanov & Buck, 2002; Mortensen & Young, 2004), the women in this study accessed the Western health services only if their sickness kept them from working and after they had used other alternatives without improvement.

The women’s spirituality significantly influenced their health seeking behaviour. These women’s Christianity and traditional African beliefs influenced their level of compliance with biomedical advice. Consistent with previous research that identified trusting in God and participating in Church activities as one of the factors determining older adults’ compliance with medical advice in USA (Arcury, Quandt, & Bell, 2001) the women, as Christians, participated in activities like praying, meditation and Church attendance. The women’s initial reaction when they fell sick was to pray. They only took tablets when they felt led by the spirit and they claimed that Jesus was their doctor. The West African women explained that they relied mostly on the direction of the divine being rather than biomedical intervention. They processed medical advice given by doctors and nurses and concluded
that the health providers’ ideas were secondary to what the spirit was telling them. They used words such as “big boss”, and “the all in all” to describe their Christian God or “Sacred Being”. These women put their faith and trust in God and this influenced their willingness to comply with medical advice.

Similar to Korean-American immigrants in USA (Hesketh & Zhu, 1997) these West African immigrant women used a combination of Western and traditional health care rather than the formal health care available in Australia. The women in this study emphasised that they used a combination of medicinal herbs and Western medicine when they were in Africa. However, since arriving in Australia, they explained that they replaced the herbs with prayers, in addition to Western medicine.

The influence of the women’s spirituality on their meaning of health is greater than that of biomedical consideration. This may explain why these women would pray first before going to the hospital. They believed in the "Supreme God"/"Sacred Being" and considered this "God" as the doctor of all doctors. They explained that nobody can adequately explain the causes of chronic diseases like cancer, diabetes, and hypertension except God. Even though these women were aware of the medical explanation of disease, they considered those explanations as part of Western ideas.

In this study, the participants’ gendered positioning as women significantly influenced their health seeking behaviour congruent with a Zambian study that identified female sex as a determining factor in 202 women’s health seeking behaviour (Needham, Foster, Tomlinson, & Godfrey-Faussett, 2001). In West African women’s determination to play their roles as women, they under-utilised health care services consistent with previous literature that reported immigrants’ under-utilisation of health care resources (Bhagat et al., 2002; J. Daly et al., 2002; M. Mahoney et al., 2001). In an attempt to accumulate enough money to cater for themselves, their nuclear family in Australia and extended family in Africa, these West African women had limited time or resources to explore available health services in Australia. They perceived it as their responsibility to provide for those family members
still in Africa. The women in this study had a strong sense of responsibility and social ties to their countries of origin. Some of these women were willing to do any work because of their perceived need to urgently provide for their loved ones in Africa. Thus despite the fact that most of them had been in Australia for more than three years, they were more preoccupied with paid work that they underutilised the health care services available in Australia.

Irrespective of the women’s experience of domestic violence, their subservient positioning and associated socio-cultural constraints made the women consult close family members and friends rather than formal counselling services. Congruent with previous studies that reported abused women’s under-utilisation of formal services such as (Boonzaier & De La Rey, 2003; Fawole, Aderonmu, & Fawole, 2005; Oyediran & Isiugo-Abanihe, 2005), the women in this study considered the official counselling services in Australia as irrelevant to them. The women in this study described the social stigma associated with seeking formal services and this consideration discouraged them from disclosing their experience of violence to avoid alienation from their African community in Australia.

6.5 Other influences on West African women’s health seeking behaviour

It is important to consider two other factors that influenced West African women’s health seeking behaviour in order to have a full understanding of these women’s stories. Migration and the women’s personal experiences with the health care providers also had some impact on their meaning of health and on these women’s health seeking behaviour.

6.5.1 Migration experiences

The West African women in this study experienced loneliness and isolation similar to that of many immigrant groups such as Korean women (Kim & Buist, 2005); Middle Eastern women (Nahas et al., 1999) and Thai women (Liamputtong & Naksook, 2003) in Australia. The women described the difficulty in making new friends in Australia, limited interaction with neighbours and absence of extended family members as indications of loneliness and
isolation. These experiences of loneliness and isolation discussed by these relatively new immigrants in Australia have been described by Ponizovsky and Ritsner (2004) as part of the experiences of immigrants in their new countries. However, while generalisations about immigrants’ experiences of loneliness and isolation are common, some of the women in this study described their neighbours as friendly. This is the first time the positive social experiences of African immigrants in Australia have been documented.

The women in this study explained that extended family members relied on one another for health information when they were in Africa. However, in the absence of family members, the women relied on African associations and church members for support and information. Unlike previous findings that community social supports and African organisations have enhanced health service utilisation among African immigrants in London (McMunn et al., 1998), the women in this study felt that they lacked social support networks resulting in an underutilisation of available health services in Australia. This echoed the importance of social support in health service utilisation that have been identified in the literature (Ogedegbe et al., 2005; Zelkowitz, 1996). As in the qualitative study of African Americans and Hispanic women (Ogedegbe et al., 2005), the women emphasised the importance they attached to social networks as they provided a cushioning effect in their adaptation to the new environment. Social networks have been found to be an important source of social support and health information (Ogedegbe et al., 2005; Zelkowitz, 1996).

Studies exploring immigrant experiences such as (Ford & Kelly, 2005; Fuller & Ballantyne, 2000; Hsiao et al., 2006; Hultsjo & Hjelm, 2005; Marks & Worboys, 1997; Organista, Organista, & Soloff, 1998) reflect the observations made by these West African women regarding their encounters with different cultural values and norms on migration to Australia. A source of confusion was that the cultural values that surrounded their notion of mothering when in Africa were different to what these women were experiencing in Australia. They explained their experiences of being confronted with conflicting ideas to what they held back in Africa. This is similar to the findings of a qualitative
study of 30 Thai immigrant women in Australia who explained that their cultural beliefs about childrearing and discipline were different to that of Australia (Liamputtong & Naksook, 2003).

Prolonged exposure to western ideas and thinking due to acculturation assisted some of these women in recognising the need to seek help for their domestic violence experience. This has been previously documented in the case of African immigrant women and adds to the prior studies that documented abused women’s help seeking (Panchanadeswaran & Koverola, 2005). In Africa, extended family members acted as custodians of traditional socio-cultural mores and rarely motivated a woman to leave an abusive relationship. They reinforced normality of abuse. However, in Australia, the women became aware of the rights of women and domestic violence support structures available, such as calling the police and applying for an Apprehended Violence Order (AVO) against their abusive husbands. For some of the women in this study who explained that they had Australian friends from Anglo-Saxon background, help-seeking for their domestic violence experience was considered important. Even though none of the women in this study have reported their abusive husbands to police, acknowledging the need to seek help is an important move towards addressing the prevalence of domestic violence among this immigrant group. This is important information for educational intervention aimed at empowering West African women to develop a no-tolerance attitude towards domestic violence.

Understanding the complexities of a new and different health care system and locating regular health care providers was problematic for these West African immigrant women resulting in their underutilisation of available health services. This supports prior literature that identified immigrants’ ignorance of available health resources as one of the reasons for their underutilisation of health resources in their new countries (Kelaher et al., 2001; Neale, Ngeow, Skull, & Biggs, 2007; Tang et al., 2000). These women discussed their lack of awareness of counselling services, as well as their limited understanding of the referral system in Australia. This study has identified an important gap in
the dissemination of information regarding health service resources to minority immigrant groups.

6.5.2 Personal experiences with health care services and providers.

The women in this study spoke about their personal experiences with both health service providers and health service provided in Australia. In terms of the health service received, the women acknowledged that the level of health care services that were provided in Australia was more advanced than that available in West Africa. They were satisfied with the diagnostic equipment they had used and the prompt attention they received from the ambulance services. The participants expressed their appreciation for the Medicare program and other aspects of the health care services provided in Australia. However, some of the women explored their experience with emergency services and expressed their displeasure with the care they received. They stated that from their experiences the minimum time they waited before being attended to was eight hours.

The women expressed their dissatisfaction with some of their encounters with the health care providers. They identified the dismissive attitude of their general practitioners and the doctors’ haste while attending to them as unsatisfactory. The women were dissatisfied with the health care workers’ adherence to routine rather than listening to what they have to say. However, the negative experience with health care providers was not reported by all the women. Some of the women identified the support, care and friendly attention they received as positive aspects of their experience with health service providers in Australia.

The reported lack of therapeutic client-provider relationships in their personal encounters with health care providers mirrored the findings of Betancourt, Green, Carrillo and Maina (2004) regarding the absence of therapeutic interaction between Latino patients and health providers in the USA. A therapeutic nurse-client relationship is usually considered as one of the factors promoting utilisation of health care services (Rosenfield et al., 1996). These West African women’s stories revealed that they have an
understanding of good client-health provider relationships consistent with Latino population in USA (Betancourt et al., 2004). West African women like the urban youths (Rosenfield et al., 1996) want to be respected, treated well, listened to, have their problems taken seriously and be treated with dignity. However, West African women’s negative experiences with some aspects of the health system hindered their health service utilisation.

Due to the unsatisfactory attitudes of health care providers, West African women underutilised available health services in Australia. This is similar to the Canadian study of West Indian immigrants who explained that their under-use of the conventional mental health service was because of their perceived physicians lack of time during consultation (Whitely, Kirmayer, & Groleau, 2006). West African women explained that the negative experiences made them lose confidence in health care providers and thereby reduced their health service utilisation.

These West African women stated that preventative health services that are highly promoted in Australia are “not in their orientation” The majority of the women in this study migrated to Australia as adults and had not observed their parents or grandparents utilising preventative health services. It was strange to them to hear of various preventative measures needed to stay healthy. The women stated that they generally self-medicated for minor health issues such as headache or stomach ache. They were not used to obtaining doctors’ prescription each time they became ill. The lifestyle they were used to in Africa influenced their health behaviour in Australia. This is congruent with the literature that focuses on the influence of lifestyle issues on people’s health seeking behaviour (Beech, 2000; Piko & Kopp, 2004; Stefansdottir & Vilhjalmsson, 2007)

6.6 Summary
This chapter has discussed the major findings of this study in the light of contemporary literature. It has demonstrated that West African immigrant women’s meaning of health is the major determinant of their health seeking behaviour. A number of similarities and dissimilarities that exist between this
study and previous studies were identified. This study is similar to previous studies, in the sense that it revealed that the meaning of health is subjective, dynamic and influenced by different models of health. This study further demonstrated that the migration experiences of isolation and loneliness as well as the cultural difference for West African immigrants in Australia is similar to that of other immigrants in Australia and overseas.

However, this study exposed a number of unique insights. This is the first time that the meaning of health and health seeking behaviour of West African immigrant women living in Australia has received academic attention. The strong influence of deep-rooted mystical beliefs was vividly emphasised in the women’s stories. In addition, new insights into the cultural significance of West African women’s perception of domestic violence may be incorporated in developing strategies aimed at empowering African women to seek help when domestic violence occurs.
CHAPTER 7: SUMMARY, IMPLICATIONS AND RECOMMENDATIONS

7.1 Introduction
Chapter six discussed the findings of this study in the light of contemporary literature. This chapter provides a summary of the study and explores the implications of the findings with reference to nursing practice and nursing education. Recommendations for future research are also included.

7.2 Reflections from the literature
In order to provide a theoretical framework for this study, a review of relevant literature was undertaken. Previous researchers emphasised the need for increasing understanding of the meaning of health. A number of worldviews including the biomedical, behavioural, cultural and gendered perspectives have enhanced our understanding of health. Few studies have endeavoured to understand the meaning of health held by African people. Health for Africans living in Africa incorporates traditional belief in mystical forces. Exploring the meaning of health for West African immigrant women is neglected in the literature despite the increasing numbers of women migrating to Western countries, such as Australia. Immigrants typically encounter different health care systems in their adopted countries and their migration experience affects their health seeking behaviour. The influence of West African women’s meaning of health, migration experience and their encounters with health services has not been reported in empirical studies. This study has attempted to remedy this oversight and has shed light on the meaning of health held by these West African women, the influence of this meaning on their health seeking behaviour, and the impact of factors such as the migration and personal health service experiences on this behaviour.

7.3 Reflections on the methodological approach
The theory and methodology of naturalistic inquiry as described by Lincoln and Guba (1985) and Guba and Lincoln (1988; 1989) was chosen to guide this study. It was considered as the most suitable approach for this research
because the paradigm focuses on the complex context that underlies people’s understanding and meaning of their world (Appleton & King, 1997; Denzin, 1971; Erlandson et al., 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985; Ross, 1995). Naturalistic inquiry can accommodate the underlying socio-cultural complexities which guide the meaning of health for West African women in Australia. It provides a methodological pathway shaped by a sound theoretical framework (Appleton & King, 1997; Denzin, 1971; Erlandson et al., 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985). Furthermore, this paradigm recommends a rigorous qualitative research process (Guba & Lincoln, 1989; Lincoln & Guba, 1985).

Thus, the study was conducted in each participant’s preferred setting. This is to ensure a conducive environment for the women to freely describe their experiences without fear of threat to their privacy. The women’s context was considered in gaining a vivid understanding of their subjective world. Twenty-one women were recruited through a snowballing technique. Individual face-to-face interviews were conducted and rigorous data transcription procedures were implemented.

7.4 Reflections on the study
The study has confirmed that the meaning of health is a complex construct. Whilst in a broad sense the experience of these women is not different to other immigrants, complex influences of biomedical notions, the belief in mystical forces and gender influence these women’s meaning of health. As African women become a more recognisable cohort in the Australian population, their meaning of health need to be understood. This understanding is required in order to provide quality health care to West African women in Australia because provision of this care is central to the promotion of health for multicultural Australia.

7.4.1 Meaning of health
West African women’s meaning of health is dominated by their African cultural heritage. The women participating in this study did not leave their cultural health beliefs in Africa, whether formed through organised religion or
traditional African beliefs. Rather, their notion of health as immigrants demonstrated a combination of Christian and traditional African mystical beliefs.

Spirituality was a significant health resource for West African women in Australia. It served as a coping mechanism in dealing with the experiences of migration. The women’s connectedness to the “Sacred Being”, “Supreme God”, and “Christian God” gave meaning to their life and thus served as a protective factor against negative health outcomes.

Even though West African women acknowledged the importance of physiological stability in their description of health, they argued that this singular perspective cannot present a complete understanding of their health. Through their detailed descriptions of their meaning of health they emphasised the need to consider their belief in mystical forces. They demonstrated this through their increasing reliance on prayer in caring for themselves and their family members. However, as most of these women are health care workers, the data supports the fact that they used biomedical concepts in caring for their patients, in a professional manner rather bringing their beliefs to work.

The women’s stories revealed that they had different experiences of migration and integration into Australia. These individual experiences affected the women’s description of their health. The change of environment from West Africa to Australia brought about a re-evaluation of certain aspects of West African women’s meaning of health; for example, they began to embrace preventative health care through fitness and attitudes to domestic violence. West African women’s notion of a healthy woman’s body as well as their concept of domestic violence was changing as a result of the migration and acculturation experience.

West African women’s traditional patriarchal background reinforced their domestic violence experience. The married women participating in this study have husbands from the same cultural background. These participants' thick
descriptions of being a woman, wife and mother from the perspective of African patriarchal system gave rare insight into the traditional socio-cultural underpinnings of domestic violence.

West African women underreported their domestic violence experience due to the fear of social consequences from the African community in Australia. Despite the fact that these women were in Australia where domestic violence is openly discouraged, they pretended and hid their suffering and smiled.

In coping with the experience of domestic violence, these women confided in close friends and warned them not to tell their husbands. They were concerned that the formal services would not understand their point of view and that the punishment would be too much for their husbands if they reported them. It would bring shame on the family and the family loses their breadwinner.

**7.4.2 Health seeking behaviour**

The findings of this study clearly indicate that the dominant influence on West African women’s health seeking behaviour is their meaning of health. These women’s notion of health and health belief determined the type of health services that they considered relevant to them in Australia. This meaning influenced the time that West African women presented to health care services and the type of symptoms for which they presented for medical intervention.

Other factors such as the migration experience as well as West African women’s personal experiences with the health care providers also impacted on these women’s health seeking behaviour. This may impact on their family’s health especially when seeking medical care for their sick children. The impact of isolation and alienation in their new country meant that the women lacked the knowledge regarding available health services. This in turn encouraged their self-medication and delay in accessing health care services. The women’s health care experiences determined their treatment compliance and consistency in the utilisation of Western health services.
7.4.3 Other influences on West African women’s health seeking behaviour

The experience of “beginning again” especially as regards starting a new career affected these West African immigrant women’s mental health. Having difficulty in obtaining employment commensurate with what they had previously in Africa led to low self-esteem, self-blame and even depression.

The dismissive attitude of some health care providers was of particular concern to these West African women. The women who participated in this study noted that some health care providers did not acknowledge their concerns or suggestions but continued with their course of action without incorporating these women’s concerns into their care. Even though this experience is not unique to these women, their reference to this negative attitude added to the number of people who are dissatisfied with the dismissive attitude of health care providers.

West African women’s experience of misdiagnosis and late diagnosis also made these women lose confidence in Western medicine. They consulted their pastors and prayed whenever they became ill and presented at the health services only as a last resort. They often felt that health professionals did not understand them and that they had to repeat themselves before these professionals could comprehend what they said. This also could be a factor that influenced the late presentation to health services.

Health screening for West African women means looking for health problems that have not manifested themselves. These women underutilised screening services, such as Papanicolaou smear and mammogram, based on their explanation that they did not see their mothers or grandmothers participate in these services when they were in Africa. In addition to other cultural factors such as FGM, they considered seeking health services when they are not sick as pointless. Cost consideration may be an underlying issue directly or indirectly affecting their decision, as many of them find it difficult to leave their work to seek health care.
Influenced by the participants’ social positioning as women, health means freedom from overwork. Attending to their social roles as women hindered them from having adequate time for rest and leisure. These women had to drop off and pick up their children as well as attend to domestic chores without significant assistance from their husbands. Not only this, West African women overworked to care for their immediate family members in Australia as well as their extended family members in Africa. These women, who were mainly employed in low-paying jobs, did double shifts and worked in more than one place in order to earn enough money to meet these obligations. This experience affected their eating patterns and emotional wellbeing.

7.5 Implications for nursing practice
The findings produced by this study provide insight into the meaning of health for West African immigrant women in Australia. Health is the central focus of nursing and understanding what it means to health care consumers will help nurses to emphasise health promotion in health care. The women’s description of their meaning of health suggests the need for nurses to pay attention to health care consumer's subjective meaning of health by asking probing questions during nursing assessment to provide individualised care. Even though the women in this study are from the same cultural background, the women’s individual experiences need to be considered by nurses in the development of nursing interventions that are satisfying and acceptable.

The meaning of health as exemplified through these women’s stories provides essential information for nurses in developing plans for symptom management and treatment regimes whenever these women present for health services. West Africans have been migrating to Australia since the 1960s however; this is the first study to explore the meaning of health held by this group of women. The women’s stories reveal these women’s health care needs. Though not conclusive, West African women’s health care issues identified in this study may indicate the nature of health care needs for this cohort of immigrants in Australia.
The findings of this study revealed that West African women’s meaning of health incorporates a holistic view of health care which includes very strong psychosocial and spiritual aspects which is exemplified in their traditional cultural belief in mystical forces. This aspect of the women’s meaning of health will not usually be put into perspective by health care providers. Rather than health professionals making assumptions about therapeutic intervention with patients, they need to assess the clients individually and learn about their specific beliefs and values and incorporate spirituality into their health care delivery. This study provides a rare insight into this widely believed African phenomenon and has the potential of informing nurses of the importance of one’s mystical belief on health seeking behaviour.

The strong influence of West African women’s meaning of health on their health seeking behaviour was apparent in the women’s stories. These women’s meaning of health determined the type of health services they considered relevant and subsequently patronised by these women. Despite the benefit of early detection of chronic diseases, West African women underutilised preventative health services. This has implications for health care providers, particularly nurses who through their interactions with clients, play significant roles in enhancing consumers’ utilisation of health services. Nurses need to consider these women’s meanings of health with regard to programs that aim to improve immigrant women’s preventative health uptake.

The experience of isolation and loneliness impacted on these West African women’s health seeking behaviour and their family health. These women who had difficulty in making new friends were unaware of a number of health services. They did not understand the referral system in Australia and subsequently self-medicated and delayed access to health services. This knowledge has implications for community nurses working in community health centres, women’s health centres, family child care centres and schools who have direct contact with this West African cohort of Australian population. These nurses are strategically positioned to identify new immigrants in the community and assess these immigrants’ risk factors for isolation.
Community nurses play significant roles in linking community members to available health services and these roles are of significant importance to recent immigrants who are encountering health care systems that are different from those they were used to in their countries of birth.

To reduce delay in West African women’s presentation to health services, nurses and other health care providers need to be aware of their attitudes that may be detrimental to positive outcomes of the care provided. Health care workers should perform their duties in an objective professional manner and avoid comments that may be misinterpreted by their patients.

7.6 Implications for Nursing Education
Nurses need to be adequately educated to provide health care to diverse patients who may have an understanding of health that differs from dominant biomedical assumptions. In a multicultural Australia, nursing education strives to prepare nursing students to assess the meaning of health held by patients from culturally and linguistically diverse backgrounds. However, adequate preparation of these students may be hindered with the paucity of scholarly literature on health beliefs of immigrants and minority groups. The more knowledge that nursing students have about specific cultures and ethnicities, the better equipped they are for practice. With adequate knowledge nursing students will also be able to deal appropriately with cultural issues they may encounter in the course of their nursing career.

Nursing education needs to prepare nurses to pay particular attention to individual patient's subjective experience that may impact or enhance an understanding of their meaning of health. This will promote the provision of nursing care that will not only meet these patients’ needs but will be satisfying for them. Nursing programs should include units on trans-cultural nursing and sociology of health care specific to multicultural populations.
7.7 Limitations of the study
The snowballing technique used in recruiting participants for this study has the potential to produce a homogenous sample. In this case all the women in this study were Christians. With snowballing technique used to recruit participants for this study, only one Muslim woman was introduced to the researcher. This potential participant declined an invitation to be interviewed.

All the women in this study lived in Sydney, New South Wales, Australia. This may be due to the area of concentration of these women in Australia. The participants could have spread throughout the states in Australia, but I was constrained by the location of the women introduced to me through the snowballing technique. While more data could have been collected nationally, the emphasis of the study was on the interaction between a culture and western medical care which would not be greatly different across the Australian continent. Furthermore, the limited time and resources available for this study as a PhD topic placed constraints on conducting more face-to-face interviews.

7.8 Strengths of this study.
A number of strengths are inherent in this study. West African immigrant women are among the recent wave of immigrants to Australia. A review of relevant literature suggested that the West African immigrants in general and the West African women in Australia in particular have not received adequate attention in scholarly literature. While a number of studies have focused on other immigrant women’s health in Australia, there was no study on the meaning of health for West African women in Australia. This study consequently fills a gap in the research literature.

This study provides a point of reference for health providers, and in particular nurses, in understanding West African women’s health beliefs and health behaviour. West African immigrant women though increasing in number may be under-represented among the patients presenting to the health care service. This and their recent entry to Australia might have led to a misunderstanding of these women’s health beliefs. Health providers may
interpret certain West African women’s health behaviours as non-compliance. This study has provided a rich description of the meaning of health for West African women in Australia. From this description, the women’s health beliefs and health seeking behaviour may be better understood.

The qualitative naturalistic model of inquiry utilised in this study enabled an exploration of West African women’s lived health experience in Australia. This approach provided a framework for the women to narrate and present their meaning of health and to explain their health as it is lived in Australia. Guba and Lincoln’s (1988; 1989) naturalistic inquiry approach enabled the West African women to give meaning to their health. It enabled the interpretation of their experience and various aspects of this constructivist approach provided adequate support for the exploration of meaning of health for West African women in Australia.

The use of naturalistic inquiry provided a convenient decision line from which conclusions could be drawn. This methodology enabled the unfolding of the inherent meaning of health for West African women and does not advocate bracketing of researcher’s pre-understanding. As it is impossible for the researcher to put aside what is already known about a phenomenon, this methodological guideline provided an opportunity for the researcher to reveal the vantage point from which a phenomenon is approached. Being an insider may have influenced the women’s openness in telling their stories.

The face-to-face interview method enabled the researcher to take note of non-verbal cues and gestures that enriched the quality of the data analysis. The assurance of confidentiality enabled the women to narrate their lived experience without a feeling of intimidation or coercion. This may also be influenced by the fact that I was an insider.

7.9 Recommendations for further research
As this is the first study to explore the meaning of health for West African immigrants in Australia, it presents a preliminary overview of socio-cultural and migration issues that impact on the meaning of health.
Further research exploring the coping strategies and resilience among immigrants' generally and West African migrant women in particular is advocated. A more comprehensive understanding of the range of West African women’s experiences and continuum of health care needs post migration is required.

Given these women’s limited insight regarding their susceptibility to major chronic diseases, studies that assess overall perception of personal risk of diseases such as cancer, Human Immune-deficiency Virus (HIV), cardiovascular diseases and cervical cancer are advocated.

Studies that explore the health service utilisation patterns of West African women in Australia in particular and West African immigrants are also imperative to inform the provision of effective health information and education for these groups of immigrants.

The women in this study did not clarify the impact of their domestic violence experience on their health. More studies are needed to investigate the effect of West African women’s domestic violence experience on their health. Future studies should be designed in ways that women from different socio-economic backgrounds (who may have diverse perceptions and experiences of domestic violence) are encouraged to participate.

Conclusions about the role that social support and membership of cultural organisations can play in enhancing West African women's health service were not made in this study. Future study is advocated in this area in order to provide insight for policy makers when making decisions that focus on enhancing these women’s health service utilisation in Australia.

7.10 Summary
The findings from this study demonstrate that meaning of health, migration experience and the participants’ personal experiences with the health care system are fundamental to their health seeking behaviour. The women’s
meaning of health is subjective, dynamic and it is influenced by a combination of world views. Despite a high level of educational achievement as well as occupation of most of the women, belief in higher mystical forces was a significant cultural framework supporting their explanations of health. As immigrants these women experienced isolation and they had positive and negative experiences as they encountered the health care system in their new country. Influenced by their cultural belief and their experiences of settling in a new country, these women underutilised health care services in Australia and delayed access. It is suggested that provision of health care services aimed at meeting these women’s health care needs should incorporate these women’s meaning of health to enhance their participation. Implications of the study for nursing practice and recommendation for further research were also suggested.
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APPENDICES COVER SHEET
APPENDIX 1

Introduction of the women in this study

Ammah

Ammah was the first woman I interviewed. Born in Ghana, a Christian, Ammah was less than 40 years old at the time of the interview. Married with two children, who were below 5 years of age, she migrated to Australia 10 years ago to join her husband. She had pre-tertiary educational qualification prior to migrating to Australia. She has been working as an assistant in nursing, since her being in Australia. She presently took time off work to care for her younger daughter who was 2 years old. After accessing her telephone number from the Ghanaian women’s association, I called her to introduce myself and the purpose of the telephone call. She was happy to participate in the interview but had difficulty in organising time for the interview. That was because she was always busy at home looking after the children while her husband went to work. After the second telephone call, she was able to give me a date and time for the interview, which happened to be her husband’s day-off at work. She suggested having the interview at home because she said her younger daughter was not very much used to being with the father. The interview was scheduled for 4 o’clock in the afternoon, and on getting to her house, she was still busy in the kitchen, the husband playing with older daughter while the baby was hugging to her. She stopped what she was doing when I got to her house and explained that she was only trying to get the dinner ready to some extent before the interview. Before we started the interview, she handed over the two children to her husband and we went to one of the rooms in her house. We were about 30 minutes into the conversation when the baby started crying. Ammah’s husband brought the baby to her and for the remaining part of the conversation; she was struggling between flowing well in the conversation and attending to the baby. She was very lively and laughed many times during the conversation. The conversation went for about 90 minutes when she said she had nothing more to say. Even though I felt rather frustrated and dissatisfied with this conversation, I felt empathetic for her caring for the children at home everyday. I felt that I had been unsuccessful in getting into a real depth in our conversation. Despite my probing further and seeking clarification when I thought necessary, it was obvious that she was only struggling to flow well with the conversation. I thought of reorganising another interview but she could not think of any other probable time. However, I was able to make some clarification on the telephone during the follow-up interview.

Anna

Anna was over 41 years old, born in Nigeria and married with four children aged between 20 and 5 years of age. The first child is an undergraduate in one of the Universities while the second child had just finished her higher school certificate. These first two children were born in Nigeria. The third child was 9 years old still in the primary school while last child was 5 years old and had not started school. She had been in Australia for more than nine years
when she came to join her husband. A Christian, Anna had a pre-tertiary education and was training to be an engineer when she had to migrate to Australia. After looking for job in related profession to which she was training without success, she was working in one of the nursing homes, as an assistant in nursing. Anna works on permanent night shift to afford her time to look after her two younger children. When I telephoned her after accessing her telephone number from the Nigerian women association in Sydney, she requested for detailed description of what the interview was about. She was very concerned about what I was going to use the information for. After giving a detailed description of what the study was all about, she sounded happy on the telephone and she gave her verbal consent to participate in the study. When I requested for a convenient time and date to conduct the interview, she requested to check her diary and she agreed to participate in the interview on one of her days off. She also requested to have the interview in her house because she said she had a 5-year old daughter to look after. When she told me of her 5-year-old daughter, I was apprehensive only hoping that the interview would not end up like the first interview. On getting there, she was ready for me, she only needed to put one of the children video programs on for her 5-year-old daughter because the other children had gone to school and her husband was at work. I heard her instructing her daughter not to disturb us, she then directed me to one of the five rooms in her two-storey house. The conversation went smoothly apart from an occasion when her daughter came to ask her if she could have a cup of apple juice from the refrigerator. She was very relaxed and willing to pour out her mind on every issue only occasionally concerned about whether she was saying something relevant. The conversation continued until she said she had nothing more to say about her lived health experience in Australia. I asked her if I could contact her regarding any area that may need further clarification and she willingly agreed.

Maureen

Maureen was below forty years of age. A Christian, born in Nigeria, she migrated to Australia over 11 years ago to join her fiancé. Now married with two boys, she just finished her final year University examination when her application to migrate to Australia was approved. Her expectation about travelling to an advanced country was very high. She left Nigeria as a new graduate without experience and on getting to Australia; she could not get a job in her area of professional interest. After much searching for job, she also had to take up an assistant in nursing job, which she said she never imagined doing in her life. She lived here in Australia with her husband and two children. She expressed her feeling of boredom and loneliness. She reflected on her level of educational achievement and took up the challenge to go back to the University in Australia to do a Bachelor’s degree in Nursing. When she completed this, she went for her postgraduate diploma in midwifery and she is now a registered midwife working in one of the hospitals in Sydney. When she was contacted about this interview, she was very happy and enthusiastic to be part of it. She was ready and at home on the day of the interview. She was at home with her sons who were on school holidays but her husband had gone to work. I observed her voice shaking occasionally when she was
reflecting on her life in Australia. The conversation went on without any interruption in one of the rooms in her quiet six-bedroom storey-building environment. She told me informally after the tape-recording that this conversation actually provided her an opportunity to reflect on her migration experience and she referred me to eight other women by giving me their telephone numbers.

**Sola**

Sola was a married woman born in Nigeria, aged over 41 years old. She obtained a post tertiary educational qualification in Nigeria and was working as chemical engineer prior to migrating to Australia. A mother of three children, she migrated to Australia more than 11 years ago and according to her “for greener pasture as per spouse adventure”. Even though Sola got an employment in her professional area that she was while in Nigeria, she lost that job when she went on maternity leave for her first child. She thought that it was mandatory for her employer to reabsorb her after the maternity leave into the same position into the same job. However, there was no more vacancy in the company. After much searching for employment in her profession of interest without any success, she went back to the University for a Bachelor of Nursing degree. She was working on permanent night shift as a registered nurse in one of the hospitals in Sydney. She was very happy to participate in this study and it was the very day that I contacted her that she said if I was ready that I could do it that day being her night-off. I did not have any other interview scheduled for that day, so I went to her house as she requested following the street directory. Sola was a soft-spoken unassuming woman. She took her time in following through the conversation and occasionally wondered if she was not talking too much. I then assured her that I was very interested and happy to hear everything she had to say about her lived health experience of living in a country different from that in which she was born. The conversation went on for about two hours.

**Sandra**

Sandra migrated to Australia from Nigeria about six years ago in order to ensure that her children have good education. A Christian, below forty years of age migrated together to Australia with her husband and one daughter as a chemist. She was a University graduate but did not get any job and when the opportunity to travel to a western country arose, she was very happy to migrate to Australia for better fulfilment. Sandra stated that her experience of loneliness and inability to get a job as a chemist in Australia made her to cry on many occasions. Due to her unemployment and the need to support her husband financially in near future, she went back to the University for a nursing degree and she is currently a final year nursing student in one of the Universities in Sydney. At this stage I was wondering why most of the women in this study were taking up a career in nursing on migration to Australia. I hope to be able to provide an answer later in this study. When I contacted her and informed her of my intention, she was indifferent and offered to have the interview done in her house. The interview was scheduled for 2 o’clock in the afternoon. When I got to her house, her first child was back from pre-school;
her second child was still in the child-care centre while the husband was still at work. After attending to her daughter at home, we commenced the conversation. When she was narrating her experience of looking for job and the struggles she had in going back to the University in Australia, I reflected back on my own personal experience. Sandra’s husband came back from work while we were in the middle of the conversation and she then wondered why he came home so early. Not wanting her husband to hear all that she had to say, she requested that we continued the interview in one of her three bedrooms. She gladly answered all the questions that ensued from the conversation but occasionally disturbed by her daughter who came to knock the door inquisitively about what we were saying in the room. We rounded up the interview with Sandra’s willingness to be contacted any time for clarification on any issue.

**Henrietta**

Henrietta was born in Ghana over 41 years ago but migrated to Australia about six years ago to join her husband. A Christian, she migrated to Australia with a post tertiary educational certificate and had been working in Ghana as a registered nurse/ midwife prior to migration. Married with four children, the youngest of her children was preparing for her higher school certificate examination. Even though, Henrietta had been practicing as a registered nurse/ midwife in Ghana and a couple of years in New Zealand, she said she had a lot of difficulty before her colleagues at work could trust her skill. Despite this difficulty, she was still working in one of the hospitals in Sydney. I made a number of telephone calls before I could contact her because she worked a rotating roaster. However, when I eventually introduced this study and my request for her to participate in the interview, she was very happy to take part. We then agreed on the date and time of the interview. We used one of her days off for the interview and it was also conducted in her house. All the children had gone out, her husband was at work, and so we had the conversation without any disturbance.

**Titi**

Titi was born in Nigeria less than forty years ago but migrated to Australia about ten years ago with her husband and three children. She however had another child in Australia and she was then a mother of four. She obtained a post-tertiary educational qualification in Nigeria prior to migrating to Australia as the primary applicant. Titi and her nuclear family migrated to Australia for a change of lifestyle. Titi stated that she was very happy since the related professional body in Australia already evaluated her certificate (to be equivalent to that of Australia) prior to migration. She was very optimistic of employment in her own profession as soon as she got to Australia. Her expectation was not fulfilled and she was working as health education officer at the time of the interview. On the day of the interview, she was just coming back home from grocery shopping and was rushing to put the grocery away when I got to her house. She was very happy to participate in this study and even though the conversation did not finish on that day because her son had a doctor’s appointment, she was very happy to organise another day.
Rita

Rita was less than forty years of age. A Christian, born in Nigeria, she migrated to Australia via Malaysia with her husband and two children. On migrating to Australia, she had two other children and she was a mother of four. She was a University graduate in Nigeria and was working as an executive secretary prior to migration. She was working as an enrolled nurse in one of the hospitals in Sydney and a final year nursing student in one of the Universities in Sydney. When I contacted her for an interview, she was very happy to participate but we could not hold the interview on the day scheduled. This was because contrary to her projection that her family would be back from holiday on that day, the trip was delayed. She however called me on the telephone of the need to change the interview day. The conversation went without any hitch on the rescheduled day and she said everything she had to say about her lived health experience in Australia until she had nothing more to say.

Agnes

Agnes was born over forty-one years ago in Nigeria, but migrated to Australia more than 11 years ago to join her husband. A mother of three, two of the children had left home and now working while the youngest one that was born in Australia was still in the primary school. She had a post-tertiary educational qualification from Nigeria and was a primary school teacher prior to migration. Her experience of not obtaining teaching employment, which she said she did for many years made her to consider going back to Nigeria. This decision was however very difficult for her to take because her husband was still in Australia. She said she was very sad, withdrawn from people and many times blamed herself for agreeing with her husband to come to Australia. Some of her friends that had been in Australia before her, told her that the only area where there was skill shortage was nursing. She said the need to support her husband with housekeeping made her to grudgingly apply for an assistant in nursing job in a nursing home. She stated that her determination not to remain at the lowest level of the nursing professional ladder challenged her to obtain an enrolled nurse certificate. She did not stop at this, she was in her final year doing University program in Nursing. One of her friends who had previously participated in this study referred her to me and when I contacted her, she was very happy to participate in the interview. Her youngest child was at home on the day of the interview because it was during one of the school holidays. There was no disturbance from this girl throughout the conversation. I took note of all the non-verbal cues and gestures that ensued from the conversation and jotted them in my journal.

Michelle

Michelle was born in Ghana less than 40 years ago and she migrated to Australia about ten years ago while she was still in the high school to join her parents. Now married with three children below seven years of age, she stayed at home to look after her three children. One of her sisters who had
participated in the interview gave her telephone number to me. When I contacted her about the study, she was happy to participate in the study but had initial difficulty in providing a specific time for the interview. This was because only one of her children was in school while the other two went to the childcare centre for certain number of hours a day. Eventually we agreed on 10am on the day of the interview. She said she envisaged that she would have taken the children to school and child-care centres and that her husband would have gone to work. I arrived at her two-bedroom unit apartment as scheduled but was not at home. Her husband said that she had gone to drop the children off in school and childcare centre. I waited for about 1 hour before she came back home apologising that she quickly had to buy some grocery on her way home. The husband left home for work before we commenced the interview, which went on smoothly without interruption. The interview went for 90 minutes.

**Kinder**

Kinder, born in Nigeria less that 40 years ago, migrated to Australia over 11 years ago. Married with four children, she had a post tertiary education at the time of the interview. Prior to migrating to Australia, she was working as a microbiologist and had been working on the same profession since her being in Australia. Maureen gave me Kinder’s telephone number and she was very willing to participate in the face-to-face interview. Kinder had all her children in School and she agreed to have the interview in her house on one of her days off from work. Kinder came to Australia with her husband and two children for a change of environment and has since settled in Australia. The interview went for about two hours within which Kinder described her lived health experience in Australia. I took note of certain gestures and non-verbal cues in my journal as observed during the course of the interview.

**Precious**

Precious migrated to Australia from Ghana over 11 years ago to join her husband. A registered nurse, she held a post-tertiary educational qualification and was a nurse from her country of birth. Precious had five children and majority of them had finished high school, now working. Precious showed her willingness to participate in the interview by giving a verbal consent when contacted on the telephone and written consent on the day of the interview. I conducted the face-to-face interview in her house as requested by her and it lasted for about 40 minutes. She requested to stop the interview midway because Precious said that she had an urgent appointment. I requested if we could continue the interview on another day, but she was not willing to continue on another day. Even though I was not sure but I perceived that, she was not feeling comfortable to talk about her health experience because her two eldest children were at home. I suggested that we organise another venue but she said that she was not willing to continue the interview.
Matilda

Matilda was born in Nigeria less than 40 years ago. Married with one son, she migrated to Australia with her husband for better opportunity. She had a tertiary educational qualification and was working as a pharmacist prior to her migrating to Australia. She was working as a customer service officer in one of the banks. I contacted her on her telephone number and she was willing to participate in the research. She was working part-time to afford her time to look after her seven-year-old son. Like other women, the venue, day and time of the interview were at her discretion. She requested to have the interview in her house. She was ready for me on the day of the interview. Matilda’s husband was at home sitting in the living room on the day of the interview but we used one of the bedrooms in her stand-alone house. Matilda shared her lived health experience in Australia with me for about 90 minutes until she had nothing more to say. She was soft-spoken and she laughed occasionally during the course of the interview. I recorded all the non-verbal cues in the interview.

Joy

Joy was married with three children and she migrated to Australia less than ten years ago for better life for her children. Born in Nigeria, she said she was working as a banker but currently working as an assistant in nursing. Joy had a post tertiary educational qualification and was introduced to me by Anna. Joy showed her willingness to be part of this research and she was ready for me on the day of the interview. The interview took place on one of the days that she was on afternoon shift. When I got to her house in the morning of the interview day, she was the only one at home. Her children had gone to school, her husband that was doing shift work too had taken his car to the mechanic workshop. I got to Joy's house meeting her drinking some of the herbal tea which she said she obtained from one of the few shops where herbal tea ingredients were sold. She talked about her lived health experience in Australia extensively and the interview went on for almost two hours after which she said that she did not have anything more to say. She was happy for me to contact her for any further clarification.

Oluwatosin

Oluwatosin was an industrial chemist from Nigeria and had since been working as an industrial chemist in Australia. A Christian, she migrated to Australia less than 10 years ago with her husband and two daughters for international exposure. Oluwatosin who was less than 40 years old at the time of the interview talked about her experience of encountering a different health care system in Australia and the meaning that this had to her and her health. Oluwatosin worked on Monday to Friday and thereby, her interview was held on a Saturday afternoon in her house as she requested. She was a soft-spoken woman living with her immediate family in their three-bedroom double storey building. I had my field journal with me through out the interview.
Onome

Onome, aged less than 40 years, migrated to Australia about five years ago to reunite with her parents who were in Australia. Married at the time of the interview, Onome was carrying her second pregnancy. Onome was an undergraduate in the University prior to migration to Australia but currently working as an administrative officer. Her first child was not yet in school but went to the family day-care centre. Onome was happy to participate in this study when contacted on the telephone. The interview was also held in her house when her husband had gone to work and her daughter taken to the family day-care centre.

Jenny

Jenny, over 41 years old was married with six children. She migrated to Australia less than 10 years ago for a change of environment. Born in Nigeria, Jenny had a post tertiary educational qualification and was working as a schoolteacher prior to migrating to Australia. She had four children in tertiary institutions in Australia while the other two children were still in the high school. Jenny requested also that her interview be held in her house. On the day of the interview she was the only one at home tidying up the house as her husband had travelled overseas. Her interview lasted for about 80 minutes and she talked about her lived health experience in Australia.

Warris

Warris came to reunite with her parents who had been in Australia. She came to Australia from Ghana as a Schoolgirl and she had been in Australia for more than 11 years. Warris was less than 40 years at the time of the interview and she was the only unmarried woman in my study. She requested that her interview be held in one of the rooms of a University library after her day’s work. Warris was PhD student at the time of the interview and she was very willing to participate in the study. She maintained her willingness throughout the interview process. She participated in a relaxed un-confronting manner and she shared her lived health experience in Australia. Her interview lasted for about 2 hours.

Rosemary

Rosemary, who was less than 40 years old, married with six children was carrying another pregnancy at the time of the interview. She willingly accepted to participate in the face-to-face interview. When I got into her house, on the day of the interview, she was in the shower but she joined me after about 10 minutes. Rosemary was born in Nigeria but migrated less than 10 years ago to reunite with her husband. Four of her children were born in Nigeria while the other two were born in Australia. She was engaged in different types of small business in Nigeria but was doing home duties at the time of interview. Her interview lasted for about two hours after which she stated that she had nothing more to say.
**Stella**

Stella came to Australia to re-unite with her parents who were already in Australia. Stella was less than 40 years and she had been in Australia for less than ten years ago. Stella was born in Ghana but married with no child at the time of the interview. Warris introduced Stella and Michelle to me. Stella was also a high school student when she left Ghana for Australia but working as an assistant in nursing at the time of the interview.

**Emma**

Emma was a married woman born in Nigeria. Migrated to Australia for more than 11 years ago, Emma had three children at the time of the interview. Aged less than 40 years, she was working as a Schoolteacher in Nigeria prior to her migration to Australia but currently working as an account clerk. A Christian, Emma showed her enthusiasm to participate in the interview and we conducted the interview in her house as she requested. She shared her lived health experience in Australia with me for about two hears.
Maureen:

1. When I say culture shock, I mean that **things are so different back at home**. Even **other form I see differently is the community life in Nigeria, but we enjoy it**. You know everybody we are all happy together, **if you have a problem, everybody shares it together** even if you don’t have, the little that you have or that the next door neighbour have everybody join them and share it together. We did things together as a community whereas here you are on your own... Most times it was just you and your husband and you see even your next door neighbour and **you try to say hello and they turn their face away** or you smile to them no response it was so different everywhere.

2. My **expectations were very high**. I thought when I come here with my degree I will be able to get something nice, I thought since I am coming to the western world that things will be so easy to get job in your area... I finished my degree **I didn’t know that our degree will be almost worthless here** in Australia that you can’t get a professional job that you want. With your degree you **have to come so low to get whatever just to get you on**.

3. My certificates were evaluated and I was given a cover letter to say that it is equivalent to their degree here **but still that didn’t help**. I resulted to something so low because I had to at least survive you can’t just stay home and sleep. **I had to stoop down to something very, very low**, which I never in my life imagine that I would do...
4. This experience made me depressed and I mean that I felt very bad, because I spent four years to acquire Bachelor of Science/education physical and health education. I found that it was made worthless, I wasted four years for nothing. Though I know that I have gained something, it has helped me through the years of going through my Uni here but I just felt worthless if I can’t do anything what’s the point? Why did I have to spend that number of years studying in my country only to come here having this bad experience. There was a point I even felt like going back home. Despite that I have got a degree and I can’t work with it what I’m I going to do until much later you know after feeling sorry, pity, depressed at home you know my husband will go to work and leave me at home, I had nothing to do. So I decided to pick up something very low which was nursing assistant then slowly I felt maybe I can actually do something because I know my worth, I knew I could do better than what I was doing then. I know I am a graduate material so I just decided to go back to Uni and do it again. So that made me go back to Uni.

5. Before I came to Australia, I thought it is only when you don’t feel sick, you don’t have malaria (laugh) which is very common in Nigeria, that means you are well. But not taking everything around into consideration. Once you are not sick or stricken down by one illness that means you are well and you are healthy.

6. No, it has to be all-round state of mental, physical and emotional well-being not just the absence of illness.
7. I can’t say I am actually well (laugh). Sometimes I get depressed, missing people from home, psychologically things are not going on as well like I said some of my experience are that of horizontal violence sometimes. It gets to me and I take them home which is not good, my family and things like that, everything else is alright just the psychological bits. If I go by the world health definition, then I am not well (laugh). It’s not complete, though I am not really sick, but all is not very well.

8. It’s hard for me to go and start talking to people about my problems. Like I have been through traumatic experience in my workplace as a midwife. One of the babies died in uterus and that was very traumatic for me and with my background, the family was very distressed and funny things happening, but luckily the result came and it said that the baby was even dead before they came to the hospital. Another one followed immediately when a lady I was looking after got the uterus grown up, ruptured uterus and everything, they recognized this as a huge stress and they offered me some counselling services. But I feel I can deal with it and I didn’t see anyone, although I saw a doctor who has to write me work cover and things like that, but just to go and talk to somebody you don’t know is very hard.

9. No, they can’t feel the gap. The briefing is alright among the colleagues, I had rounds with doctors and most of them re-assured me not to worry and things like that, that’s enough. Though I am still distressed, I am still carrying it but I don’t know, they told me to
see a psychologist, my doctor even referred me to a psychiatrist. I didn't go because I am not mad, though I was disturbed by certain experience. I can’t imagine why they are sending me to a psychiatrist, because back at home in Africa only mad people are referred to psychiatrist. Although I tried not to let my belief affect my professional practice, if someone else is in my situation, I will offer professional help to him, but for me, I can’t do it.

10. Yes. It is part of the beliefs in Africa that your enemy or people that are jealous of you can inflict some illness on you... If somebody is sick and you can not find the cure or even the cause, Africans will believe that it must be caused by some witches and wizards and people that practice black medicine or may be there is a curse or things like that. I was very worried that time because they did all the tests to see what the problem, they couldn’t find anything. It was then I knew it was spiritual and I started praying, my pastor then in the church we were going was involved too, we prayed a lot and the boy got better without any of their treatment.

My interpretation of Maureen’s lived experience in the light of the phenomenon of interest was that Maureen’s living in a country different that in which she was born brought her in contact with a different world. From the extract, she was continuously making reference to what her experience was while in her country of birth as this formed the ideal of what she was looking forward to in a new country. Being used to a communal way of living where chores, responsibilities, burden and pains are shared with extended family members, she presented a feeling of loneliness and isolation in living outside her country of birth. To Maureen she considered living outside home as having to begin life again from the beginning. It meant settling down in a new country, looking for new friends, searching for new jobs and searching for a
new identity. She mentioned her experience of looking for gainful employment commensurate with her degree. To her surprise, all efforts to find employment in her profession were not successful. Her financial problem and the need to feed and maintain her forced her to take up any available job not minding having to start from the lowest level of the ladder. This experience had a lot of negative effect on her health as this made her to lose her self-confidence. She mentioned her experience of being sad, sorrowful, having low self-esteem and feeling worthless. However, this experience challenged her to discover herself and this assisted her as she started the journey of University life all over again where she obtained her Bachelor of Nursing.

Maureen’s living outside her country of birth has influenced her concept of health. Rather that conceptualising health as a physical construct, she now has a holistic view of conceptualising health. Her orientation from her country of birth has tremendous impact on her accessing and utilising available health services in Australia.

Maureen’s spiritual belief in the ability of witches and wizards to cause illness and the efficacy of prayer to heal was also identified by Maureen and her utilisation of alternative method of healing was presented. Significant words, phrases and statements extracted from Maureen’s conversation were:

- Things are so different back at home.
- Other form I see differently is the community life in Nigeria, but we enjoy it.
- If you have a problem, everybody shares it together
- Where as here you are on your own...
- You try to say hello and they turn their face away.
- My expectations were very high
- I didn’t know that our degree will be almost worthless here
- Have to come so low to get whatever just to get you on.
• But still that didn’t help.
• I resulted to something so low because I had to at least survive
• I had to stoop down to something very, very low which I never in my life imagine that I would do...
• This experience made me depressed and I mean that I felt very bad
• Made worthless
• I wasted four years for nothing.
• Though I know that I have gained something, it has helped me through the years of going through my Uni here
• But I just felt worthless
• I even felt like going back home.
• Despite that I have got a degree and I can’t work with it what I’m I going to do
• Feeling sorry, pity, depressed ...
• I had nothing to do
• Picked up something very low
• I know my worth,
• I knew I could do better
• I know I am a graduate material
• Do it again.
• I thought it is only when you don’t feel sick
• Not taking everything around into consideration. Once you are not sick or stricken down by one illness
• It has to be all-round state
• Not just the absence of illness.
• I can’t say I am actually well
• It gets to me
• I take them home.
• It’s not complete, though I am not really sick, but all is not very well.
• It’s hard for me to go and start talking to people about my problems.
• Very traumatic for me
• Funny things happening
• They offered me some counselling services.
• I feel I can deal with it
• But just to go and talk to somebody you don’t know is very hard.
• No, they can’t feel the gap.
• The briefing is alright among the colleagues
• That’s enough.
• I am still distressed,
• I am still carrying it but I don’t know
• I didn’t go because I am not mad,
• Though I was disturbed by certain experience, I can't imagine why they are sending me to a psychiatrist,
• Back at home in Africa only mad people are referred to psychiatrist.
• I will offer professional help to him, but for me, I can’t do it.
• People that are jealous of you can inflict some illness on you
• If somebody is sick and you can not find the cure or even the cause, Africans will believe that it must be caused by some witches and wizards and people that practice black medicine or may be there is a curse

• I knew it was spiritual and I started praying,

• We prayed a lot and the boy got better without any of their treatment

Rita

1. All the while since I was young I have always wanted to travel abroad to a western country or as we call it in my country a “white man’s land”

2. In Nigeria, life wasn’t bad for us given that both my husband and I are both graduate, we were really enjoying then in Nigeria... My husband had a good job, he was a registered professional surveyor in Nigeria, he was working as a contract staff in an oil company and I was working as an executive secretary.

3. Yes, psychologically speaking even though I enjoyed looking after the old people, but I used to think that if it wasn’t for the situation in my country, why should somebody like my self with a university degree end up with the nursing home work? With all the education that I have acquired and all the opportunity available in my country, why should I be subjected to the level of working as an assistant in nursing? Even though I loved the job I was thinking that it is below the level of my qualification and that is why I am doing my nursing degree
today. That was the main thing that encouraged me to do the degree otherwise given the commitment of a mother of four children and also working, it is not easy to combine all these but I can’t continue working as an AIN.

4. We know that nursing is also physical, even as I am an enrolled nurse when you consider the responsibilities back at home and people that you have to send money to, I discovered that as African migrants we are not just here to fend for ourselves alone, we have to take care of our loved ones back at home. Now combine that with working as AIN or even as enrolled nurse you want to do as many shifts as you can, to have more money but the physical pain is there and all these have effects on our bodies. Emotionally also, there are times that I have been treated as …if you don’t know anything, people have asked me if I know how to take patents up, they have asked if I know how to use the observation machines. They ask you all these unnecessary questions to humiliate you as an enrolled migrant nurse. In nursing, there are good and bad ones especially among the RNs, there are some of them that will treat you as if you are nothing.

5. There are times that one will tend to feel a bit weighed down…

6. Sometimes I just feel depressed, I feel sad especially given that one is kind of alienated from ones family, I am here with my husband and children and that's all, as far as relatives are concerned in Australia, we don’t have any relatives here. Given the kind of background one has, Australia is not like Nigeria where you have that kind of communal type of family relationship. Generally speaking, even among your
friends we still look out for one another but that is a bit different in Australia because people don’t want to step on other people’s toes, they don’t want to encroach on their personal state and things like that. **So what happens here is that everybody keeps to himself/herself.** In Nigeria we look out for each other, **sometimes you feel lonely even though you may be in the midst of the crowd.** Psychologically, it affects me…for example when you have done so many shifts, may be it was an extra shift and time for you to go home and relax or you have days off. In this situation if you don’t have a migrant like you in the neighbourhoods, you may be left with no one to actually go to and **so in this way migration is affecting our health.**

7. **Sometimes I just feel lonely and I just thank God that I have Christian friends,** but even church members I tried to be understanding and considerate of other people’s feelings.

8. **I am aware of all these services** especially given the fact that I am a nurse, **but I don’t think that they will be able to meet my needs.** When I said that I internalise, I mean that I have my own way of dealing with those things, my friends have drawn me closer to God. I don’t mean that I just bottle it… **but a lot of time I cry a lot but at the end of it I feel better.** That is one of my coping mechanisms.

9. **I mean that they (health providers in Australia) will not be able to understand what I am saying** and where I am coming from. For example if I tell them that I miss my mum, I want to see her physically even though we talk on phone, what can they do for me? Can they provide the money and send me to her in Nigeria?
10. **I don’t have the time to be going about to see counsellors.** Again, if I want to see a counsellor I will probably need to make an appointment. Sometimes one needs an urgent and immediate intervention and not wait for a long time before you could talk to somebody.

11. **For me especially now that I started my degree program at the University it is really hectic.** Basically I do about seven night shifts at work in a fortnight. This is 70 hours okay. So in a typical day say Monday, I go to work, come back in the morning take the kids to school, come back home maybe between 9:30am-10am, **I may manage to grab a breakfast or maybe go without depending on how tired I am, I just go to sleep.** My husband comes home by 5:30pm, sometimes he picks the other two kids from the carers or sometimes I do the picking. So by the time we come home between 6pm and 7pm, I will serve the dinner. **By 8pm if I’m lucky I may just grab an hour to rest before I go to resume for the night duty** otherwise sometimes I may just lie down for 30minutes and get up about 8:30 pm to start preparing for the night duty. However when the University are in session there are times when I will go straight to the University from 10hour shift. I will be extremely tired and really worn out that all I just want to do is just go home and crash... like I said it **affected me in so many ways. It affected my joy, when I don’t rest enough it affects my joy and I really don’t feel happy as I should.**

My interpretation of Rita’s lived experience based on the extracts above is that living in country different from that in which she was born means loneliness to her. She sited her experience of loneliness and isolation even in the midst of multitudes. She had the feeling of not being
understood by people around her and there was also the feeling that the health providers may not be able to understand her. She felt sad that she could not physically reach out to her extended family members. This according to her, affected her emotional and mental health.

Rita’s significant phrases and sentences are as follow:

- All the while since I was young I have always wanted to travel abroad to a western country or as we call it in my country a “white man’s land”
- …we were really enjoying then in Nigeria
- I was working as an executive secretary
- Psychologically speaking even though I enjoyed looking after the old people, but I used to think that if it wasn’t for the situation in my country, why should somebody like my self with a university degree end up with the nursing home work
- …why should I be subjected to the level of working as an assistant in nursing
- …it is not easy to combine all these but I can’t continue working as an AIN.
- …when you consider the responsibilities back at home and people that you have to send money to...
- As African migrants we are not just here to fend for ourselves alone, we have to take care of our loved ones back at home
...you want to do as many shifts as you can, to have more money but the physical pain is there and all these have effects on our bodies. Emotionally also

...there are some of them that will treat you as if you are nothing.

There are times that one will tend to feel a bit weighed down...

Sometimes I just feel depressed, I feel sad especially given that one is kind of alienated from ones family

Australia is not like Nigeria where you have that kind of communal type of family relationship

...so what happens here is that everybody keeps to himself/herself

...sometimes you feel lonely even though you may be in the midst of the crowd. Psychologically, it affects me

...so in this way migration is affecting our health

Sometimes I just feel lonely...I just thank God that I have Christian friends

I am aware of all these services

...but I don’t think that they will be able to meet my needs

...but a lot of time I cry a lot but at the end of it I feel better.

I mean that they will not be able to understand what I am saying

I don’t have the time to be going about to see counsellors

For me especially now that I started my degree program at the University it is really hectic
• For me especially now that I started my degree program at the University it is really hectic

• I may manage to grab a breakfast or maybe go without depending on how tired I am, I just go to sleep

• By 8pm if I’m lucky I may just grab an hour to rest before I go to resume for the night duty

• ...it affected me in so many ways. It affected my joy, when I don’t rest enough it affects my joy and I really don’t feel happy, as I should.
APPENDIX 3

Identified categories of significant statements.

With the use of the significant statements and phrases from the conversation with Maureen and Rita, some categories were identified below:

Concept of health

• I thought it is only when you don’t feel sick
• Not taking everything around into consideration. Once you are not sick or stricken down by one illness
• It has to be all-round state
• Not just the absence of illness.
• I can’t say I am actually well
• It gets to me
• I take them home.
• It’s not complete, though I am not really sick, but all is not very well.

Community life

• Other form I see differently is the community life in Nigeria, but we enjoy it.
• If you have a problem, everybody shares it together
• Where as here you are on your own...
• You try to say hello and they turn their face away.

World of difference

• My expectations were very high
• Things are so different back at home.

Low self esteem
• But I just felt worthless
• I even felt like going back home.
• Despite that I have got a degree and I can't work with it what I'm I going to do
• Feeling sorry, pity, depressed …
• I had nothing to do
• Picked up something very low
• I had to stoop down to something very, very low which I never in my life imagine that I would do…
• This experience made me depressed and I mean that I felt very bad
• Made worthless
• I wasted four years for nothing.
• I didn’t know that our degree will be almost worthless here
• Have to come so low to get whatever just to get you on.
• But still that didn’t help.
• I resulted to something so low because I had to at least survive

Challenged to raise self-esteem
• I know my worth,
• I knew I could do better
• I know I am a graduate material
• Do it again.
• Though I know that I have gained something, it has helped me through
the years of going through my Uni here

_Spirituality_

• People that are jealous of you can inflict some illness on you
• If somebody is sick and you can not find the cure or even the cause,
  Africans will believe that it must be caused by some witches and
  wizards and people that practice black medicine or may be there is a
  curse
• I knew it was spiritual and I started praying,
• We prayed a lot and the boy got better without any of their treatment

_Encounter with the health care system_

• It’s hard for me to go and start talking to people about my problems.
• Very traumatic for me
• Funny things happening
• They offered me some counselling services.
• I feel I can deal with
• But just to go and talk to somebody you don’t know is very hard.
• No, they can’t feel the gap.
• The briefing is alright among the colleagues
• That’s enough.
• I am still distressed,
• I am still carrying it but I don’t know
• I didn’t go because I am not mad,
• Though I was disturbed by certain experience, I can’t imagine why they are sending me to a psychiatrist,

• Back at home in Africa, only mad people are referred to psychiatrist.

• I will offer professional help to him, but for me, I can’t do it.

These significant phrases and sentences were further grouped to bring about minor themes. This was still at the preliminary stage as some of these sub-themes were reworded later in the analysis as emerging minor themes, which were later grouped again to produce the emerging themes:

**Absence of sickness**

• I thought it is only when you don’t feel sick

• Not taking everything around into consideration. Once you are not sick or stricken down by one illness

**All round state**

• It has to be all-round state

• Not just the absence of illness.

• I can’t say I am actually well

• It gets to me

• I take them home.

• It’s not complete, though I am not really sick, but all is not very well.

**Loneliness/Isolation**

• Other form I see differently is the community life in Nigeria, but we enjoy it.

• If you have a problem, everybody shares it together

• Where as here you are on your own...
• You try to say hello and they turn their face away.

**World of difference**

• My expectations were very high

• Things are so different back at home.

**Self-appraised**

• But I just felt worthless

• I even felt like going back home.

• Despite that I have got a degree and I can’t work with it what I’m I going to do

• Feeling sorry, pity, depressed …

• I had nothing to do

• Picked up something very low

• I had to stoop down to something very, very low that I never in my life imagine that I would do…

• This experience made me depressed and I mean that I felt very bad

• Made worthless

• I wasted four years for nothing.

• I didn’t know that our degree will be almost worthless here

• Have to come so low to get whatever just to get you on.

**Facing challenge**

• I know my worth,

• I knew I could do better

• I know I am a graduate material

• Do it again.
Though I know that I have gained something, it has helped me through the years of going through my Uni here

Belief about disease causation

- People that are jealous of you can inflict some illness on you
- If somebody is sick and you cannot find the cure or even the cause, Africans will believe that it must be caused by some witches and wizards and people that practice black medicine or may be there is a curse

Efficacy of prayer

- I knew it was spiritual and I started praying,
- We prayed a lot and the boy got better without any of their treatment

Orientation

- It’s hard for me to go and start talking to people about my problems.
- Very traumatic for me
- I didn’t go because I am not mad,
- Though I was disturbed by certain experience, I can’t imagine why they are sending me to a psychiatrist,
- Back at home in Africa only mad people are referred to psychiatrist.

Under utilisation of health service

- They offered me some counselling services.
- I feel I can deal with
- But just to go and talk to somebody you don’t know is very hard.
- No, they can’t feel the gap.
- The briefing is alright among the colleagues
- That’s enough.
• I am still distressed,
• I am still carrying it but I don’t know
• I will offer professional help to him, but for me, I can’t do it.
Participants’ information sheet

Title of Study: Meaning of Health: Migration Experience and Health Seeking Behaviour of West African women in Australia.

Name of Researcher: Olayide O. Ogunsiji

Name of Supervisors: Prof. Lesley Wilkes

Prof. Debra Jackson

Dr. Kath Peters

I am inviting you to be part of a study I am conducting for my PhD Degree in Nursing. The purpose of this research is to explore the health perception of the West African born women living in Australia.

If you volunteer, I will interview you for about 60 minutes and the interview will be recorded on an audio tape, which will later be transcribed and analysed. There are no expected risk from participating in the study. If discussing personal experience is upsetting to you, you may choose not to answer those or any other questions. If you feel, you need counselling I may give you the telephone numbers of appropriate counselling service providers. It is hoped that the information gained in this research may enable a better understanding of the West African born women living in Australia and their health perspectives. All information will be kept confidential. No names of the participants will be required.

Typed transcripts will be identified by pseudonyms provided by the participants. No individual’s complete interview will be available to anybody except the researcher and the supervisors. The result of the study will be reported in form of a thesis. The identity of the participants will be protected during any communication of the results. Participation in this study is voluntary and if you decide not to take part or decide to withdraw at any time, you can do so at any time and this will not affect you in any way. If you have any concern about the conduct of this study, please do not hesitate to discuss them with Olayide or secretary of the ethics committee of the University of Western Sydney that has approved this project. The Study has been approved by the University of Western Sydney Human Research Ethics Committee. If you have any complaints or reservation about this research, you may contact the ethics committee through the Human Ethics Officer, Kay Buckley, Ph: 02 47360883. Any issues you raise will be treated with confidentiality and fully investigated and you will be informed of the outcome.

If you would like further information about this study, please contact Olayide through Anna McManua on 02 47343181. Thank you.
APPENDIX 5

Consent to participate in the study

I…………………….hereby voluntarily consent to participate in the research project entitled “West African born women in Australia: A health perspective”.
This project is being conducted by Mrs. Olayide Ogunsiji and supervised by Prof. Lesley Wilkes and Prof. Debra Jackson.
I have read and understood the information presented to prospective participants in this research project. I have agreed to participate on the understanding that I may withdraw from the study at any time. I am aware and agree to the interview being recorded on audiotape.

I understand that the findings from this study may be used in future research and may also be published. I have been re-assured that any information from this study concerning myself will be treated with confidentiality.

I understand that should I become distressed and require further counselling during the interview I will have access to an experienced counsellor.

Name:……………………………………
Signature:………………………………
Date:……………………………………
Preferred contact no:……………………
Preferred contact time:……………………

THANK YOU FOR PARTICIPATING IN THIS STUDY
Appendix 6

Demographic questions and Interview Guide

Appendix 6a: Demographic questions

Age in years: 18-25 □ 26-30 □ 31-35 □ 36-40 □ 41-45 □ 46-50 □ 51-55 □ 56 and above □

Marital status: Married □ Single □ Divorced □ Widowed □

Resident status: Permanent resident □ Australian citizen □

Educational achievement: Pre-tertiary education □ Post-tertiary □ Others □

Religion: Christianity □ Islam □ Others (Specify) □

Country of birth: Ghana □ Nigeria □

Length of stay in Australia: 0-5 years □ 6-10 years □ 11 years and above □

Occupation before migration to Australia----------------------

Occupation since migration to Australia----------------------

Reasons for migration---------------------------------------------

Nationality of spouse---------------------------------------------
Appendix 6 b: Interview guide

Leading question:

Can you please tell me your health experience since you have been living in Australia?

Other questions:

- What do you mean by health?
- Can you please enumerate the health services you have utilised in Australia?
- Please describe your experience with the Australian health care system?
- Can you please explain your perception of the various health care encounters you have had in Australia?
- Tell me about your life generally back in Africa?
- What were your expectations before migrating to Australia?
- Please describe your experience since migration to Australia
## Appendix 7

**Table 8: List of free counselling services in Sydney.**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Contact number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auburn Community Health Centre</td>
<td>(02) 9646 2233</td>
</tr>
<tr>
<td>Blacktown Community Health Centre</td>
<td>9881 8700</td>
</tr>
<tr>
<td>Camperdam mental health services-</td>
<td>9515 9000</td>
</tr>
<tr>
<td>Crisis Counselling</td>
<td>(02) 9677 1962</td>
</tr>
<tr>
<td>Doonside Community Health Centre</td>
<td>9881 8650</td>
</tr>
<tr>
<td>Hills Community Health Centre</td>
<td>8853-4500</td>
</tr>
<tr>
<td>Katoomba Community Health Centre</td>
<td>4782 2133</td>
</tr>
<tr>
<td>Merrylands Community Health Centre</td>
<td>9682 3133</td>
</tr>
<tr>
<td>Mt Druitt Community Health Centre</td>
<td>9881 1200</td>
</tr>
<tr>
<td>Parramatta Community Health Centre</td>
<td>9843 3222</td>
</tr>
<tr>
<td>Rockdale Community Health Centres</td>
<td>9087 8300</td>
</tr>
<tr>
<td>Ryde Community Mental Health Centre</td>
<td>9858 7777</td>
</tr>
</tbody>
</table>
