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Abstract
This paper documents and reflects on a specific event during ethnographic research on the development of friendship and kinship networks within African communities in Perth. These communities have formed over the past fifteen years through the predominantly humanitarian immigration of black Africans from more than a dozen countries affected by war and civil unrest. The paper uses narratives of African refugee women and the researcher’s reflection in order to explore issues such as relationship building, community support and social inclusion. The paper aims to show the level and significance of support that these relationships provide for individuals as they strive to establish themselves in their new social context.

Tears and support
It was a beautiful early autumn day. The sky was intensely blue, the sun warm but not hot, and the breeze just strong enough to stir the leaves on the trees. It was a perfect day for a picnic in the park or perhaps a relaxing walk on the beach.

This particular Sunday, however, I had been invited to attend a funeral service. The invitation had come about as a result of making contact with Faye, the Chairperson of the Women’s Group of a particular African community, with regard to possible interview participants for my research project. Although I had not met Faye, or indeed any other member of the community, she had invited me to come along so that I could get to know this group of people, gain some first-hand understanding of their lives, and therefore identify with them to some extent.

I felt honoured to be included, to be able to witness the community say their farewells to a child who had died unexpectedly, and to experience the support and good will that was being provided for the grieving family. I also felt uncomfortable and uncertain as to what my role was and what would be expected of me in this situation. Although I had been invited primarily as an
observer, to facilitate future interaction and trust with this particular community, I was also ultimately there as a fellow human being and witness to tragedy. The unknown qualities contributed to making me feel anxious; I had not met any of these people before and was entering their lives at a time of grief. I had little idea of what the day ahead held.

As requested, I arrived at the grieving family’s home well ahead of time, so that I could meet Faye and then be introduced to members of the family. The house, alive with the movement of people and the background noise of popular music hits on the television set, filled up rapidly as more and more people arrived. Each family brought with them a contribution to the meal that would be provided after the service, and came into the house to pay their respects to the young parents, Susan and John, and to Elizabeth, the grandmother of the child, before moving outside to wait.

After an hour or so, once a sizeable crowd had assembled, it was decided that we would all walk across to the church, as it was only about five hundred metres down the road. This we duly did, the mourners talking to one another and the children scampering on ahead. I took the opportunity to ask Faye about the surrounding circumstances and the age of the child involved. She told me that the child was a two-day-old infant, lost through what appeared to have been medical mismanagement.

Faye went on to explain that the young mother, Susan, had gone to the local hospital three times over a period of a couple of weeks, experiencing abdominal pains and insisting that something was wrong with her baby. She had been sent home after a cursory examination on two of these occasions, with little or no attention given to the details she was trying to convey, and with assurances that all was well. Susan, although convinced that there was a problem, felt she had no alternative but to place her trust in the system and go home.

The third time she went to the hospital, however, she refused to be sent home. The medical staff then finally appeared to take the situation seriously enough to monitor the foetus, at which point they established that there was foetal distress and did an emergency caesarean. The baby girl was born with brain damage and died two days later.
On our arrival at the church, we found that a number of people had already gathered there and I was introduced to several community elders before being invited inside. The church hall was a large rectangular room, with folding chairs set out in rows leading up to the stage area at the front. Between the first row of chairs and the stage, a full drum kit and three microphone stands had been set up. The immediate family of the infant was seated at the front and Fay encouraged me to sit just behind them. The hall was, by this time, filling up rapidly — there were well over a hundred people in attendance.

Once we had all taken our seats, the funeral director came in carrying the coffin. As he walked past me, I saw that it was tiny, less than a metre in length; white, with silver handles and catches, and a small silver plaque on the top. The funeral director placed the coffin on a stand, centre front-stage, undid the catches and removed the little lid, putting it to one side.

There was something incredibly heart-rending about that moment — and even more so when the young mother, who had appeared stoically calm the whole time, started to weep uncontrollably. Women from the community quietly gathered around her and comforted her, and she gradually calmed down, although she clenched her handkerchief so tightly in the fist that she had pressed up against her mouth that it was agonising to observe. Her husband was also clearly affected by the events, wiping away the tears that streamed silently down his face. The child’s grandmother was sitting directly in front of me and her body was wracked by small shudders as she tried to internalise her grief. It, too, was utterly devastating to witness.

The Master of Ceremonies (MC), a member of the community and family friend, then greeted those present. She invited members of the congregation to go up on to the stage to say their final farewells to the baby. After this, she said, the coffin would be sealed and the service would commence.

Just about everyone filed slowly past the little coffin, climbing up the short staircase at the one end of the stage, some pausing only briefly in front of the coffin. Others, such as the grandmother, stood and gazed down for some time before leaving the stage via the stairs at the other end. The child’s parents did not go up; they had already said their farewells to their daughter privately before everyone else arrived.
Once everyone had resumed their seats, the funeral director came in again, secured the lid on the coffin, and the service began. The MC welcomed everyone and invited a young woman to come forward to lead the congregation in a hymn. The singer came up to the front of the hall followed by her accompanists, a backing singer and the drummer. The congregation all rose to their feet and joined in, singing and swaying and clapping in time to the rhythm. There was an outpouring of emotion and religious fervour that seemed to shake the roof and which included every mourner in the room.

The MC then addressed the congregation again, comforting the family and calling on various other people in turn to come forward to say a few words: a community elder, a representative from the Women’s Group, and then Elizabeth, the child’s grandmother. Each of the speakers expressed their sympathy and compassion for the family’s loss and, indeed, that of the community, comforting them with assurances that the infant had gone to a better place — a place, they said, where she will not have to endure the trials of this world, where she will be safe and loved and will be waiting for them.

Elizabeth also reminded everyone that lunch would be served at her house after the service and that everyone was welcome to attend. Another elder then sang a traditional song before the pastor was invited to give his address and benediction. This was followed by a final farewell hymn to the little girl by the congregation, who put their whole heart into it. The funeral director then came forward once again, picked up the tiny coffin and slowly proceeded outside, followed first by the family and then by rest of the congregation.

When Susan, the bereaved young mother, surrounded by female relatives and friends, walked past the hearse, she completely lost what remained of her composure. Although she had tried desperately not to break down again in the church, out there in the open air, with her baby about to be taken away so definitively, she could no longer control her overwhelming grief. She was inconsolable.

Many other people were tearful, possibly as much in response to the mother’s grief as to the actual events. Certainly I felt overwhelmed. This was, without a doubt, the most moving and saddest event I have ever witnessed or been involved in. It was
also the most amazing display of community support, shared care, and loving concern.

During the walk back to the family home to regroup and share a meal, Faye told me that a large part of the grief that the young mother felt resulted from her conviction that, if she had been listened to and taken seriously in the first place, this whole tragedy could very probably have been averted. Susan, Faye said, felt that she had no ‘voice’ with regard to the wellbeing of her child and that her views were not acknowledged or given credence when she tried repeatedly to be heard.

I was left in no doubt that this is how this African community viewed the outcome – that a combination of misunderstanding, due to cultural differences and language difficulties, and the resultant mismanagement, had made what might otherwise have been a day of relaxation and family sharing, a day of sadness and tears instead.

Various other women in the community reinforced this notion, telling me that this was the second infant death in their community in a relatively short period, and that they felt that these events had a common theme: that practitioners assume that their African patients either don’t know what they’re talking about when they provide information on their own health, or may not understand what they are told by the doctors. A number of the women emphasised how tragedies such as these could potentially be avoided if community members were heard.

By late afternoon, when I finally left, I felt overladen, challenged emotionally and intellectually by the events of the day. As observer and researcher I had a wealth of data and a number of challenges to face. Faye reinforced this when saying goodbye. She told me:

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\text{Members of our community think that making their stories heard and recorded could result in attention being directed to the health promotion of our women in our community, especially those of child-bearing age, to prevent further infant deaths in our community}^2.\]

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Stories have the potential to shape the world in which we live (Finnegan 1998:4-6; Nelson 2001:84-85; Graham 1984:119). The
story related above is only one of a vast number of stories that could be told about the refugee communities in Australia and the challenges of their settlement in the new environment. This particular story focuses on the personal experiences of the refugee women involved in the funeral and my inclusion in that event. It is an example of the complexity of building up networks of trust, and of what can emerge as a result of attempting to do so. Framed as a rich ethnographic description, this piece aimed to provide a window into the world of an ‘emerging’ African community, one made up of recently arrived refugees who are trying to establish themselves in Perth, Western Australia, to highlight the value of friendship and community bonds, and to pinpoint some of the issues of current concern to this particular community.

As such, the story does not represent the voices of refugee women from other communities or, indeed, those of the medical practitioners referred to in the story. These are issues that can be taken up elsewhere. Here, I have attempted to show not only the support and community interaction provided by friends and family alike, which are invaluable to the settlement process, but also some of the confusion and frustration that can, potentially, hamper settlement. This story is about one specific instance of a silenced minority in Australian society and an attempt to provide some voice regarding their concerns, however limited in reach. This was, as mentioned, their explicit wish.

There are few personal details about the participants provided in the story and this is a direct result of a request from Faye, my key contact in the community. Given that Perth is relatively small and the African communities can be easily identified, I was asked to ensure that the anonymity of the community was preserved. This, I was told, is because there were concerns in the community that any perceived criticism may have a negative impact either on social security payments or, indeed, on the visa status of those concerned.

I therefore excluded descriptions of the protagonists, other than in the broadest terms, and am unable to be specific about their country or region of origin. What I can say, however, is that the people who shared this story with me have lived through unimaginably difficult and stressful events, where sheer persistence and a will to survive kept them going. They are
certainly not victims — they are survivors who have waited a long time before they reached safety.

My interaction with this community came about as a result of my search for interview participants in the early phases of my research project. The project itself sets out to examine the formation and re-formation of social bonds and community interaction within the Australian-African refugee diaspora in Perth. This includes examining the development of friendships and fictive kinship relationships and the support these provide for individuals. The aim of the project is to explore African notions of friendship and kinship and try to uncover what is held in common by black Africans in this context and what they perceive has been lost on coming to Australia.

As creators and nurturers of social bonds, it is often African women who appear to sustain and promote kinship and friendship ties. These relationships provide the support structures that help people deal with some of the problems, such as unemployment, depression, racial discrimination, loneliness, and unfulfilled expectations (Udo-Ekpo 1999).

My study focuses on a relatively small number of participants, about twenty women, and includes interviews and observations directed at the question of how personal support networks are rebuilt. In preliminary conversations and subsequent interviews, we have discussed participants’ feelings and understandings of friendship, family and settlement. In the course of these interactions the women have shown great willingness to talk about a wide range of issues, which has enabled me to gain some insight into their settlement expectations, joys and concerns.

What came through very clearly in these conversations was that coming to Australia was seen as the culmination of what was often years of desperate hope for a better life. These people spent prolonged periods living in fear and uncertainty, they had lost the protection of not only their homes, but also their government and, often, their families (Lubbers 2004:vii; Martin 2004:13-15; Jok 1999:428; Ward 2002:7; McWilliams 1998:114; Crisp 2000:631; Pittaway 1991:8). Many of the refugees arriving from Africa have been traumatised physically and emotionally (Benard 1986:617; Martin 2004:1-14; Feller 2001:581; Iredale et al. 1996; Pittaway 1991) and it is therefore not surprising that these women place great emphasis on the notion of Australia as a safe haven.
Although the majority of the women I have spoken with have emphasised that they actually knew little or nothing about Australia and its culture and the way of life before arrival, they nevertheless all had very high expectations. The core hope revolved around the belief that they would be physically safe, that they would no longer be hungry and that there would be easy access to the advanced medical care, schooling and legal aid.

Participants have told me that they feel safe in Australia. They say that it is a wonderful thing that they can walk down the street and look at people and feel no fear. Another great joy, they say, is the availability of food. No longer do they have to survive on daily rations such as a cup of grain, a little oil and a few lentils, as is common in refugee camps (Henry and Seaman 1992:359).

It is clear that many refugees anticipate that upon resettlement they will live in a ‘Western paradise’, a place where they can rebuild their shattered lives. Often, they experience initial feelings of euphoria when finally resettled (Stoller 1981:31). What they also often find, however, is a new set of problems, both social and practical, to which they have to adjust. Not the least of these is that many have had limited schooling and come to Australia with varied levels of English competency.

The Australian government acknowledges that people entering Australia under the Humanitarian Program have a range of special needs and has strategies in place to address them through the Integrated Humanitarian Settlement Strategy (IHSS), which provides intensive settlement support for approximately six months after arrival (DIMA 2005). Within IHSS, the Adult Migrant English Program provides English language tuition (DIMA 2006).

However, there are social challenges that strategies such as these have difficulty addressing. Government initiatives have limited scope in addressing the loss of social bonds which used to provide the practical and emotional support in everyday lives. The adjustment problems that refugees face can be particularly severe where the originating culture is significantly different to that of the host country. The transition from a rural or semi-rural traditional African environment, to the rigours of life in a refugee camp, and, finally, to the challenges of an urban, industrialized society, such as Australia, is bound to require significant ability to adapt (Martin 2004:131).
This brings me back to the story of young Susan’s loss of her newborn daughter. The despair and devastation she felt were, I was told, compounded by the fact that she expected there were experienced doctors and nursing staff to manage the pregnancy and the delivery. Notwithstanding her concerns before the birth of her child, it did not occur to her that the Australian medical system and the hospital staff would, in the end, be unable to ensure a positive outcome of her pregnancy.

The refugee women explained to me that infant deaths were not unexpected when fleeing from war and when violence and starvation were constant threats. This was also not unusual in the refugee camps where, one participant told me, more than one hundred children die every day as a result of malaria, cholera and other diseases. Living conditions, she said, were very harsh — housing was inadequate, there was limited access to clean water, sanitation was poor and little or no healthcare was available.

Whilst deaths in such circumstances are no less sad than Susan’s loss, the death of this baby came as much more of a shock because of the expectations regarding medical expertise and care in Australia. Most of the refugee women with whom I have spoken have carried several babies to term in the past, often in the harshest of circumstances in Africa. They have then come to Australia, where they expected to find good hospitals, excellent sanitation, clean water and plenty of doctors. I have been told that it is of concern to the Africans that several women who have had otherwise healthy pregnancies have lost their babies at birth or soon after here in Western Australia. The concept of losing a child in an Australian hospital, with doctors, nursing staff and emergency procedures to hand was hard to understand and accept.

Many women with whom I have spoken expressed views which showed that there were levels of both perceived and actual social exclusion in various situations, such as in medical services, but also more generally. Several women have mentioned that, because of their ‘visible difference’ in the mainly white ‘Anglo’ population of Australia, they felt they were homogenized by the mainstream society and that assumptions, usually erroneous ones, are made about their ability to understand and explain issues relating, for example, to their own health care, as in the case of Susan and her baby.
All too often, participants told me, the media portrays refugees, especially those from Africa, as needy, uneducated and prey to disease. These representations, they said, do not show their pride in their survival, their knowledge of their land, their commitment to the wellbeing of their children, or their willingness to learn. One participant in particular, Iris, took great exception to a particular media advertising campaign which uses pictures of a young black African children trying to find food in a garbage bin. This, Iris said, is not all of Africa or all of refugees. Iris has, however, experienced these perceptions being taken up and assumed to be the norm. She found highly offensive and degrading, she said, for people in her place of work to assume that she came from such a background. It made her angry and resulted in strained relations with her workmates.

This homogenisation, and the refugees’ perception of it, can work to undermine successful settlement. It exacerbates another issue, which is that many of the women feel that they are not heard when visiting doctors. It appears that language difficulties play a part in this problem, as do the range of medical issues which Australian doctors may have had little exposure to. In order for doctors to understand African clients, consultations can end up taking longer than a standard consultation period, which is not necessarily easily accommodated by all practitioners with whom the refugees interact.

However, in order to feel included, these ‘new Australians’ need to be afforded sufficient time to explain their issues and be understood. My interaction with the African diaspora has taught me that it is only through spending time listening to individual and group stories, by taking the time to try to make connections and to make sense of what is heard and experienced, that compassionate and ethical cross-cultural interaction can be achieved. In a society where ‘time is money’, this is not always feasible.

Whilst my research is unlikely to have any tangible impact on solving these issues, my involvement nevertheless presents me with an ongoing challenge of how I could get such a story out into the mainstream community and, potentially, draw attention to the situation. The recent workshop on the social inclusion of refugees, from which this publication has resulted, provided such an opportunity and forum in which to air the community concerns.
The described events at the funeral and afterwards were the most intrinsically sad, and yet the most uplifting experience. I found the combination of the grief surrounding Susan and the high levels of not just familial, but also community support, to be extraordinary. I felt privileged to have attended, and moved beyond words by what I had witnessed. This community had invited me, a total stranger, to attend a private and emotionally charged event. They had extended the hand of friendship to me, inviting me to identify with their community and to start to build bonds of trust and friendship. I had been included at every stage, as a friend and witness to grief, extended family support and community cohesion, by people grieving the outcome of perceived exclusion.

A day of immersion as a ‘visibly different’ white person in this black African community left me with a powerful feeling of inclusion and acceptance which has stayed with me ever since. It was so freely and warmly offered that it has made me infinitely more sensitive to the issue of inclusion and the importance of ensuring that refugees are offered the same level of easy acceptance that I was.

References


**Notes**

1 Pseudonyms are used by request throughout this narrative to protect individual identities of participants, and of communities as a whole.

2 'Faye' 26/03/2006.