Health Promotion International, 2026, 41, daag021
https://doi.org/10.1093/heapro/daag021
Published: 17 February 2026
Article

Health literacy needs and community-based solutions for African Australians in NSW and Victoria at the point of care

Abela Mahimbo [1]*, Salma A.E. Ahmed [1], Zoe Trabe-Templeton[1], Sheila Uyirwoth[2], Cordelia Oyekan-John[2], Michael Camit[3,4,5]

[1]School of Public Health, Faculty of Health, University of Technology Sydney, 235-253 Jones St, Ultimo, NSW 2007, Australia
[2]African Health, 146 Denison Road, Dulwich Hill, NSW 2203, Australia
[3]School of Population Health, Business School, University of Technology Sydney, 235-253 Jones St, Ultimo, NSW, 2007, Australia
[4]School of Population Health, Faculty of Medicine and Health, University of New South Wales, Building C29 HTH, Level 5, UNSW, Sydney, NSW 2052, Australia
[5]South Western Sydney Local Health District Multicultural Services, Liverpool Hospital, Locked Bag 7279, Liverpool BC, NSW 1871, Australia
*Corresponding author. School of Public Health, Faculty of Health, University of Technology Sydney, 235-253 Jones St, Ultimo, NSW 2007, Australia. E-mail: Abela.Mahimbo@uts.edu.au; abby2585@gmail.com

Abstract

Health literacy, the ability to access, understand, appraise, and use health information, is critical for active healthcare engagement, yet little is known about African Australians' needs at the point of care. We conducted a qualitative descriptive study involving six focus groups with 22 community members and nine community intermediaries in NSW and Victoria, to explore African Australians' health literacy needs, including the current organizational health literacy environment and strategies to improve their health literacy at the point of care. We identified five themes: health literacy is complex and context dependent, experiences determine and shape health literacy, social determinants impact access to and active engagement with healthcare services, experiences of feeling misunderstood and unsupported at the point of care, and a whole-of-systems approach is needed across individual, provider, system, and policy levels to enhance the health literacy of African Australians. Our findings highlight how social determinants, such as culture and identity, and organizational contexts intersect, underscoring the need for a systems-wide, intersectional approach to address health literacy gaps at the point of care.

Keywords health literacy, African Australian communities, culturally responsive care, social determinants of health, intersectionality

Contribution to Health Promotion

- Highlights the unique health literacy needs of African Australian communities at the point of care.
- Identifies social and cultural factors that influence access to and use of health information and services.
- Emphasizes the importance of holistic, person-centred, culturally responsive healthcare approaches.
- Advocates for codesigned health services and resources tailored to multicultural communities.
- Supports a systems-wide, intersectional approach to address health literacy gaps at the point of care.

Introduction

Health literacy, defined as the ability to access, understand, appraise, and use health information to make informed decisions and take actions that influence health outcomes (Nutbeam and Lloyd 2021), is essential for navigating the complex demands of modern healthcare (McKenna *et al*. 2017). It encompasses a spectrum of skills, including literacy and numeracy, which vary among individuals and are shaped by contextual factors (Nutbeam and Lloyd 2021). As a personal asset, health literacy plays a pivotal role in patient empowerment, autonomy, and agency during healthcare encounters (Mårtensson and Hensing 2012). Importantly, health literacy is dynamic and context specific, requiring individuals to adapt their skills across diverse situations (Nutbeam *et al*. 2018). Even those with strong health literacy may struggle in unfamiliar environments, such as clinical

settings, due to complex medical terminology and physiological concepts (Kyle and Shaw 2014). While traditional approaches emphasize individual capabilities, focusing on the ability to access, understand, appraise, and use health information, they often overlook societal and structural determinants that shape health choices and opportunities for well-being (Tshekiso 2022).

Migrants represent a distinct population facing multiple acculturative challenges when adapting to new environments, including unfamiliar cultures, societal structures, and health systems. Confusion or misinformation about available healthcare services, early detection guidelines, the need and value of screening, disease prevention practices, and negotiating care and treatment further limit their access to, uptake of, and utilization of healthcare (Bhopal 2014, Kalengayi *et al*. 2015). Research consistently shows inadequate health literacy among migrant populations. For example, over 75% of migrants in Lisbon reported difficulties understanding health information (Medina *et al*. 2022), and more than half of 278 immigrants in Spain had inadequate or problematic health literacy (Poza-Méndez *et al*. 2022). Arabic-speaking migrants in Sweden similarly demonstrated lower comprehensive and electronic health literacy compared with Swedish-speaking residents (Bergman *et al*. 2021). However, a study of 825 migrants in Germany found generally low health literacy levels comparable to the general population (Berens *et al*. 2022). Education, social status, age, gender, duration of stay, and interethnic contact were positively associated with health literacy in some domains. These findings highlight the need to contextualize migrant health literacy, as diverse determinants shape outcomes across communities.

Australia is home to migrants from diverse countries, including a growing number of people of African descent. Over the past two decades, migration from Africa to Australia has increased, driven by skilled migration and humanitarian resettlement (Prout Quicke 2023). As of 2024, more than half a million African-born people live in Australia, over double the number from 20 years ago, representing about 2% of the national population and 7% of the overseas-born population (ABS 2024). Migrants from South Africa (~41% of the African-born population), Zimbabwe, Egypt, Mauritius, and Kenya comprise ~71% of all African-born people in Australia (Prout Quicke 2023). Reflecting the continent's diversity of 54 countries, over 2000 languages, and numerous ethnic groups, African communities in Australia are highly heterogeneous in culture, religion, language, literacy, and English proficiency, factors that shape access to health information and services (African Australian Communities Leadership Forum 2016).

Migration pathways vary, with African Australians arriving through skilled, family reunion, and humanitarian programmes (Prout Quicke 2023), shaping their health experiences and outcomes. Research, predominantly from South Australia, shows that skilled African migrants face employment barriers, financial strain, and cultural adjustment challenges, alongside stressors, such as racial discrimination, shifting family dynamics, identity negotiation, and social isolation (Gatwiri *et al*. 2021, Mwanri *et al*. 2021, 2022). Most studies on African migrants' health focus on refugees, who often experience higher comorbidity burdens and poorer health outcomes. Multilevel barriers across individual, community, and systemic domains further restrict healthcare access (Sheikh-Mohammed *et al*. 2006, Parajuli and Horey 2020, de-Graft Aikins *et al*. 2023). Patients from refugee backgrounds often have inadequate health literacy, particularly in health promotion and system navigation (Peprah *et al*. 2023), leaving them less equipped to manage their own health or support family well-being, contributing to poorer outcomes.

Despite growing literature on the health needs, service use, and health literacy of African refugees, there remains a notable gap concerning African Australians who arrive through skilled migration pathways, particularly regarding their health literacy needs at the point of care. An informal needs assessment by African Health, a social enterprise of healthcare providers of African descent supporting health literacy in African communities in Australia, highlighted persistent challenges with communication and treatment adherence among clients of African descent. Recognizing the influence of context on access to and use of health information both before and during healthcare encounters (Nutbeam and Muscat 2021), this study, in partnership with African Health, addressed the following research questions:

1. What are African Australians' health information needs and information delivery preferences at the point of care?
2. What is the current health literacy environment at the point of care?
3. How might we improve health literacy for African Australians at the point of care?

Materials and methods

Study conceptualization and design

This study employed qualitative methods grounded in the principles of participatory action research (PAR). PAR is a collaborative, iterative approach that prioritizes lived experience and generates actionable knowledge through relationships and change-oriented processes (Cornish *et al*. 2023). The lead author (A.M.) partnered with a multicultural health literacy manager (M.C.), who had identified underrepresentation and health literacy gaps among African communities. With input from African Health codirectors (S.U. and C.O.-J.), a small UTS industry partnership grant enabled the project.

A community advisory panel was established, including two community members of African descent (from Somalia and Burundi), an African academic (Ugandan), a multicultural health representative (Asian), and a community development representative (Sierra Leonean) to guide study design, ethics, recruitment, and data collection. Members were reimbursed ($50) and engaged primarily through an initial meeting and follow-up email consultations. Reflexive practices, including researcher reflection notes and informal debriefs, helped the team consider how positionality and lived experience shaped the research process. Ethical considerations were negotiated collaboratively; for instance, when a panel member questioned how to balance institutional requirements with community-driven knowledge and goals for social transformation, it prompted a transparent dialogue about funder expectations, accountability, and building trust within the research process.

Aligned with PAR principles of participation, empowerment, and social change (Cornish *et al*. 2023), this study recruited African community members and community intermediaries to explore strategies for strengthening individual and

organizational health literacy. Community intermediaries are trusted figures who help bridge health literacy gaps within multicultural communities (Seale *et al*. 2022).

Study setting and participants

To enhance triangulation, participants were recruited from NSW and Victoria. Eligible participants were adults aged 18 years and older who identified as African Australian (of African descent), spoke English proficiently, and resided in either NSW or Victoria.

Participants were recruited in two phases. First, purposive and snowball sampling were used to recruit community members from African backgrounds. Recruitment materials were shared through advisory panel networks, professional platforms (LinkedIn and Facebook), and African community WhatsApp groups and at the Africultures Festival (Sydney Olympic Park, October 2024). The flyer outlined the study and invited participants to register online or contact the study lead (A.M.). Focus group participants also shared the study within their networks. In the second phase, community intermediaries were recruited to achieve thematic saturation, particularly on complex health literacy needs and community-based solutions. Advisory panel members recommended key stakeholders, who were subsequently contacted by email. Each participant received a $50 supermarket gift voucher in appreciation of their time. Ethical approval for the study was granted by the University of Technology Sydney Human Research Ethics Committee (UTS HREC Reference Number: ETH24-9517).

Data collection

Eight focus groups were conducted between September and December 2024, six with community members and two with community intermediaries, via Zoom/Teams at times convenient for participants. Written consent and electronic demographic questionnaires, including measures of English proficiency and confidence in completing medical forms (Sarkar *et al*. 2011), were collected beforehand. S.A.E.A. facilitated all discussions. With consent, sessions were audio-recorded, transcribed verbatim, and analysed in NVivo 14. All data (recordings, transcripts, and questionnaires) are securely stored on UTS's STASH platform. Focus groups ran for 60–90 minutes.

Interview guide

The interview guide examined four main areas: (i) the health literacy of African communities (e.g. understanding of health literacy, information sources, comprehension of instructions, and follow-up), (ii) the health literacy environment within healthcare organizations (e.g. provider communication strategies and involvement in health information and services design), (iii) specific health information needs and preferred modes of delivery at the point of care, and (iv) strategies to improve health literacy among African communities at the point of care. The interview guide was amended for community intermediaries to reflect the nuanced and complex health literacy needs of African communities, with a particular focus on point-of-care interventions.

Data analysis

Data were analysed using thematic analysis (Braun and Clarke 2006). After familiarization with the data, transcripts were coded and subsequently categorized based on patterns constructed from the data in line with the research questions. The first two focus group transcripts were independently analysed by A.M. (a researcher of Tanzanian background), S.A.E.A. (a researcher of Sudanese background), and Z.T.-T. (a research assistant of Caucasian background) and then compared to identify initial themes. The remaining four community member transcripts, along with the two transcripts from community intermediaries, were analysed to assess the adequacy of the initial categories and to ensure thematic saturation. Syntheses from the three researchers were then compared, and themes were refined where necessary. These themes were subsequently shared with the broader research team, and consensus was reached through discussion. A summary report was prepared and circulated to all participants to ensure the identified codes and themes accurately represented their perspectives.

Ethics

Ethical approval for the study was granted by the University of Technology Sydney Human Research Ethics Committee (UTS HREC Reference Number: ETH24-9517).

Results

Twenty-two community members participated in the focus groups, most of whom were male (see Table 1). Twelve were from New South Wales, nine were from Victoria, and one had an unspecified location. Notably, two participants were also healthcare providers. In addition, nine community intermediaries were recruited, comprising four males and five females (see Table 2). Most community intermediaries were based in New South Wales ($n = 7$), with two in Victoria. Participants represented nearly all regions of Africa, predominantly Western and Eastern Africa.

Among participants who provided demographic data, the most common age group was 25–34 years ($n = 11$), followed by 35–44 ($n = 10$) and 45–54 ($n = 6$). Most were university graduates ($n = 22$), and five had completed high school. The majority rated their English proficiency and confidence in completing medical forms as high (see Tables 1 and 2).

Themes

Five key themes were identified from the analysis of the transcripts: health literacy is complex and context dependent, experiences determine and shape health literacy, social determinants impact access to and active engagement with healthcare services, and feeling misunderstood and unsupported at the point of care. A whole-of-systems approach, including the need for person-centred care considering the social determinants of health, enabling, empowering, and engaging clients, and diversifying services, the health workforce, and health information resources, was suggested as key to enhancing the health literacy of African Australians at the point of care.

Table 1 Demographic characteristics of the study participants (community members).

Gender	State	African heritage/ background	Length of stay in Australia (years)	Age group (yrs)	Marital status	Residency status	Highest level of education	Ability to speak English	Ability to read English	Confidence in filling out medical forms
M	Victoria	Angola	6	25–34	Married	No details provided	No details provided	No details provided	No details provided	No details provided
M	NSW	South Africa	12	25–34	Never married	Permanent resident	High school	Well	Well	Extremely
F	Victoria	Cameroon	3	25–34	Never married	No details provided	College/ university graduate	Very well	Very well	Quite a bit
F	NSW	Ghana	4	25–34	Never married	No details provided	College/ university graduate	No details provided	No details provided	No details provided
F	Victoria	South Africa	4	25–34	Married	No details provided	College/ university graduate	Very well	Very well	Quite a bit
M	Victoria	Angola	5	25–34	Never married	No details provided	College/ university graduate	Very well	Very well	Quite a bit
M	Victoria	Liberia	6	45–54	Married	Permanent resident	High school	Well	Well	Extremely
M	NSW	No details provided	27	25–34	Never married	Australian citizen	College/ university graduate	Very well	Very well	Extremely
M	NSW	Kenya	No details provided	25–34	Never married	No details provided	College/ university graduate	Very well	Very well	Quite a bit
F	NSW	Ghana	25	25–34	Married or partnered	Australian citizen	College/ university graduate	Very well	Very well	Extremely
F	NSW	Ghana	No details provided	35–44	Married or partnered	Australian citizen	College/ university graduate	Very well	Very well	Extremely
F	NSW	Tanzania	21	35–44	Married or partnered	Australian citizen	College/ university graduate	Very well	Very well	Extremely
M	Victoria	Gambia	12	35–44	Never married	Permanent resident	High school	Well	Well	Extremely
M	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided

Table 1 Continued

Gender	State	African heritage/ background	Length of stay in Australia (years)	Age group (yrs)	Marital status	Residency status	Highest level of education	Ability to speak English	Ability to read English	Confidence in filling out medical forms
M	NSW	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided
M	NSW	South Africa	10	35–44	Never married	Permanent resident	High school	Well	Well	Extremely
M	NSW	Kenya	>20	45–54	No details provided	Australian citizen	College/ university graduate	Very well	Very well	Extremely
M	Victoria	Nigeria	4	25–34	Never married	Temporary resident	High school	Well	Well	Extremely
F	NSW	Uganda	4	35–44	Never married	Temporary resident	College/ university graduate	Very well	Very well	Quite a bit
M	Victoria	Kenya	6	25–34	Married	No details provided	College/ university graduate	Very well	Very well	Quite a bit
M	Victoria	Zimbabwe	5	35–44	Married	No details provided	College/ university graduate	Very well	Very well	Quite a bit
F	NSW	Uganda	12	35–44	Never married	Australian citizen	College/ university graduate	Very well	Very well	Extremely

Table 2 Demographic characteristics of the study participants (community intermediaries).

Gender	State	African heritage/ background	Length of stay in Australia (years)	Age group (years)	Residency status	Highest level of education	Ability to speak English	Ability to read English	Confidence in filling out medical forms
M	NSW	Ethiopia	21	45–54	Australian citizen	College/ university graduate	Very well	Very well	Extremely
M	NSW	South Sudan	20	45–54	Australian citizen	College/ university graduate	Well	Very well	Quite a bit
F	NSW	South Sudan	19	35–44	Australian citizen	College/ university graduate	Very well	Very well	Extremely
M	NSW	Sierra Leone	20	45–54	Australian citizen	College/ university graduate	Very well	Very well	Extremely
F	NSW	Uganda	13	35–44	Australian citizen	College/ university graduate	Very well	Very well	Extremely
M	NSW	Sierra Leone	7	35–44	Australian citizen	College/ university graduate	Very well	Very well	Extremely
F	Victoria	Ethiopia	32	45–54	Australian citizen	College/ university graduate	Well	Well	Quite a bit
F	Victoria	Eritrea	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided
F	NSW	Zimbabwe	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided	No details provided

Theme 1: health literacy is complex and context dependent

Participants demonstrated a sound understanding of health literacy, often using related terms, such as 'health education' and 'awareness', to describe its core elements. Many acknowledged that health literacy is a complex and context-dependent concept that needs to be personalized. Their interpretations encompassed a broad range of aspects, including the ability to access health services; seek reliable health, disease prevention, and wellness information; and effectively navigate the healthcare system. Importantly, participants highlighted that health literacy is not only about knowing where and how to find information but also understanding its significance at the point of care. They emphasized key components of health literacy as the need for skills, knowledge, and confidence to communicate effectively, make informed decisions, and take appropriate action to improve their health:

> *I guess it's health literacy is it's a complex kind of term to different individuals. It really varies. I guess to me, health literacy is, is really having good knowledge and understanding of what health is about. Like, you know, what are the drivers of good health or what are the risk factors? Yeah, it's knowing what would make you sick and what I guess you need to do to prevent, you know, getting sick. For example, if you have a family history of high blood pressure, probably health literacy means that you probably want to, you know, keep your weight, you know, keep a healthy weight and reduce your salt intake…. To other people, it might be different. And again, this is not even talking about the health systems thing.* (community member (CM) 3, female, NSW, FGD 5)

Community intermediaries described access to health information as complex and multifaceted. They emphasized that health literacy extends beyond basic literacy to include digital skills, particularly given the increasing reliance on the internet for health information and service navigation. Factors influencing access included confidence using search engines, prior knowledge of the health issue, critical appraisal skills, and willingness to seek care. Participants also stressed the need to assess the credibility of information on social media platforms, such as Facebook, WhatsApp, and TikTok, which are widely used but saturated with misinformation. Health literacy was seen as shaped by education, cultural background, and English proficiency, all of which affect how individuals access and understand information, participate in healthcare interactions, and advocate for their care preferences. This sense of patient agency was viewed as central to health literacy, not only during consultations but also earlier in

the care journey: when booking appointments, describing symptoms over the phone, and interacting with reception staff:

> *….also if we include language as a cultural barrier, sometimes we some people, they don't have the confidence to access and, and, and to clearly explain their issues or even to make in person and make the and make the appointment or even through the phone. The accent might be a barrier. And then the lady who's in the other part of the phone…. "Hey, good day. What do you say your name is then I will be saying that please repeat what are you saying?"* (community intermediary 2, female, Victoria, FGD2)

Health literacy was closely linked to participants' ability to navigate the Australian healthcare system, specifically knowing where, when, and how to seek care. Many contrasted it with systems in their countries of origin, where specialists could be accessed directly, or medicines obtained from pharmacies without prescriptions. In many African countries, individuals can access doctors, including specialists, simply by presenting at a hospital and self-medicate through pharmacies. In contrast, Australia requires patients to first see a general practitioner (GP), who serves as the gateway to specialists, allied health services, and medical prescriptions. Participants found the healthcare system complex, with multiple models of care: community health, hospitals, family doctors, and specialists, and limited information about the scope and distinctions between these services. Participants expressed their frustration with the need to book appointments in advance and long waiting times in some areas, which discouraged care-seeking:

> *It's a bit tiresome, you know, in Africa you don't book, it's about you having your money and you simply walk into a hospital clinic and you get treatment. But here strictly you have to book. So sometimes you know, these issues of seeing GPs or what, that's why, that's why sometimes they end up going to the pharmacists "cause you may book even until you come back, you know, unless it's really, really urgent and then you have to come. The next appointment you're given is 2 weeks, one week depending on how you're busy your GP is".* (CM 1, female, NSW, FGD5)

Limited access to GPs after hours and challenges in navigating emergency services were also barriers. A recurring issue was the lack of accessible information about how health insurance works, what Medicare covers, and what qualifies as out-of-pocket expenses. Additional gaps included how to find reputable specialists, access Centrelink payments for injuries, and navigate allied health services, issues that also affected participants who were healthcare providers themselves:

> *Even for me as a health professional, I think I even struggle with that [knowing about services available], so I can imagine somebody who's not in the health field, it would be a huge maze, and if they don't have a very strong, let's say English background and all those things, it'll probably be next to impossible.* (CM 2, female, NSW, FGD2)

The cultural appropriateness of health services and information was reported to influence health literacy among African communities. Participants emphasized that true accessibility involves respecting community preferences, such as having cultural workers or family members available to translate information in a culturally sensitive manner. Some also highlighted the importance of gender-concordant providers in healthcare settings. This is particularly essential during culturally sensitive procedures such as Pap smears: 'For me that what that comes to to mind straight away is you know gender if you go to a doctor you sometimes you prefer a doctor of your own gender. So yeah let's say you want to do a pap smear. A lot of us won't be comfortable doing a pap smear with a, with a male doctor as well' (community intermediary 1, female, NSW, FGD2).

For individuals with lived experience of female genital cutting, access to and use of services are shaped by the healthcare system and the availability of culturally safe and responsive providers. Participants also stressed the importance of ensuring that health messages are relevant, understandable, and meaningful to their communities. For some, health literacy was not only about language but also about the specific terminology used by services, which could inadvertently alienate or exclude them as clients:

> *Health, health literacy for me as an African is the the resource, the language, the vocabulary that the certain service as are using targeting me as a client. If I'm understanding, if I will understand this language or not. So when it comes, when they say literacy, it's straight away it comes to my brain that I'm, I'm an English speaker, I speak English as #4 language for me. So am I understanding this message?* (community intermediary 2, female, Victoria, FGD2)

Theme 2: experiences determine and shape health literacy

Health literacy in African communities is shaped not only by personal experiences but also by trusted word-of-mouth guidance from family, friends, and community networks. These narratives are especially important given challenges navigating Australia's complex healthcare system, identifying credible information, and understanding health conditions and services. Community members with longer settlement experience were viewed as valuable supports for newer arrivals, particularly when dealing with complex conditions and specialized care. One participant described agreeing to their child's recommended surgery only after receiving reassurance from another community member whose child had undergone the same procedure:

> *We knew no one else in our community whose child had had to do that surgery for snoring and any of that….It took somebody, a community member coming to our house to visit. Through conversation, we happened to mention about the situation [snoring] and he told us, "Actually, my child had the same exact thing. We did the surgery, and it was life changing. You guys should do it." And full on encouraging us. From that, we got the confidence to go and do the surgery. And it has been really good.* (CM 5, female, NSW, FGD2)

However, the power of the word of mouth was associated with negative consequences impacting access to and utilization of

services. Negative experiences shared within the community shaped community members' attitudes and perceptions towards the healthcare system, often leading to reduced trust and engagement with services. Some participants who had experienced negative encounters with the healthcare system, including racism and discrimination, culturally inappropriate care, misdiagnoses, incorrect treatment, and being taken advantage of due to difficulties understanding informed consent processes and treatment plans, reported having mistrust in the healthcare system. This mistrust influenced their overall attitudes and perceptions towards healthcare and engagement with health services:

> *When we talk about the mistrust, mistrust, you know some African people will mistrust the healthcare system because of the past experience from what they've had from it due to maybe discrimination, stigma, and things like any negative encounter they might have had with the healthcare providers in the past can really be a barrier to the proper follow-up system from the Africans.* (CM 5, male, Victoria, FGD 1)

A few participants also highlighted the negative influence of community leaders and elders, particularly in relation to diagnoses and treatment plans intertwined with connections to their culture, identity, and own lived experiences dealing with similar ailments. In some cases, community leaders advised against taking multiple medications or discouraged the use of certain drugs altogether. Consequently, individuals were often left confused as they tried to navigate conflicting information from family members and healthcare professionals:

> *..sometimes we're working with our aged people, like people 80 years, 90 years, then they'll be like… …These are not the things we do, maybe 90 years ago. These are not the way we cope with healthcare. You shouldn't do it this way….You're supposed to maybe kind of taking up to three tablets with that. ….. Then you'll be like, trying to fight, having confusion with what your doctor or your therapist is saying… Okay, this problem doesn't really need medications. These are the things you need to do. Maybe you're not supposed to take this type of drugs.* (CM 3, male, Victoria, FGD1)

Theme 3: social determinants impact access to and active engagement with healthcare services

Participants identified a range of factors that influence access to health information and active engagement at the point of care. Identity, language, and culture were consistently highlighted as significant determinants of healthcare access and engagement. Some participants described how members of their communities, particularly men, often seek care only when seriously ill, with limited attention given to preventive care. For example, while cancer screening services are available for both men and women, community intermediaries suggested that participation rates remain low. This was attributed to unfamiliarity with such practices and a limited understanding of the value of preventive health interventions, even among individuals who are otherwise literate:

> *We have different tests out there.…., prostate, bowel cancer and also breast screening. All those screenings are there, but our people usually they don't participate. And that is simply because number one, understanding language and tradition thinking that why I'm going through all those things. And with the bowel cancer people, they say that why I'm going through this very terrible testing system, but it is more about prevention, therefore those are sort of things that we have got.* (community intermediary 2, male, NSW, FGD1)

Several participants also reported a reliance on herbal remedies as the first line of treatment often contributing to delays in seeking medical attention and delays in presentation. Participants explained that this reliance on herbal remedies is deeply rooted in tradition, passed down through generations, with grandparents and mothers commonly advising the use of herbal medicine as an initial response to common illnesses:

> *I think for me, where I come from in Angola, we love this herbals remedy. And then a whole lot of Africans are used to using herbal remedies. And then, you feel that a whole lot of things will make you spend a whole lot of money, and you can easily use some dogoyaro leaves and then some other leaves to make sure you get well. And you will take some herbal remedies, herbal teas, and those things at times really work for us. That mentality, and a whole lot of Africans, we grew up using these things, and then it does really sink into our brain, that we find it difficult to align with the health system, because we are not just used to it.* (CM 5, male, Victoria, FGD1)

English language proficiency and overall literacy were also identified as key determinants shaping health literacy needs. Participants noted significant variability within African communities, with those possessing higher levels of proficiency and literacy demonstrating greater ability to navigate the health system, understand medical instructions, adhere to treatment plans, and actively engage with healthcare providers by asking questions and seeking clarification. In contrast, those with lower levels of proficiency, more often from non–English-speaking countries, were reported to face significant challenges in these areas:

> *A whole lot of Africans, especially those that come from the non-English speaking countries, have issues understanding the prescriptions and understanding the information, basically given in the prescription for follow-up steps and medications or treatments.* (CM 3, male, Victoria, FGD1)

Other sociocultural factors, including faith, spirituality, and religious beliefs, were also identified as barriers to accessing and being receptive to health information, particularly where there was limited trust in conventional medicine. In addition, stigma and cultural taboos surrounding mental health were described as major obstacles to accessing mental health information and services. Some participants highlighted that feelings of shame and a reluctance to openly discuss mental health issues contributed to limited information sharing within affected communities, particularly in relation to conditions, such as autism and attention-deficit hyperactivity disorder. Financial constraints

were another prominent issue, with most participants highlighting that rising out-of-pocket costs for services not covered by Medicare or not bulk billed or when accessing specialist services, significantly limit access to healthcare:

> *… there's a financial cost associated with it as well. When it comes to a specialist, you have to pay at least $300 to see a specialist. So sometimes members of the community with limited income can just choose not to proceed to that specialist consultation and then that's it. So, they will just keep around with their health until the health continues to become worse and deteriorate from time to time.* (community intermediary 1, male, NSW, FGD1)

These financial barriers, compounded by other sociocultural challenges, not only restricted service use but also undermined the ability to adhere to treatment plans, including filling prescriptions and purchasing necessary medications:

> *..Financially, a whole lot of us that just came into the country, we are just struggling to make sure we meet end meets and then we made some things back home to take care of a whole lot of people that are there. Financially, you might not be so [inaudible] to follow up these prescriptions, follow-up with the medications.* (CM 5, male, Victoria, FGD1)

Theme 4: feeling misunderstood and unsupported at the point of care

At the point of care, almost all participants described feeling misunderstood, rushed, and unsupported by healthcare professionals. Some expressed deep frustration with the healthcare system, describing repeated visits to hospitals where their symptoms were dismissed after brief assessments, often in emergency departments. This cycle of being sent home without clear answers and having to return days later left them feeling unheard, misunderstood, and discouraged. As a result, some questioned the value of seeking medical help at all, believing they would not receive meaningful care. One participant recounted a time when he had severe malaria and called an ambulance and was asked to grab a taxi and walk to the emergency department instead. Another recalled being told by a doctor at the emergency department to 'Google' their symptoms to find out what was wrong:

> *But there's a time I also went to emergency, and I saw a doctor who was on shift asking me to actually Google to try and know what was going on with me. And I was like, so I felt like he's rushed. He hasn't done his homework very well. It's at night, you know.* (CM 1, male, NSW, FGD4)

Despite being proficient in English, participants emphasized that the healthcare system is not designed to meet their individual needs. Lack of trust and rapport with providers, along with cross-cultural communication gaps, were key contributors to this sense of disconnect. Building rapport and trust was viewed as essential for meaningful engagement and patient empowerment, yet many felt the system did little to support patient agency or informed decision-making. Participants said they were more likely to trust clinicians who showed genuine concern rather than those perceived as rushed, transactional, or quick to prescribe medication. Trust and rapport were seen as central to asking questions, following medical advice, and attending follow-up appointments and were especially strong when care was provided by culturally or ethnically concordant providers:

> *s: I don't know if this is a generalization, but a lot of the ethnic GPs, they were the ones that were better at building rapport, and for our family, that was one of the key factors that built trust, that you could be consistently engaged in all of these children and mom and dad's health, and not treat it as a simple in and out.* (CM 3, male, NSW, FGD 2)

However, building trust requires time, something participants consistently felt was lacking within the current health system. Many described their consultations, particularly with GPs, as rushed and impersonal, leaving them feeling unsupported and often misunderstood. Participants viewed this as a systemic issue, emphasizing the need for meaningful consultations and stronger relationships to support the delivery of tailored, person-centred care that is more sustainable in the long term:

> *… my main concern is quality time between a doctor and patient. A country of the stature of Australia, with so much money can afford to bring in so many doctors and so many health providers, enough for our care to be improved. That doesn't mean the care is bad, it just means that it can get better. Because increasingly I feel like whenever I want to see my doctor, my tele, tee, teledoctor, teleconsultation is he's asking me whether my scripts are run are run out, so he can just send me a script straight away. I feel like that continued rush, that continued lack of serious engagement between myself and my doctor is not sustainable in the long run.* (CM 1, male, NSW, FGD 4)

Cross-cultural communication gaps were identified as major contributors to participants feeling misunderstood and unsupported at the point of care. Although most preferred providers who clearly explain health issues and treatment options, this was not their typical experience. Participants described frustration with clinicians who prescribed medications without explaining the rationale or considering their values and concerns. One community intermediary recounted a case where a woman declined free mental health care because she felt clinicians did not listen and only offered medication with severe side effects that affected her ability to care for her children. She preferred a more holistic approach that addressed her social circumstances, which was not readily available:

> *But one of the things that sometimes stopping them of accessing the service [mental health] is because what they said to us is the doctor don't take us serious and straight away they prescribe tablet to us… And ….. one of the ladies, she shared this with me and it was really generous from her. She said, I have six children or say seven children. And when the doctor described for me a tablet, this tablet has side effect. I can't woke up in the morning. I can't drive the car, I can't drop my kids. So I would prefer another way of treatment that can help me to go over my, my, my hardship or, or well being or mental health.* (community intermediary 2, female, Victoria, FGD2)

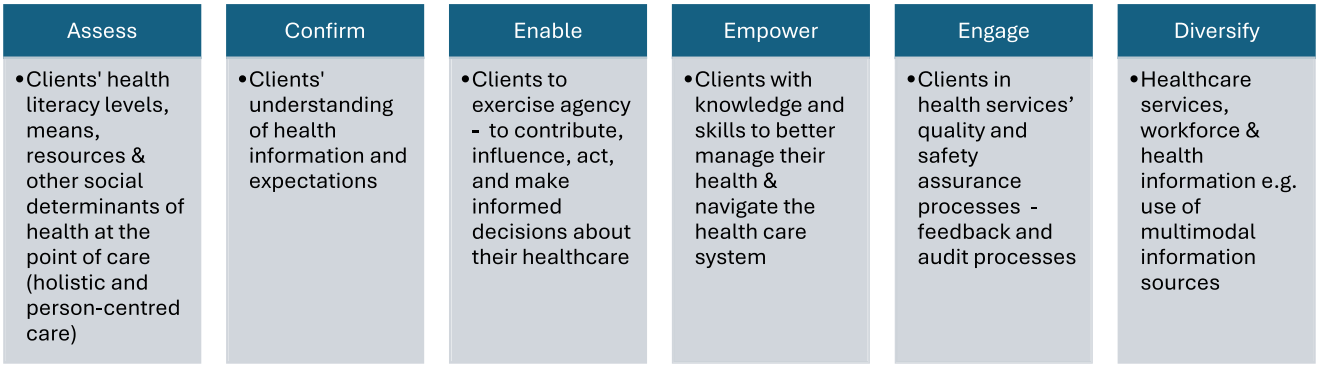

Figure 1 A health literacy framework to improve the health literacy of African Australians at the point of care.

Providers who were dismissive, not respectful, or not empathetic were reported to discourage not only general healthcare engagement but also adherence to healthcare advice and the uptake of recommended services, including screening programmes:

> *.. I got a referral from my GP, and I was at work and I thought, "Okay, there's a good chance I can just quickly go to this place and just get the [breast] scan done." So, I went there, checked in, reception was fine, waited for quite some time, got in, and the nurse was so rude, so rude, "Just take this off, and da-da-da," . It's just rude. No caring, nothing, just… And so, I just went along, did what I needed to do. She was not very communicative, very dismissive, and I felt really like, this is so bad. I didn't want to go back to anywhere else, really.* (CM 5, female, NSW, FGD2)

Participants reported that their English accents often led to miscommunication in consultations, compounded by providers who failed to listen or assist, sometimes reflecting unconscious bias, racism, or discrimination. Communication difficulties were frequently attributed to patients rather than acknowledged as a shared responsibility:

> *..and I think I've heard of people's experiences that they find it challenging because health providers not taking the time to assist and understand them. So, I think it comes from that almost an unconscious bias in assuming that because you don't understand some certain words, you are the problem, as opposed to trying to find simpler ways of explaining things or trying to communicate in a culturally appropriate way.* (CM 1, female, NSW, FGD 3).

Cross-cultural communication gaps were further exacerbated in general practice and specialist healthcare settings due to significant shortcomings in the provision of interpreter services, as highlighted by community intermediaries. Specialist services were recognized as critical for managing complex health conditions; however, limited access to interpreters and/or the use of complex medical terminology, even when interpreters were present, created communication barriers. These challenges often left patients unable to adequately describe their symptoms, feel misunderstood by providers, or fully understand their diagnoses, potentially resulting in mistreatment:

> *So, when it comes to referral to specialists, this is where the big problem starts. No interpreter service is used even if the interpreters are being used, but sometimes the terminologies used in the medical space by itself is not conveyed to the sick person, or the sick person cannot tell exactly what is wrong with them in terms of health, this is very common.* (community intermediary 1, male, NSW, FGD1)

Additional concerns were raised regarding the limited awareness of context-specific health issues affecting some African communities among healthcare professionals. For example, participants noted that despite repeated efforts to raise awareness, some health professionals lacked an understanding of the health implications of female genital cutting for pregnant women and their babies. As a result, community intermediaries have taken on the role of empowering individuals to self-advocate by proactively sharing their health history directly with providers to ensure they receive appropriate care.

Theme 5: whole-of-systems approach to enhancing health literacy

Participants offered several recommendations to strengthen the health literacy of African Australians at the point of care. These recommendations adopt a whole-of-systems approach, targeting individuals, providers, health systems, and policy and are presented within a health literacy framework in Fig. 1.

Participants emphasized the need for healthcare providers to **assess** clients' health literacy, language, and social needs and to **confirm** understanding through strategies, such as teach-back, encouraging questions, and inviting feedback. They highlighted the importance of **enabling** and supporting informed decision-making with personalized written resources that clarify treatment plans and enable ongoing conversations with providers. **Empowering** clients with practical tools to manage their health and navigate the system was viewed as essential, alongside creating culturally responsive environments that enable two-way communication. Participants also stressed the value of **engaging** clients in service design, feedback, and quality improvement and called for a more **diverse** workforce and culturally relevant resources to better meet the needs of African communities.

Table 3 provides a summary of each recommendation supported by sample quotes from the participants.

Table 3 Summary of the whole-of-systems approach to enhancing health literacy of African Australians supported by quotes from the participants.

Recommendation	Brief summary	Quotes from participants
ASSESS	A holistic and person-centred approach is needed to assess clients' health literacy and other intersectional factors that may impact their understanding, engagement, and health outcomes. Healthcare providers need to assess patients' health literacy at the point of care; tailor support to language, literacy, cultural values, migration status, and digital literacy; organize appropriate support at the point of care, such as interpreters/social workers where needed; and recognize limits of basic English comprehension.	*I think the first thing would be not understanding what the health advice or recommendations are. So that's one thing, whether it's a language barrier or just the information that has been provided isn't clear and so the patient or the client hasn't been able to understand it.* (community member 1, female, NSW, FGD 3) *I think something that I've noticed in studying [medicine] that became a reflection for me is that it's part of the provider's responsibility to…. assess the health literacy of the person they're providing for.* (community member 3, male, NSW, FGD 2) *And you know what they talk about the health professional, they talk about person centred care. But when it comes to us [African communities], they don't. They, …they put us in the books. They should treat a person as a person, find out about that person as an individual because even from the same community, people are different. Yeah. So it's not a blanket, you know, thing for everyone.* (community intermediary 1, female, NSW, FGD2) *And that is one thing I always I will always recommend that in every facility we should have social workers because these are the people that knows how to manage patients very properly.* (community member 2, male, Victoria, FGD4)
CONFIRM	Check clients' understanding of diagnoses, treatment, and follow-up. A trusting environment enables patients to share concerns freely without fear of being judged or misunderstood. Clear, simple communication is key to supporting patient understanding. Suggested strategies to check and enhance understanding included encouraging patients to repeat back information, providing space for questions, and allowing opportunities to give feedback or raise concerns about their care. Provider-specific attributes that facilitate engagement include empathy, active listening, respectful care, cultural competence, cultural humility, and professionalism.	*Well, I think it is in terms of asking you questions about what have you understood, can you repeat to me what you need to do next or can you repeat what I've told you are the key things that you're supposed to do or the key things… So I think you need to check with the client what their understanding is. So for them to repeat it in their own words so that the health professional can check whether or not they're on the same page*. (community member 1, female, NSW, FGD 3) *OK, I, I, I think the strategy is what I would love to speak here is just like evaluation aspect of it. You know the doctors, what I know is outside they do monitor and see if at all you are following the instruction. And this is done by asking series of questions. And if by asking questions and you give them answers that matches your expectation, that means they know OK, this person, I've been listening, I've been taking care of instruction given. So the only simplest way for me I know is just by being inquisitive, asking question.* (community member 2, male, Victoria, FGD4) *Not just giving good response, good response in a manner that I myself will understand, in a manner that I myself will understand. Imagine, for instance, a doctor goes to a doctor, tells the doctor, "I'm having a heart problem and I'm having a chest pain," he's just telling me, "You have cardiovascular issues," using medical terms, I might not be able to understand what the provider really means about what he's talking about, but breaking it down to my terms, breaking it down to my term as a layman, who make me understand what he's trying to talk about*. (community member 1, no further details provided, FGD2)

Table 3 Continued

Recommendation	Brief summary	Quotes from participants
		I think as African immigrants, we're used to being told do this and then you just take it wholesale. I think there should be a bit of a shift in trying to understand why this is being prescribed. Is there another option? Can I do something different? (community member 3, female, NSW, FGD5)
ENABLE	Enable clients with means and resources to exercise agency through supportive, culturally safe environments. Client agency is only possible within a supportive and enabling environment, one built on trust, rapport, mutual respect, and cultural sensitivity. Providers need to take the time to understand what patients need and creating culturally safe and responsive spaces where African communities are not discriminated against and where their sociocultural values and preferences are acknowledged and respected. Tackling systemic racism and discrimination is fundamental to achieving this, along with treating all individuals with dignity and equality. Enabling patient agency requires addressing existing communication gaps using multimodal sources of information (written instructions or referral to credible online sources for independent searching on complex diagnoses). Fact sheets, booklets, pamphlets, and summaries could help with tracking treatment plans and goals, serve as a reference, and support ongoing conversations with health professionals to monitor clients' progress. Addressing stigma around sensitive conditions including HIV and mental health, at both the provider and community level, crucial in enabling patients to openly engage and make informed decisions.	*Okay, I think with that I would say giving me the proper information maybe considering a particular illness and person, making me to know what to expect, the symptoms to expect, and the line of managements the treatments planned and also the prognosis. I think that will help me more.* (community member 2, male, Victoria, FGD3) *Yeah, I think having just anything that you can take to just check for yourself if you are keeping up with all the goals that we've set out. So having written, I think I've seen more now than in the past, pamphlets and things, which feels helpful sometimes, but also sometimes too much information. So just either written on what we discussed or if there is a pamphlet, "Oh, this is why I'm giving it to you and this is what you can get out of it".* (community member 3, male, NSW, FGD2) *Then I think there should be environmental support. It be healthcare sector, they should make available people that can really understand my culture, people that can really understand my language, people that can really think the same way I think to really get to explain things better for me, in case even I'm dealing with a GP or a provider that that doesn't really understand me properly, that doesn't really know what I'm talking about, someone else will be able to jump in and then explain to him.* (community member 1, no further details provided, FGD 2) *And also, in terms of Black people like us, making sure that measures are put in place to avoid any form of mild treatment or discrimination of any kind in health healthcare sector, although I know it's not only in the healthcare sector, but I think the healthcare sector should also do something about it to alleviate the forms of discrimination and making sure that the healthcare services are being made accessible for everyone.* (community member 2, male, Victoria, FGD 3) *I always ask him [the doctor] to email me a copy of those results after he has explained what he asked to test, you know, blood and I don't know what and what and so some of what he asked to be tested I don't know. But as he's giving me a copy of now my results, I want him to run me through everything, so I know what did he ask for, and how is that important. So he gives me the breakdown in in a language that I can understand because medical language is a little bit difficult. They have all these terminologies that you know only them understand but so make me understand so that I follow my own health. So what you asked for in terms of cholesterol, it is down. What does that mean? I want to know why was that necessary for you to ask? In terms of my fatty liver, it's now gone down. What does that mean? How is that connected to anything, if possible?* (community member 1, male, NSW, FGD4)

Table 3 Continued

Recommendation	Brief summary	Quotes from participants
		When it comes to mental health, most ladies, they don't like to access even you know how with the GP they have like 10 sessions for free that they can access. One of the thing that's stopping them of accessing mental health service though they have lots of issue, anxiety, stress, hardship, whatever, even depression. Some of them they have like a shown sign that you can see that they are mentally not well and they know they are aware. But one of the things that sometimes stopping them of accessing the service is because what they said to us is the doctor don't take us serious and straight away they prescribe tablet to us. (community intermediary 2, female, Victoria, FGD 2)
EMPOWER	Empower clients with knowledge and skills to better manage their health and navigate the healthcare system. Address information gaps on healthcare financing, complex medical conditions, and the rationale for management and different models of care and services available. Healthcare providers serve as key health literacy mediators by delivering reliable information, explaining procedures and treatment options, coordinating referrals and follow-ups, and advocating for patients to ensure they receive appropriate care and understand their rights. Health literacy champions like community leaders, bicultural staff, and community-based organizations also critical in bridging health literacy gaps by providing culturally relevant information for African communities and advocating for communities' health literacy needs within mainstream services. Beyond the point of care, targeted webinars and workshops facilitated by service providers in culturally safe spaces, such as churches, school holiday camps, barbecues, and festivals, along with referrals to credible resources, are valuable in empowering communities with the skills and knowledge needed to navigate the healthcare system and make informed health decisions.	*So, if the doctor is able to communicate that well with me to get me to understand, "This is what's actually going on in your body at the moment, this is the treatment that I would recommend, because A, B, C," and it makes sense to me, 90% I'll go with that. But if the doctor is explaining, but I can see that it doesn't actually link to make sense, then I'm not going to do it.* (community member 5, female, NSW, FGD 2) *Yeah, I'm not sure if someone already said it, but I think they [African communities] also do rely on their community leaders. I know in most cases most of our communities do have community associations and what happen is they do have platforms like WhatsApp forum or that sort of thing. So, in most cases if there's anything usually the leader of the community would deliver that information via that platform and I think they take it seriously when it's coming from the leader.* (community intermediary 6, female, NSW, FGD 1) *And also I can add something as you know now the the current project that we are working on the BeB [Best beginnings for babies] project. So such a project… it's like an advocacy for our community. And this is what brings the community together. So more projects, more funds, it will allow us to advocate for our clients. But if you are tied in your chair doing that job that has a certain description, you can't go anywhere. So more projects, more funds, more talk that will make the community come together and we can advocate for them.* (community intermediary 2, female, Victoria, FGD2)
ENGAGE	Engage clients in health services' quality and safety assurance processes. Transparent mechanisms must be in place for patients to provide feedback, lodge complaints, offer recommendations, and participate in audits, without fear of retaliation or negative consequences.	*I was just going to add that I think one of the things that needs to be clear in health services is how to escalate concerns or escalate things that you're not happy or comfortable with. I think a lot of times when people have bad experiences or they don't feel safe in a particular situational setting, they kind of just hold it onto themselves and then later on, they might go and debrief it. But it needs to be made very explicitly clear if you experience say X, Y, and Z, or if you feel uncomfortable, if you have any concerns, you can contact this person, you can contact this person or this person to address it rather than you just leaving unhappy, and yeah.* (community member 2, female, NSW, FGD2) *I think there should be a kind of room that you get insight and feedback from*

Table 3 Continued

Recommendation	Brief summary	Quotes from participants
		African people….If they [healthcare providers] don't know what is happening, nobody can change, because they'll just feel this whole system is just running normal, but they'll not know that some people are not really benefiting from the system the way they should benefit from. (community member 5, male, Victoria, FGD1) *I can be part of someone who wants to influence care, change or direction…. I would like a situation where there are many doctors and so therefore we have more quality time with your GP, I would like that…..But even if I put in a serious recommendation or a serious complaint to the NSW government or the federal government, I know they already know that they don't have enough doctors. And the doctors they have are really stretched. The doctors in Australia, they're working so they're, you know, they're under the pump like almost 24/7. So maybe nothing will happen.* (community member 1, male, NSW, FGD4)
DIVERSIFY	Promote workforce diversity by increasing the number of African healthcare providers within the healthcare workforce. Support multicultural staff and community organizations with targeted funding to bridge health literacy gaps. Increase the availability and accessibility of interpreter services in general, but more specifically within specialist and general practice settings. Support African doctors and leverage telehealth for culturally safe healthcare services. Engage with African communities and codesign health services, programmes, and health education materials to ensure cultural and linguistic nuances are accurately reflected and that resources are tailored to meet the specific needs of each community.	*There's like Africans who want to become providers, give a pathway specifically to minority groups to be able to do that without jumping through other hoops because there's obviously a great need as well.* (community member 5, female, NSW, FGD 2) *I'll add in terms of advocacy really will be around… We'll talk about cultural competency or whatever every now and then for the workforce. My advocacy will be around making sure the workforce reflects the demographic of the people we work with we serve. So yeah, that will be my key advocacy really, because you don't really get people who are culturally competent in every culture. If you have someone from that background who is part of the workforce. And that makes it more practical for our people to, because again, when you know that there are someone from my background is in that particular clinic or hospital. I feel comfortable when I walk in and see someone who looks like me or who speaks language. Yeah, I feel more comfortable. So that would be my number one advocacy really, instead of just talking about cultural competency, which is far-fetched for me. It's more about really kind of making sure you employ people from those background.* (community intermediary 4, male, NSW, FGD 1) *The specialists are not required to use the interpreting services and this is also very key area because those who have got underlying health issues who require the attention of specialists and all stuff like that because of the language and other things, that is also something that requires systematic advocacy to make sure that the specialists also can use the interpreting services.* (community intermediary 2, male, NSW, FGD 1) *But I'm saying because we don't have many doctors, Africans all over Australia, medical professionals need to have a network by which, if a GP identified their client to be speaking this particular language, they can be able of linking them with that doctor from West Australia to communicate with them in their own*

Table 3 Continued

Recommendation	Brief summary	Quotes from participants
		language. So, that they can get the message, or brief them. (community intermediary 1, male, NSW, FGD 1) *For me, it's more about really working very closely. Like consulting with communities when you're developing this health literacy awareness-raising programs. And what really appeals more to people, from what I've seen, is audiovisual. People are not… Most… Not everyone is literate in their languages or even just simple English. Some people do not even read and write English, let alone say in their own languages. They never had a school there. So, audiovisual languages or the visual messages, in terms of, awareness raising and that should be done in consultation with communities. We often hear about, not here for us, without us, kind of thing. So, consulting with people to hear from what really kind of appeals to them. And what really stands out for them will be very crucial.* (community intermediary 4, male, NSW, FGD 1)

Discussion

This study explores the health literacy needs and care preferences of African Australians, highlighting how social determinants, such as culture and identity, and systemic factors shape access to and use of health information and services. This study highlights how culture plays a central role in how health information is accessed, interpreted, and acted upon, affecting service use, communication with providers, and the application of care beyond the clinic through compliance, adherence, and follow-up. Word of mouth, though trusted, can both support and misinform, reinforcing the importance of distributed health literacy within families and communities. To address these complexities, this study proposes a whole-of-systems health literacy framework targeting healthcare consumers, providers, and organizations, with broader relevance for multicultural populations across Australia.

This study highlights the importance of distributed health literacy within African communities. In the absence of accessible and culturally relevant health information, many participants relied on word of mouth from trusted family, friends, and community members. Although this form of communication was readily accessible and widely trusted, it was a double-edged sword: while it fostered connection, the sharing of negative experiences often fuelled mistrust in healthcare services and, at times, spread misinformation. Distributed health literacy, a relatively recent concept, recognizes that health information is often shared across families, communities, and networks (Muscat *et al*. 2022) and can be leveraged to strengthen the collective health literacy of African communities.

Identity, language, and culture consistently shaped participants' access to and engagement with healthcare. Norms around masculinity, a tendency to seek care only when illness becomes severe, unfamiliarity with preventive screening, and limited awareness of available services further reduced engagement, findings echoed in the broader literature (Malika *et al*. 2020, Henry Osokpo *et al*. 2021, Wearn and Shepherd 2024). To address this, participants highlighted the vital role of community leaders as health literacy champions empowering multicultural populations with health knowledge and bridging communication gaps, a finding well supported in the literature (Khalid *et al*. 2022, Mahimbo *et al*. 2022, Seale *et al*. 2022, Peprah Lloyd and Harris 2023). Bicultural staff were also key, providing information in native languages to build trust and advocating for community needs within mainstream services (Zanchetta and Poureslami 2006, Mistry Harris and Harris 2022, Sharma *et al*. 2023). These intermediaries often work beyond standard hours due to their deep commitment, adapting to evolving needs. However, to ensure their sustainability, dedicated support, including training, resources, and fair compensation, is essential (Seale *et al*. 2022).

Despite being highly educated and proficient in English, participants reported feeling misunderstood and unsupported in healthcare interactions, reflecting persistent systemic barriers. Key contributors included limited trust and rapport with providers, cross-cultural communication challenges, and systemic issues, such as racism, discrimination, cultural incompetence, and time-pressured consultations. Trust is central to person-centred care (Australian Commission on Safety and Quality in Health Care 2025); when patients trust their providers, they are more likely to ask questions, attend follow-up appointments,

and participate in shared decision-making, behaviours linked to better health outcomes (Peek *et al*. 2013, Hong *et al*. 2020). Yet trust requires time and continuity, which are often lacking in the current healthcare system (Peprah *et al*. 2023). Addressing these structural barriers is essential to strengthening trust, improving communication, and advancing equity for multicultural communities at the point of care.

Effectively addressing systemic barriers requires moving beyond cultural competence towards culturally safe and responsive care that is attuned to the specific needs, values, and expectations of multicultural communities (Curtis *et al*. 2019). Acknowledging and addressing racism and discrimination at individual, organizational, and systemic levels is essential to ensuring culturally safe, responsive, inclusive, and equitable services (Muralidharan *et al*. 2024, Peprah *et al*. 2024). At the provider level, participants emphasized the importance of empathy, respect, attentiveness, clear communication, and genuine efforts to understand client needs as core to person-centred care. International evidence reinforces this, highlighting behaviours, such as active listening, clarification, detailed explanations, and respect for privacy as critical to inclusive care (Gagliardi *et al*. 2020). Cultural responsiveness training is essential to ensure these practices are effectively embedded at the point of care (Henderson *et al*. 2021).

Cross-cultural communication gaps were key barriers to client engagement and informed decision-making at the point of care. In addition to mandating interpreter use in specialist and family doctor services, participants recommended multimodal health information sources, including written instructions, fact sheets, and personalized booklets at the point of care to enhance understanding, support treatment adherence, and facilitate ongoing communication with healthcare professionals. Patient passports, customized booklets summarizing demographic and clinical details, show promise in improving communication, care quality, and satisfaction among migrant populations (Lee *et al*. 2016). Further research should explore their role in enhancing health literacy for African Australians, with emphasis on codesign to ensure cultural appropriateness and usability.

Diversifying the health workforce, services, and health promotion resources is essential for delivering culturally appropriate and responsive care to African communities. A racially, ethnically, and linguistically diverse workforce strengthens trust, communication, and access while embedding culturally sensitive practices that address the social determinants of health (LaVeist and Pierre 2014, Williams and Cooper 2019). It also reduces racism and discrimination by fostering social cohesion and organizational resilience (Abubakar *et al*. 2022). Effective strategies include integrating international medical graduates and implementing career development and mentorship programmes (Rubio *et al*. 2018, Baumann *et al*. 2021), though long-term sustainability requires stable funding, affirmative action, and institutional commitment (Taylor *et al*. 2022). Similarly, codesigned, demographically reflective health promotion materials may enhance cultural relevance and uptake as was evident during the coronavirus (COVID-19) pandemic (Zachariah *et al*. 2022, Crawshaw *et al*. 2024). Limited awareness of specific health issues, compounded by sociocultural barriers to reliable information, reinforces the need for active community involvement in designing these initiatives. Ultimately, health services must remain dynamic, culturally safe, and inclusive, underpinned by sustained community engagement to ensure continued relevance and effectiveness.

Strengths and limitations

This is the first study to examine African Australians' health literacy needs at the point of care, revealing how culture, identity, social determinants, and organizational contexts intersect. Drawing on insights from community members, community intermediaries, and providers, it highlights sociocultural influences and proposes a scalable whole-of-systems framework for multicultural communities. A diverse advisory panel enhanced cultural sensitivity and methodological rigour. However, this study is not without limitations. The study sample was highly educated and English proficient, restricting generalizability to the broader African communities. Future research should include a broader range of educational and language backgrounds to validate and expand these findings.

Conclusion

This study highlights the need for a whole-of-systems, intersectional approach targeting healthcare consumers, providers, organizations, and policy to address African Australians' health literacy at the point of care. Future research should examine tools, such as patient passports, to bridge communication gaps and prioritize culturally sensitive, context-specific health promotion resources. Sustained community engagement and authentic codesign are essential to ensure effectiveness and acceptance.

Acknowledgements

We would like to acknowledge all the research participants for their contribution to this project. We would also like to thank the advisory panel for their guidance and support throughout the project.

Author contributions

Abela Mahimbo (Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing—original draft, Writing—review & editing), Salma A.E. Ahmed (Formal analysis, Investigation, Project administration, Writing—review & editing), Zoe Trabe-Templeton (Formal analysis, Writing—review & editing), Sheila Uyirwoth (Conceptualization, Formal analysis, Methodology, Writing—review & editing), Cordelia Oyekan-John (Conceptualization, Formal analysis, Methodology, Writing—review & editing), and Michael Camit (Conceptualization, Formal analysis, Methodology, Writing—review & editing)

Conflicts of interest

All authors have no conflicts of interest to declare.

Funding

This study was funded by the UTS Faculty of Health Internal Grants—Industry Partnerships category.

Data availability

The data underlying this article cannot be shared publicly due to the privacy of individuals that participated in the study. The data will be shared on reasonable request to the corresponding author.

References

Abubakar I, Gram L, Lasoye S *et al.* Confronting the consequences of racism, xenophobia, and discrimination on health and health-care systems. *Lancet* 2022;**400**:2137–46. https://doi.org/10.1016/S0140-6736(22)01989-4

African Australian Communities Leadership Forum (AACLF). Inquiry into migrant settlement outcomes submission 61—exhibit. 2016. https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Migration/settlementoutcomes/Submissions

Australian Bureau of Statistics. Australia's population by country of birth [Data set]. 2024. https://www.abs.gov.au/statistics/people/population/australias-population-country-birth/latest-release

Australian Commission on Safety and Quality in Health Care. Person-centred care. 2025. https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care

Baumann A, Crea-Arsenio M, Ross D *et al.* Diversifying the health workforce: a mixed methods analysis of an employment integration strategy. *Hum Resour Health* 2021;**19**:62. https://doi.org/10.1186/s12960-021-00606-y

Berens EM, Klinger J, Carol S *et al.* Differences in health literacy domains among migrants and their descendants in Germany. *Front Public Health* 2022;**10**:988782. https://doi.org/10.3389/fpubh.2022.988782

Bergman L, Nilsson U, Dahlberg K *et al.* Health literacy and e-health literacy among arabic-speaking migrants in Sweden: a cross-sectional study. *BMC Public Health* 2021;**21**:2165. https://doi.org/10.1186/s12889-021-12187-5

Bhopal RS. *Migration, Ethnicity, Race, and Health in Multicultural Societies*. Scotland: OUP Oxford, 2014.

Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;**3**:77–101. https://doi.org/10.1191/1478088706qp063oa

Cornish F, Breton N, Moreno-Tabarez U *et al.* Participatory action research. *Nat Rev Methods Primers* 2023;**3**:34. https://doi.org/10.1038/s43586-023-00214-1

Crawshaw AF, Kitoko LM, Nkembi SL *et al.* Co-designing a theory-informed, multicomponent intervention to increase vaccine uptake with Congolese migrants: a qualitative, community-based participatory research study (LISOLO MALAMU). *Health Expect* 2024;**27**:e13884. https://doi.org/10.1111/hex.13884

Curtis E, Jones R, Tipene-Leach D *et al.* Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 2019;**18**:174. https://doi.org/10.1186/s12939-019-1082-3

de-Graft Aikins A, Sanuade O, Baatiema L *et al.* How chronic conditions are understood, experienced and managed within African communities in Europe, North America and Australia: a synthesis of qualitative studies. *PLoS One* 2023;**18**:e0277325. https://doi.org/10.1371/journal.pone.0277325

Gagliardi AR, Kim C, Jameel B. Physician behaviours that optimize patient-centred care: focus groups with migrant women. *Health Expect* 2020;**23**:1280–8. https://doi.org/10.1111/hex.13110

Gatwiri K, Mwanri L, McPherson L. Afro-diasporic experiences of highly skilled Black African immigrants in Australia. *Aust Soc Work* 2021;**74**:480–91. https://doi.org/10.1080/0312407X.2020.1856393

Henderson S, Kendall E, See L. The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review. *Health Soc Care Community* 2011;**19**:225–49. https://doi.org/10.1111/j.1365-2524.2010.00972.x

Henry Osokpo O, James R, Riegel B. Maintaining cultural identity: a systematic mixed studies review of cultural influences on the self-care of African immigrants living with non-communicable disease. *J Adv Nurs* 2021;**77**:3600–17. https://doi.org/10.1111/jan.14804

Hong H, Oh HJ. The effects of patient-centered communication: exploring the mediating role of trust in healthcare providers. *Health Commun* 2020;**35**:502–11. https://doi.org/10.1080/10410236.2019.1570427

Kalengayi FK, Hurtig AK, Nordstrand A *et al.* 'It is a dilemma': perspectives of nurse practitioners on health screening of newly arrived migrants. *Glob Health Action* 2015;**8**:27903. https://doi.org/10.3402/gha.v8.27903

Khalid A, Haque S, Alvi S *et al.* Promoting health literacy about cancer screening among Muslim immigrants in Canada: perspectives of imams on the role they can play in community. *J Prim Care Community Health* 2022;**13**:21501319211063051. https://doi.org/10.1177/21501319211063051

Kyle S, Shaw D. Doctor–patient communication, patient knowledge and health literacy: how difficult can it all be? *Ann R Coll Surg Engl* 2014;**96**:e9–13. https://doi.org/10.1308/rcsbull.2014.96.6.e9

LaVeist TA, Pierre G. Integrating the 3Ds—social determinants, health disparities, and health-care workforce diversity. *Public Health Rep* 2014;**129**:9–14. https://doi.org/10.1177/00333549141291S204

Lee LK, Mulvaney-Day N, Berger AM *et al.* The patient passport program: an intervention to improve patient–provider communication for hospitalized minority children and their families. *Acad Pediatr* 2016;**16**:460–7. https://doi.org/10.1016/j.acap.2015.12.008

Mahimbo A, Kang M, Sestakova L *et al.* Factors influencing refugees' willingness to accept COVID-19 vaccines in Greater Sydney: a qualitative study. *Aust N Z J Public Health* 2022;**46**:502–10. https://doi.org/10.1111/1753-6405.13252

Malika N, Ogundimu O, Roberts L *et al.* African immigrant health: prostate cancer attitudes, perceptions, and barriers. *Am J Mens Health* 2020;**14**:1557988320945465. https://doi.org/10.1177/1557988320945465

Mårtensson L, Hensing G. Health literacy—a heterogeneous phenomenon: a literature review. *Scand J Caring Sci* 2012;**26**:151–60. https://doi.org/10.1111/j.1471-6712.2011.00900.x

McKenna VB, Sixsmith J, Barry MM. The relevance of context in understanding health literacy skills: findings from a qualitative study. *Health Expect* 2017;**20**:1049–60. https://doi.org/10.1111/hex.12547

Medina P, Maia AC, Costa A. Health literacy and migrant communities in primary health care. *Front Public Health* 2022;**9**:798222. https://doi.org/10.3389/fpubh.2021.798222

Mistry SK, Harris E, Harris MF. Scoping the needs, roles and implementation of bilingual community navigators in general practice settings. *Health Soc Care Community* 2022;**30**:e5495–505. https://doi.org/10.1111/hsc.13973

Muralidharan P, Hosseini Y, Arashiro Z. *An Anti-Racism Framework: Experiences and Perspectives of Multicultural Australia. Report on the National Community Consultations, Commissioned by the Australian Human Rights Commission*. Canberra, ACT: Federation of Ethnic Communities' Councils of Australia, 2024.

Muscat DM, Gessler D, Ayre J *et al.* Seeking a deeper understanding of 'distributed health literacy': a systematic review. *Health Expect* 2022;**25**:856–68. https://doi.org/10.1111/hex.13450

Mwanri L, Anderson L, Gatwiri K. Telling our stories: resilience during resettlement for African skilled migrants in Australia. *Int J Environ Res Public Health* 2021;**18**:3954. https://doi.org/10.3390/ijerph18083954

Mwanri L, Fauk NK, Ziersch A *et al.* Post-migration stressors and mental health for African migrants in South Australia: a qualitative study. *Int J Environ Res Public Health* 2022;**19**:7914. https://doi.org/10.3390/ijerph19137914

Nutbeam D, McGill B, Premkumar P. Improving health literacy in community populations: a review of progress. *Health Promot Int* 2018;**33**:901–11. https://doi.org/10.1093/heapro/dax015

Nutbeam D, Muscat DM. Health promotion glossary 2021. *Health Promot Int* 2021;**36**:1578–98. https://doi.org/10.1093/heapro/daaa157

Nutbeam D, Lloyd JE. Understanding and responding to health literacy as a social determinant of health. *Annu Rev Public Health* 2021;**42**:159–73. https://doi.org/10.1146/annurev-publhealth-090419-102529

Parajuli J, Horey D. Barriers to and facilitators of health services utilisation by refugees in resettlement countries: an overview of systematic reviews. *Aust Health Rev* 2020;**44**:132–42. https://doi.org/10.1071/AH18108

Peek ME, Gorawara-Bhat R, Quinn MT *et al.* Patient trust in physicians and shared decision-making among African-Americans with diabetes. *Health Commun* 2013;**28**:616–23. https://doi.org/10.1080/10410236.2012.710873

Peprah P, Lloyd J, Harris M. Health literacy and cultural responsiveness of primary health care systems and services in Australia: reflections from service providers, stakeholders, and people from refugee backgrounds. *BMC Public Health* 2023;**23**:2557. https://doi.org/10.1186/s12889-023-17448-z

Peprah P, Lloyd J, Harris M. Responding to health literacy of refugees in Australian primary health care settings: a qualitative study of barriers and potential solutions. *BMC Health Serv Res* 2024;**24**:757. https://doi.org/10.1186/s12913-024-11192-9

Prout Quicke S. Africans in Australia: a population overview. WORKING PAPER No. 1/2023. 2023. https://sites.google.com/view/africanimpactinoz/resources/publications

Poza-Méndez M, Bas-Sarmiento P, Erahmouni I *et al.* Assessment of health literacy among migrant populations in Southern Spain: a cross-sectional study. *Nurs Open* 2023;**10**:2600–10. https://doi.org/10.1002/nop2.1520

Rubio DM, Mayowski CA, Norman MK. A multi-pronged approach to diversifying the workforce. *Int J Environ Res Public Health* 2018;**15**:2219. https://doi.org/10.3390/ijerph15102219

Sarkar U, Schillinger D, López A *et al.* Validation of self-reported health literacy questions among diverse English and Spanish-speaking populations. *J Gen Intern Med* 2011;**26**:265–71. https://doi.org/10.1007/s11606-010-1552-1

Seale H, Harris-Roxas B, Heywood A *et al.* The role of community leaders and other information intermediaries during the COVID-19 pandemic: insights from the multicultural sector in Australia. *Humanit Soc Sci Commun* 2022;**9**:1–7. https://doi.org/10.1057/s41599-022-01196-3

Sharma RK, Cowan A, Gill H *et al.* Understanding the role of caseworker-cultural mediators in addressing healthcare inequities for patients with limited-English proficiency: a qualitative study. *J Gen Intern Med* 2023;**38**:1190–9. https://doi.org/10.1007/s11606-022-07816-7

Sheikh-Mohammed M, MacIntyre CR, Wood NJ *et al.* Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. *Med J Aust* 2006;**185**:594–7. https://doi.org/10.5694/j.1326-5377.2006.tb00721.x

Taylor KJ, Ford LD, Allen EH *et al.* Improving and expanding programs to support a diverse health care workforce: recommendations for policy and practice. Urban Institute; 2022. https://www.urban.org/research/publication/improving-and-expanding-programs-support-diversehealth-care-workforce

Tshekiso T. Why is health literacy failing so many? *Lancet* 2022;**400**:1655. https://doi.org/10.1016/S0140-6736(22)02301-7

Wearn A, Shepherd L. Determinants of routine cervical screening participation in underserved women: a qualitative systematic review. *Psychol Health* 2024;**39**:145–70. https://doi.org/10.1080/08870446.2022.2050230

Williams DR, Cooper LA. Reducing racial inequities in health: using what we already know to take action. *Int J Environ Res Public Health* 2019;**16**:606. https://doi.org/10.3390/ijerph16040606

Zachariah D, Mouwad D, Muscat DM *et al.* Addressing the health literacy needs and experiences of culturally and linguistically diverse populations in Australia during COVID-19: a research embedded participatory approach. *J Health Commun* 2022;**27**:439–49. https://doi.org/10.1080/10810730.2022.2118910

Zanchetta MS, Poureslami IM. Health literacy within the reality of immigrants' culture and language. *Can J Public Health* 2006;**97**:S28–33. https://doi.org/10.1007/BF03405370