Exploring health-seeking behaviours among Nigerians in the UK: Towards improved healthcare utilisation.

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Abstract

The changing face of patient's populations in the UK has resulted in notable increases in cultural diversity that impact on health care service provision, access and utilisation; with health services underutilisation, prevalent more among immigrants due to heavy reliance on cultural and religious cure methods. The aim of this thesis therefore, was to explore how Nigerians in the UK engage with the British health system. This objective was pursued by integrating immigration issues, with factors associated with decisions to seek medical help, including health beliefs, access, attitudes, cognitions, and socio-political and religious experiences (past and present) that impact upon health outcomes. A triangulation approach was employed, involving a critical review of measures, and four empirical studies consisting of qualitative and quantitative research methodologies. Results show that health-seeking behaviours among Nigerians were best accounted for by their religious and cultural beliefs, as typified by their health context before migration. Religion was not found as a barrier to medical help-seeking; the regression analysis revealed that belonging to the Christian religious group predicted increased medical help-seeking; although assimilation to the British culture was associated with reduced religious behaviours. However, the role of other religious groups regarding medical help-seeking remains unclear, and needs a more focused study. In addition, care providers mainly agreed on the benefits of integrating the spiritual methods into formal healthcare systems, bringing some challenges which were tentatively negotiated through the theory of transformative coping (TTC). Findings have implications for research, policies, and clinical practice, particularly when culture-sensitive and integrated health interventions are tailored to the needs of the diverse immigrant populations in the UK.

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CHAPTER ONE

1.1   **INTRODUCTION**

There is a continuing and increased need to enhance appropriate health behaviours towards achieving good health and wellbeing among diverse populations. This need is more urgent with the increased effects of globalisation and migration, reflected through cultural diversity and observable health inequalities in multicultural population s. Therefore, the changing face of patient's populations has resulted in notable increases in the awareness of the impact of cultural diversity on health care service provision, access and utilisation among immigrants (Szczepura, 2005). In this regard, there is rich research evidence on interventions for improving health seeking behaviours in order to address health inequalities emanating from poor health services utilisation. The World Health Organisation (WHO) recognised spirituality in its seven principles for health promotion (Fleming & Evans, 2008), but failed to include faith-based cure methods as an aspect of alternative therapy (WHO, 1979). This is a significant oversight because spirituality and religion have been identified as important resources in effective health management (Karekla & Constantinou, 2010), and if integrated into the formal care setting can help to reduce the incidence of various treatable diseases/illnesses through early recognition of symptoms, and presentation to appropriate health care professionals for diagnosis and treatment. The key factor is to reduce the time between onset of disease and cure because of effective decision-making process during illness: to seek treatment, at an early stage and from recognised professionals. The complexity of this decision-making process has become obvious in recent times, as it involves a plethora of influencing factors (barriers and facilitators) around patients and health professionals (Richards, 1990 as

cited in Berry, 2004), as well as factors surrounding the illness and health facilities, such as access and perceived quality (Tipping & Segall, 1995); within which there could exist some gaps needing to be addressed, especially for migrants.

1.2 General background to thesis

This thesis explored how Nigerian immigrants engage with the British health system or other cure alternatives in response to illnesses and symptoms. Evidently, some gaps in health status and outcome were found in the literature (2.1). To address the 'patient-health-systems gap', this research aims to tap into the recent reorganisation of the NHS by the UK government (Health and Social Care Act, 2012). This reorganisation exercise is a crucial tool as it aims to put patients at the heart of the health scheme, devolve power to clinicians, and reduce bureaucracy. By this, local authorities have more powers to make decisions for their communities; and the new Clinical Commissioning Groups (CCGs) can take decisions regarding the provision of certain services through potential providers outside the NHS. The public health implication is a patient-led NHS that encourages out-of-hospital care; so, patients could be allowed to choose from a range of potential providers for the services of their choice within the scheme. This development can provide an opportunity to extend the integrative health approach initiated by the WHO as previously noted (1.1), by way of negotiating the involvement of faith-based cure approaches within the formal care system through collaboration. Such an inclusion strategy is aimed at enhancing the bio-medical treatment approach for those found to underutilise such services, rather than any attempt to replace it with the faith-based or spiritual approach (Waldfogel, 1997). To achieve this objective, future research could develop a potentially convenient process of integration by borrowing from the theory of transformative

coping (TTC: Corry, Mallett, Lewis & Abdel-Khalek, 2013; Corry, Lewis & Mallett, 2014).

However, for this scheme to achieve its aim, it is important that CCGs and other parties to the implementation take cognisance of cultural diversities of potential users of the scheme. To this end, it is important that decision makers (local authorities) and health workers understand the relational role of the Nigerian person to their broader milieu, in particular, their belief system, dominant spiritual/religious metaphors and narratives, the socio-cultural and politico-historical antecedents; and how these can shape illness perception and consequently impact on health-seeking behaviours. To address such issues, the research presented in this thesis draws on relevant sociological and health psychological models and concepts to explore inductively, specific barriers and determinants to health care utilisation among Nigerian immigrants in the UK. This information will be further considered in the context of the social and cultural terrain (moral, affective, religio-spiritual, socio-cultural and political economy) within which relevant health decisions are negotiated. Health psychological research is ideally suited to the investigations presented in this thesis because they provide the theoretical and conceptual structure incorporating health beliefs, attitudes, cognitions, and concepts such as self-efficacy and illness perceptions, which are known to contribute to health outcomes.

Therefore, the research described in this thesis presents four main studies based on the mixed methods approach to address aspects of cultural and religious diversities in Nigerian immigrants' health care utilisation in the UK. The present chapter outlines the immediate background and summary to the research carried out for this PhD. Chapter 2 describes relevant research, theory and practice relating to the health care needs, use of healthcare – potential facilitators and barriers; with a view

to an integrative scheme that can reduce barriers and enhance its access and use among immigrants; with particular reference to people of Nigerian descent – a context duly explored in this chapter. These introductory chapters (Chapters 1 & 2) will identify some of the research needs which are addressed in this thesis; followed by the four empirical studies in subsequent chapters (3-7) and finally the general recommendations and conclusions in chapter 8.

CHAPTER TWO

2.1   **A REVIEW OF LITERATURE**

This literature review chapter is divided into six main areas of research relevant to the questions addressed in this thesis. The first contains an overview of the notion of health and wellbeing and its importance among diverse populations (2.1.1). This aspect culminates in a review of differences in health outcomes among different populations necessitated by immigration factors as people move from one place or country to another, alongside their religion and culture. This focus on health among immigrant populations was concluded regarding health behaviours among immigrants from Nigeria and other African countries. The second component (2.1.2) of this review focuses on the relationship between immigration and health-seeking behaviours within the UK context; and how the diverse ethnic, cultural, and religious backgrounds that make up the UK population can influence the social life of both the British and immigrant populations in the context of inter-group relations. The third part relates to a more detailed exploration of Nigerian descent: specific Nigerian historical developments highlighting the political, cultural, and religious landscape. The impact of Christianity on the political, religious and cultural life of the people, and its overall implications on people's health behaviours, both at home and in the diaspora, are also covered (2.1.3). The fourth part is dedicated to broader issues of spirituality/religion, with reference to African religio-cultural worldview, and its implications for health behaviours among African immigrants (2.1.4). An exploration of the basic model that informs the research questions and objectives within this PhD is presented in section 5 (2.1.5). The chapter concludes with an explication of some concepts involved in this thesis (2.2); followed by an overview of the research methodology employed in the four empirical studies conducted within this thesis (2.3).

2.1.1 Health and Wellbeing

Appropriate health behaviours are important to achieving good health and wellbeing among any population. This is because it helps to reduce the incidence of various treatable diseases/illnesses through early recognition of symptoms, and presentation to appropriate health care for diagnosis and treatment. Existing research shows that early detection and diagnosis reduces the time between onset of disease and cure (Burgess, Hunter & Ramirez, 2001), both for mental and physical health conditions. The distinction between physical and mental health conditions are better understood with clinical examples, which have universal classifications, but with variations for incidence rates, especially among refugees/immigrants (Burnett & Peel, 2001). Typical examples of physical illnesses include, hepatitis B surface antigen, hepatitis A, meningitis, malaria, HIV/AIDS, tuberculosis and other communicable diseases. Also, included in this list are parasitic diseases and gastrointestinal conditions, diabetes, hypertension and coronary heart disease, as well as some conditions with musculoskeletal origin which can manifest as headaches, backaches and other non-specific pain conditions to mention but a few. However, mental illnesses are classified as conditions of psychological needs (Burnett & Peel, 2001), which may also be associated with physical illnesses (psychosomatic). Among immigrant refugees, studies have identified such psychological conditions as depression, anxiety, panic attacks, poor sleep patterns, and PTSD (Fazel, Wheeler & Danesh, 2005; Phillimore, 2014; Tempany, 2009). These conditions and other emotional problems associated with prolonged exposure to traumatic conditions have been associated with typical examples of mental illnesses among African and Asian refugees (Chu, Keller & Rasmussen, 2013). However, the interpretation and treatment of psychological conditions are also related to immigrants' country and culture of

origin; as each culture has its own frameworks for mental health conditions and associated help-seeking behaviours (Burnett & Peel, 2001).

To improve health outcomes and achieve health and wellbeing therefore, it is necessary to enhance acceptability of the health facility, and its accessibility by service users. The underlying principle is the decision to consult appropriate health services for treatment, and to do so early enough. Research has shown that many factors affect patients' health decisions in care seeking (where and how to access health-related care, and what type of health care to utilise), such as difficulties in doctor-patient communication and relationship due to lack of familiarity with norms obtainable in patient's culture as well as language barriers (Damafing, 2008; Faust, Spilsbury & Loue, 1998). Similar factors arise from poor patient satisfaction (Zastowny, Roghmann & Cafferata, 1989), available social support and family dynamics (Meyer-Weitz et al., 2000a; Horowitz, 1998), ethnicity and level of acculturation, (Damafing, 2008; Darman, Getachew, Jabreel, Menon, Okawa & Teklamarian, 2001). Others include illness perception (Nyamongo, 2000), patients' attitude and cognitive styles (Leong, 1999), patients' belief and locus of control, (DoH, 1992, as cited in Berry, 2004), as well as health professionals' values, beliefs and stereotypes (Herschkopf & Peteet, 2016; Richards, 1990 as cited in Berry, 2004; Roter & Hall, 1989 as cited in Berry, 2004). Also, some research advances have been made towards understanding the socio-behavioural determinants of health among diverse immigrant populations (Bhattacharya, 2002, 2004; Kim, 2002; Mui, Kang, Kang & Domanski, 2007; Riffe, Turner & Rojas-Guyler, 2008); but there seems to be a gap on what is known in this area about Nigerian immigrants in the UK. The multiplicity of factors involved in determining health and well-being show the complex nature of the issue, which is

reflected in the long-standing definition of health by the World Health Organisation (WHO) (1948) as:

> …a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (p. 100)

However, Marks and colleagues proposed an amendment to the above definition to further address important aspects associated with health thus: "Health is a state of well-being with physical, cultural, psychological, and economic and spiritual attributes, not simply the absence of illness." (Marks et al., 2005, p. 4). This comprehensive view implies that it is equally essential to include multi-disciplinary and inter-disciplinary perspectives to identifying other factors outside the strict ambience of health and illness that can influence patients' health behaviours; especially with the increased impact of globalisation and migration.

2.1.1.1 Immigration, Health and Wellbeing

Migration is a term used to describe the movement of people from one place or country to another, which usually occurs because people want to escape from effects of war, religious or civil crisis, or simply for economic or political reasons (Enegho, 2005; Iroegbu, 2005, 2007; Stalker, 2001). The flow of people from other countries to the UK is not a recent occurrence, ranging from the Huguenots of France, the Jewish communities escaping from religious persecution of the 17th - 20th centuries, to economic migrants from former British colonies; and the recent migration from Eastern

Europe, not to mention the increasing rate of asylum seekers from conflict zones of Africa, Asia and the Middle East (Hatch et al., 2011; Phillimore, 2011). This phenomenon raises new challenges for immigrants whose health conditions and health behaviours are influenced by their previous circumstances ranging from the trauma of war, experiences of religio-political conflicts, persecutions from cultural practices, as well as poverty (Malmusi, Borrell & Benach, 2010; Ronellenfitsch & Razum, 2004). Moreover, the consequences of adjusting to a new environment are associated with perceived and experienced stress, frustration, depression, and anxiety which individual migrants may view as beyond their coping resources (Lazarus & Folkman, 1984; Phillimore, 2014). Also, immigration involves cross-cultural interchanges, with additional acclimatisation challenges that impact immigrants' health and wellbeing, especially as they do not always understand to what extent they should or need to adapt to the host culture (Organista, Marin & Chun, 2010). This is particularly important where religio-cultural differences are marked between the old and new cultures.

As the consequences of immigration have continued to increase, adjustment issues associated with it are now widely recognised as important indices in health, education, and government policy (Castles & Miller, 2003). In this regard, researchers have focused on such factors as ethnicity, racism, language, culture and religion, negative stereotypes and health inequalities, as necessary considerations for understanding migrants' health seeking behaviours and outcomes (Gerrish, Chau, Sobowale & Birks, 2004). In particular, the UK government and the EU have embarked on integration programmes and policies (Home Office, 2005, 2009) aimed at successful integration, health and wellbeing for immigrants, especially among the refugees and asylum seekers. Substantial investments have been made towards this

initiative due to its relevance for health and wellbeing, with emphasis on the development of cohesive communities that can bridge the gap between the old and new cultures (Cantle, 2005; CIC, 2007), promote language and communication, skill development, and cross-cultural dialogue (Phillimore, 2011). However, despite these efforts, the UK immigration and asylum policy has been best described as a deterrent (Phillimore, 2011); while the array of research on immigrants' health has not addressed the obvious gap in the literature on how social forces interact with individuals in the process of health decision making. Moreover, there is no available research in this area with reference to Nigerian immigrants in the UK; hence the reason for the research focus presented in this PhD.

New research in this area is therefore, necessary as the United Kingdom has experienced significant immigration from diverse ethnic and cultural backgrounds with observable changes in the demographic composition and patient population. For instance, Black Africans make up 22% (59,000) of the total British population with an average annual growth of 6.2%, and those from the Caribbean numbering 73,000 make up 43% of the total population, with an average annual growth of 0.9%; while White/Black Caribbean numbering over 240,000 has 3.3% average annual growth of the UK population, and other Blacks numbering over 98,000 has an average annual growth of 3.2% (ONS, 2012). With this data, Black Africa has the highest growth rate at 6.2%. Considering cultural diversity in London, Africans constitute 7.0% of the population, with people from the Caribbean accounting for 4.2% of the London population. Within these black minority ethnic groups, it is important to take cognisance of the distinction between British-born and non-British born populations which has important implications for this thesis. Between 2001 and 2011, there was a record increase of 45% in the total UK population, out of which 13% (7.5 million) were

identified as immigrants born outside the UK (ONS, 2011). Of the top ten countries contributing to the rate of annual population increase in the UK population, Nigeria ranks second, with 87,000 immigrant population (0.2% annual increase) in 2001 and 191,000 immigrants (0.3% annual increase) in 2011.

2.1.1.2 Immigration, religion, culture and health

As culture, religion and other demographic factors make up important indices for understanding the actual composition and distribution of a country's population, the UK population recorded a significant drop (5.3%) in the total number of Christians in the country, from 37.2 million to 33.2 million Christians between 2001 and 2011 (ONS, 2011). However, using the same measure in calculating the distribution of immigrant populations by religion, there is currently a record increase of 1.2% in the number of non-UK born Christians living in the UK (ONS, 2011). This significant change in the composition of the UK population, especially regarding immigrant cultural and religious backgrounds, has resulted in increased awareness of the impact of cultural and religious diversity on health care service provision and access. Hence, health professionals and policy makers are faced with the challenge of delivering adequate health care in a culturally (and religiously) sensitive setting. In this regard, the UK Parliamentary report on Ethnicity and Health acknowledges that there are ethnic differences in delivery and access to health care services, with black minority ethnic groups (BME) reporting more dissatisfaction with National Health Services (NHS) than their White British counterparts (Postnote, 2007). According to this report, where most members of the BME groups access primary care at a similar rate as the general population, there is evidence of lower access to hospital care among them. Further research aimed at identifying the factors responsible for this outcome, showed that

individuals from various ethnic backgrounds tend to use different cultural and religious methods while coping with physical and emotional conditions (Aldwin, 1994; Snyder, 1999). In view of this, relevant research among Nigerians shows that health facilities are not sufficiently utilised due to poor health seeking attitudes (Olujimi, 2006). On the contrary, ethno-cultural and religious groups are shown to serve as reliable sources of help/support for health related conditions (African Traditional Medicine, alternative/complementary methods) (James & Gashinki, 2006); because of beliefs, costs and accessibility, which are connected to religious practices, poor infrastructural facilities and economic situations that form part of the social capital prevailing within the Nigerian context (Abioye-Kuteyi, Elias, Familusi & Akinfolayan, 2001; Iyalomhe, 2009). Hence, the attitudes of Nigerian immigrants to health and wellbeing, and the means used to achieve this have been shown to be influenced by African oriented religious and spiritual practices (Omotosho, 1998), as well as the psychological, political, and cultural impact of colonisation and evangelisation (Van Dyk & Nefale, 2005).

Spirituality and religion have a pervading role across civilisations, and have been adapted among various peoples and cultures. Consequently, religious and spiritual coping resources have been identified as unique coping methods among many patients, and have occupied research interests within the health and medical professions (Karekla & Constantinou, 2010; Thune-Boyle, Stygall, Keshtgar & Newman, 2006). In the face of life-threatening and life-changing conditions, religious and spiritual resources have been shown to serve as the basis for finding meaning and acceptance for many patients (Park, 2005). Similar studies showed that spirituality is an important aspect of achieving health and wellbeing (Seybold & Hill, 2001). Notwithstanding these relevant findings on the beneficial role of religion/spirituality,

other research evidence shows that most health professionals have difficulties integrating it into their health intervention programmes, nor paid adequate attention to its role in health and wellbeing (MacDonald & Holland, 2003).

In the context of the NHS, adequate recognition and application of spirituality in health intervention by health professionals may be compromised because of the demands of public policy on equality in the face of diverse religions, and different beliefs among patients and health professionals (DoH/EHRG, 2009). However, despite such challenges, the need to maintain equity in a multicultural UK made it necessary for the NHS to provide opportunities for patients using their services to experience spiritual care through its chaplaincy unit. Chaplains (employed or voluntary) are part of the NHS multi-disciplinary teams that supply spiritual, religious, and pastoral care to patients, as well as other services users/carers and staff. According to the guidance on chaplaincy issued in 2004, spiritual care is defined as, '…care provided in the context of illness which addresses the expressed spiritual needs of patients, staff and service users' (www.healthcarechaplains.org, 2014). Although, the chaplaincy programme is designed for in-patient care, and to advise providers on issues regarding religion, beliefs and values (NHS Chaplaincy Guidelines, 2014), this unit has remained one of the smallest groups in the NHS; considering its existence as the sole responsibility of the NHS since 1948. Also, where service provision is matched by faith (an average of 35 in-patients to 3.75 hours of chaplaincy attendance), and corresponding to user populations within the NHS (www.healthcarechaplains.org, 2014), it is possible that some faith groups could be underrepresented. Considering that the record of patients' religious beliefs is sometimes omitted and frequently inaccurately recorded (NHS Chaplaincy Guidelines, 2014), most patients still experience unmet religious/spiritual needs during clinical

consultations. Moreover, chaplains could be poorly trained, in which case they can cause serious harm to patients and families, hence the need for improved training advocated for chaplains (Redbridge CVS, 2008). Also, the shortage of chaplains in hospitals located within some boroughs dominated by ethnic minorities (such as Nigerians), such as South-East London NHS Foundation Trust can mean missed opportunities to address the religious/spiritual concerns, especially among the more at-risk-patients as acknowledged by the Healthcare Commission (2008).   This situation has been perceived as 'a total disregard of the importance of spirituality to many ethnic minority and indeed White British communities, and of the role it has to play in recovery.' (Redbridge CVS, 2008, p.24).

For instance, a North-East London NHS Foundation Trust (NELFT) audit in 2010 found that low numbers of in-patients in the Trust had their spiritual needs considered in treatment, despite a high percentage of those desiring this; and many also reported that the environment was not helpful in exploring their spirituality which could have helped in their recovery (Igboaka, 2010). A similar investigation in Newham (another area dominated by ethnic immigrant minorities) reported that, patients did not talk about their spiritual/religious beliefs for fear of being misdiagnosed and sectioned (Copsey, 1997). This report continued to show how lack of attention to such matters among health workers could turn patients to seek faith-based healing approachs; which can enunciate negative atitudes to medical help (Copsey, 1997).

2.1.1.3 Health and Help-seeking methods: professional vs. faith-based

Evidence from America, confirms that about 25% of those seeking treatment for mental health problems are found to do so from a minister of religion (Christian or Jewish), which implies that members of the clergy were as likely as mental health

professionals to see people with severe mental health problems (Hohman & Larson, 1993). Similarly, in England patients regard spirituality as important in dealing with mental health issues (Redbridge CVS, 2008). Young African men interpreted psychotic symptoms within a spiritual frame of reference, and sought help more from spiritual/religious leaders, and young Asian men also showed strong reliance on faith as vital in their recovery process (Redbridge CVS, 2008). Despite this, Christian ministers feel challenged when responding to severe health conditions, and lack the necessary skills to treat these effectively (Wang et al., 2003). More recently, another British study explored the experiences of clergy from different faith groups regarding their responses to people with mental health problems and the pastoral care they provide. Mainstream Christian clergy referred to professional health workers, whereas the evangelical ministers offered treatment (Leavey, 2008). Further research confirmed that the more theologically liberal and educated clergy were more likely to refer to mental health services, while those less educated, with more theologically conservative orientation were more likely to offer treatment for these problems (Gottlieb & Olson, 1987). In this case, non-referral by religious ministers could hamper adequate health services utilisation, with potential risk of morbidity and mortality.

A London news report (Church-Prayer-Cure Claims, BBC News, 2011) showed reported that HIV patients were advised against adherence to their medical regimen by some Evangelical Christian pastors, resulting in patient mortality. One of the churches under investigation was of Nigerian origin, and the victims were mostly from Nigeria, providing evidence that religious practices in health care (Hadzic, 2012) could result in detrimental health outcomes. In spite of these negative influences regarding religion/spirituality, Coyte, Gilbert, and Nicholls (2007) note that most research shows varying degrees of positive relationships between religion/spirituality and health

outcomes – both for physical and mental health. However, there is no existing research on the unique nature of how and what mediates health decisions among Nigerian immigrants in the UK considering their unique religious, social and cultural contexts; vis-à-vis coming from a developing economy, and a political system that is known to influence health care provision and utilisation (Burnett & Peel, 2001; Fosu, 1994).

Therefore, the recent NHS reorganisation is an opportunity to explore religious and culture-sensitive programmes that can encourage hard-to-reach immigrant communities (known to show low access/use of the healthcare services) to incorporate the use of orthodox medicine as well. This is of special importance for Nigerian immigrants as Nigerian culture is shown to rely heavily on family networks, with personal identities rooted in community life (Kamya, 1997); which can become barriers to health services utilisation. In this case, Nigerian-based religious groups/churches is a major source of cultural identity, with potential for satisfying multiple needs; especially health needs for those trapped in the challenging and isolating circumstances of immigration. Also, considering the interplay between culture and other factors in health decisions (Good, 1985) there are considerable challenges in applying western treatment models among Africans, such as using psychotherapy in addressing their symptoms of mental illness (Oyewunmi, 1986). Therefore, research has advocated that African cultural practices should be incorporated into psychotherapy, such as Family therapy (Nwadiora, 1996) and the Ubuntu therapy (Van Dyke & Nefale, 2005), already shown to be successful. This success is because persons with such conditions as mental illness among African immigrants are kept at home and discussed within the family circle (Darman et al., 2001) or at most, help is sought from traditional or spiritual healers or community heads, and religious leaders

(Dein & Sembhi, 2001). The implication is that any successful health interventions among African immigrants should involve Africans themselves, especially through an ethnographic approach (Leigh, 1998) where the client assumes the role of a cultural guide for the clinician. This is a good means of establishing rapport and ensuring client self-disclosure to the therapist/clinician; where the lack of such atmosphere resulted in considerable obstacles for most Africans who become sceptical of the therapeutic process because it is new and foreign (Nwadiora, 1996). The foregoing circumstances form the basis for proposing a form of collaboration among formal and informal health care services (see 8.3).

2.1.1.4 Healthcare seeking among Nigerian/African immigrants

Research focusing upon the experiences of immingants' health-seeking behaviours have been described in the previous sections. From a public health perspective, little is known about the motivations for health seeking among Nigerian immigrants in the UK; nor how their historical, traditional/cultural, and religious orientations can influence health care utilisation in relation to immigration issues - acculturation, and other variables such as education, occupation, and self-efficacy. A few published studies in the UK (Bagley, 1971; Brown, Evans-Lacko, Aschan, Henderson, Hatch, & Hotopf, 2013; Littlewood & Lipsedge, 1997; Nedetei, 1986; Rwegellera, 1977) focused on mental health among African/West African immigrants; and found psychiatric morbidity to be on the increase, with culture-relevant factors as determinants for certain forms of mental illness. Comparing West African students and their UK-born counterparts, Kidd (1965) reported some difference in general psychiatric conditions with a greater increase among West African students. In later studies, Sharpley and colleagues (2001) estimated that 1 in 4 of Africans in the UK will experience mental health conditions, with higher risks of psychotic disorders

compared to non-Africans. In the report by the African Health Plan Network (AHPN) on mental and emotional wellbeing of Africans in the UK, about 68% of respondents never accessed statutory services and 77% never utilised community services for a health condition that costs the government over £105 billion each year (DoH, 2011). It is interesting however, to note that the AHPN report showed that respondents emphasised faith groups as sources of support for mental health conditions, a similar observation noted among Afro-Caribbean and Pakistani immigrants in the study by Cinnirella and Loewenthal (1999), which focused on the influence of religion and ethnic groups on beliefs about mental illness. Other aspects of migration studies in Britain that focused on health among asylum seekers and refugees, showed that their migration experiences both in their countries (such as war and other acts of violence) and other countries on their escape route, affect their mental and physical health (Burnett & Pell, 2001), with consequences for health inequalities in Britain. However, the current thesis focuses not on refugees, but on economic migrants whose migration history are related to the post-colonial migration of ethnic communities and families (usually from post-colonial Africa), which now forms part of the new migration wave involving hundreds of thousands of migrants from many countries with increased diversity (Cantle, 2008; Parekh, 2008). In particular, this form of new migration has radically transformed the social landscape of Britain (Vertovec, 2008).

Few other studies among African immigrants have been conducted in regions outside the UK, such as America, Canada and Israel (Amri & Bemak, 2012; Faust, Spilsbury, & Loue, 1998; Fung & Wong, 2007; Morgan, Reavley, & Jorm, 2014). In the Netherlands, Selten and Sijben (1994) recorded a high rate of schizophrenia among male adolescents from Morocco in North Africa. Studies of mental illness among Ethiopian immigrants in Israel (Ratzoni, Amo, Weizman, Weizman, Modai, & Apter,

1993) also found a high prevalence of sleep disorders, and other mental health conditions attributed to low income and high rate of unemployment. Damafing's study (2008) focused on three African countries – Somalia, Nigeria and Ethiopia. This study found cultural factors and acculturation process, family dynamics, financial issues, identity and threat to social status, as well as loneliness, as some factors responsible for mental health conditions among these populations. As Damafing noted, the classification of place of origin using East Africa or West Africa is not consistent between studies. Also, most of the research tended to use the concept of 'African culture' in a very general sense to imply one culture for all peoples of African descent. Although there could be an African worldview that is similar among African immigrants, there are cultural variations (unique narratives, myths and superstitions), shaped by the context of modern historical, religious, and political economy (see subsection 2.1.3 for Nigerian history) that make it impossible to discuss these groups in one collective piece (Rong & Brown, 2002). In one focus group study on healthcare attitudes and utilisation among African immigrants in Rhodes Island, Kolawole (2011) reported that religion was not a strong theme in the female groups, and was skipped in the male group. However, the study noted that a female participant after receiving three conflicting reports from doctors, resorted to 'pray, and turn herself over to God for healing and was healed in that way' (Kolawole, 2011, p.7). From this report, such assertion that religion did not represent a strong theme in health services utilisation could be misleading as the research sample was not representative (and did not show how different African nations were represented), and the extent and type of religious influence before migration were not accounted for; neither were age at migration nor educational level assessed. Also, the extent of acculturation may have skewed the result because participants were well integrated into American culture (average of 24

years), and health services utilisation was promoted among some participating groups prior to data collection.

Owing to these diversities and the difficulties in discussing African immigrants under one unique reference point, the research presented in this PhD adopted a holistic approach that considered health seeking behaviour in relation to all kinds and degrees of illness/symptoms while especially focusing upon the Nigerian immigrant population. Moreover, the currently available research on collaboration focuses on African traditional medicine, while overlooking the important role of religious/spiritual healers who use Christian faith-based methods (Pentecostal/Charismatic Healing); especially in Nigeria which has been reported as having the largest population of Pentecostal following in Africa (http;//www.christianpost.com, 2014). Therefore, attempts to explain and harness the vantage position of the spiritual/miracle healers, both in Nigeria and here in the UK forms a vital part of this thesis.

2.1.2 Migration, Ethnicity and Health: The UK context

The current wave of migration shows that people move largely from regions where collectivism is an outstanding cultural value (such as Africa, Latin America, Asia, the Middle East and the Caribbean), and settle in regions where individualism is emphasised over collectivism, typified by North America, Western Europe, and Oceania (Schwartz, Unger, Zamboanga & Szapocznik, 2010). Collectivism is viewed as a cultural value where the individual's success and well-being is largely dependent upon the well-being of the family, clan, society, nation, or religion; whereas individualism as a cultural value focuses on the needs of the individual person (Triandis, 1995). Various studies among immigrants have shown that cultural values change when two contrasting cultures interact within the same context over a period

(Schwartz, Montgomery & Briones, 2006). The concept of acculturation deals with such changes and challenges resulting from the interaction of culturally and socially different peoples/groups (Berry, 1980, 2006). In view of these differences, and inherent changes following immigration challenges, there are potentials for gaps in cultural values between Nigerian immigrants and their receiving society in the UK, which can have cultural, psychosocial and health consequences.

With the recent changes in global economic and politico-social affairs enhanced by migration and globalisation, the UK has experienced an influx of immigrants from diverse ethnic, cultural, and religious backgrounds. This unique ethno-cultural influx has a strong influence on the social life of the British people (especially in the cities), which is of interest for researchers and policy makers. The social interaction amongst diverse groups is regarded as an inter-group relation. From a sociological perspective, this relation is described as 'multipolarity' – which means the relationship that exists between all the ethnic groups within the country (Etzioni, 2012). In the face of multipolarity among other cultural and environmental factors, there exists for migrants in particular, challenges in progressing and integrating within the socio-cultural and economic milieu of the host community. This has considerable consequences for their health and well-being. Therefore, research shows that cultural and environmental influences on migrants' healthcare utilisation is compounded by such problems as ethnicity, racism, negative stereotypes and inequality in health care service provision (Tang, Zhan & Ernst, 1999). Inequality in healthcare provision can be measured in terms of equity in access to available health services among different groups that make up a health population. This can be justifiably construed as equal access in relation to need; and ethnicity is considered as a vital variable that can affect access and utilisation of the healthcare system.

Ethnicity is defined as a cultural system concerned with group boundaries and differentiation (Joseph, 1987); and in a multi-ethnic society such as the UK, the composing groups usually do not share the same cultural values. This lack of homogeneity in cultural orientation can occasionally give rise to friction and inequalities. Hence, where strong ethnic loyalty exists, and the state fails to ensure equity within its social and political structures, the consequence becomes a lack of social integration. Confronted with such situations, minority ethnic groups can become compelled to fall back to their ethnic community for social, economic and political security. This could result in significant underrepresentation in healthcare utilisation among immigrants (Szczepura, 2005). In England, for instance, research shows that differences in accessing health care services among migrant populations has considerable consequences for their health and well-being, which is a determinant in observable health inequalities among the population (Saxena, Eliahoo & Mageed, 2002).

The issues identified above led to some attempts by the UK Government on policy developments to tackle these anomalies. Sir Donald Acheson's *Independent Inquiry into Inequalities in Health* (1998) was a laudable initiative with emphasis on the effects of poverty and social exclusion on health inequalities, which led to extensive government work on health inequalities through the *Treasury's Tackling Health Inequalities: A Programme for Action* (2003). Unfortunately, this programme focussed on deprivation based on socio-economic class and geographical area rather than inequalities emanating from ethnicity (Postnote, 2007); much like the Marmot review of health inequalities (2010) nearly a decade later. Another attempt was *The NHS Plan* (2000) which was aimed at reducing health inequalities by the year 2010, by tackling important indices like deprivation and poor health care delivery. Notwithstanding these

attempts, evidence from Parliamentary reports showed that health inequalities continued to increase among the minority, migrant population (Postnote, 2007). For example, the gap in life expectancy increased by 2% for men and 8% for women, and the gap for infant mortality rate increased by 6%. Interestingly, according to the report from the *Acheson Inquiry,* the reason for this unwanted result was the departure of policies from the focus on ethnicity. Yet, over a decade later this issue was not addressed as the Marmot report (2010) also noted a disparity in health (quality of life and life expectancy) between the rich and poor at an average total difference of seventeen years. The overall consequence of neglecting the importance of ethnicity can reflect on such issues as poor doctor-patient relationships, and its impact upon health services utilisation and outcome; as consistent with existing research showing that client-clinician cultural matching is vital for successful health outcome (Blignault, Pinzio, Rong & Eisenbruch, 2008; McKinney, 2007).

The tendency for immigrants to adhere to their original home culture is related to the issues of enculturation, which is vital when considering migrant health behaviours and outcome. This can be made more ostensible when state structures and policies on healthcare provision do not accommodate its diversities. Hence, it seems inevitable that, where groups are many and prone to differentiation, the institutional recognition of groups may risk the emergence of social instability (Ejobowah, 2001). Yet, systems which deny recognition are bound to promote intense conflict and lesser stability than those that accord recognition. In so far as this could have some counterproductive effects on acculturation and integration, any discriminatory practice will not encourage integration either; instead it erodes trust and enunciates enculturative feelings that can have adverse health consequences (Held, 1999). To achieve a balance therefore, it demands that ethnic recognition should be

worked out to ensure unity between the need for the expression of differences and the need for social stability. For this reason, priority ought to be given to the factors that can facilitate acculturation through the processes of integration and collaboration to ameliorate the effects of ethnic discontent. In this regard, the UK government has integration policies and various support programmes to help with integration of Nigerians and other immigrants in the UK. Such programmes for learning the English language for speakers of foreign languages are useful in overcoming language barriers experienced while trying to access and use health services, especially during consultations. The availability of NHS Direct (Chapman, Smith, Warburton, Mayon-White, & Fleming, 2002), the Accident and Emergency (A&E), and NHS chaplaincies for spiritual care could provide motivations for integration/collaboration towards improved healthcare utilisation. These are useful support schemes that can facilitate integration and access to medical services among immigrants, but more needs to be done. The current reorganisation of the NHS (Health & Social Care Act, 2012), is another way forward as already discussed (see 1.2). However, the plan to implement these changes by April 2013, with Clinical Commissioning Groups (CCGs) replacing the PCT's in performing such duties as community health services and maternity services, has significant import for this thesis. The value lies in the arrangement for CCGs to take decisions regarding the provision of certain services through potential providers outside the NHS, alongside the GPs. In line with this, patients can choose from a range of potential providers for the services of their choice within the scheme. This arrangement has potential to aid collaboration among care providers within and outside the NHS, which hitherto, was not possible. Apart from this recent action, to date (2016) there is no policy or acclimatisation programme aimed at preparing Nigerian immigrants before or during their arrival for smooth integration into the host

culture. This lack of a coordinated, preparatory programme leaves immigrants vulnerable, and consequently delays the integration process. This gap could be contributory as to why immigrants find easy access to their ethno-cultural and religious groups as an option for much needed support as already mentioned above (enculturation). Therefore, the research described in this thesis explores and provides useful information for bridging this gap between the formal and informal care systems, using Nigerian Christian immigrants as a reflexive community.

Considering the relevant factors mentioned above, this research deals with African religio-cultural factors, focusing on Nigerian historical antecedents that shaped it from the time of colonisation and evangelisation (pre-migration) to the present (post-migration). The gaps identified within previous research has inspired the leading questions that shaped this research [(i) In view of the risk factors noted above, and within the context of a better healthcare system in the UK (NHS), what are the prevailing health-seeking methods among Nigerian immigrants in the UK; and what are the barriers and facilitators to health services utilisation? (ii) What are the experiences of care provision by Nigerian clergy, other complementary care providers, and healthcare professionals; and the potential for collaboration/integration with the healthcare system in the UK? (iii) What other variables and demographic factors (within and outside the individual) influence health-seeking behaviours among this research population?]. Addressing these questions is of research interest as health professionals are faced with the increased challenges of providing adequate healthcare services to a diverse population; an objective which can be better achieved if health services are adequately utilised. Further to this, the factors militating against adequate health care utilisation are complex, especially in the context of migration due to the diverse nature of migrants' religious and cultural beliefs, as well as the interplay

of salient factors within their social milieu which can easily escape immediate attention. Therefore, it is among the aims of this research to explore existing religious and cultural factors that impact health decisions among Nigerian immigrants, which are understood in relation to the way they perceive their present socio-cultural environment. Understanding these aspects will help in predicting health behaviours; change any maladaptive cognitions, attitudes or belief systems that serve as barriers towards desirable health outcomes. This achievement can consequently enhance integration and reduce health inequalities in a multicultural UK. The need for integration cannot be more urgent now the UK policy on immigration and asylum is being interpreted as negative and unwelcoming (Phillimore, 2011) as already noted (2.1.1.1). Overall, these issues can be addressed through authentic information that can facilitate integrative health intervention through collaboration and this needed information can be provided through this research. To obtain the needed information therefore, there is a need to focus this review on the research population and their historical antecedents (politics, religions, and cultures), that can influence illness perceptions and health behaviours which is the content of the next sub-section (2.1.3).

2.1.3 The research population: Africa/Nigeria

2.1.3.1 Historical Developments

Immigration studies and other studies involving Nigerians and other immigrants of African descent usually group the research populations under one common term: 'Africans/Black Africans', 'West Africans', 'Sub-Sahara Africans' or generally as 'Black immigrants' (Butcher, 1994; Cooper, 2014). London has the highest population of Nigerian immigrants in the UK, with a total of 55,600 non-UK born spread mainly across Greenwich (13,000: 5.1% of all residents in the area), Southwark (13,600: 4.7%

of all residents), Barking/Dagenham (8,700: 4.7 of residents), Lewisham (9,600: 3.5% of residents), and Hackney (6,700: 2.7% of all residents) (ONS, 2011). This is not surprising, as research evidence in the UK shows that, its inner cities (such as London), are the most likely places for immigrants to settle; a situation similar to other parts of the globe (Hatch et al., 2011).

Nigeria is in West Africa and rated the most populous country in the continent of Africa with a population of over 150 million (half that of the continent) and 250 ethnic groups with three major religions – Christianity, Islam, African traditional religion/animists (Anonyuo-Nwaenyi, 2009). The continent of Africa ranks as the second largest continent of the world, constituting a tenth of the world's inhabitants, with over one thousand indigenous languages (Stone, 1998). The slave trade across the Sahara Desert and the Atlantic Ocean can be viewed as the earliest form of forced migration in the continent (COI Report, 2013). Indeed, the transatlantic trade alone accounted for the forced migration of about 3.5 million Africans in the period between the 1650s and 1860s (COI Report, 2013). Nigeria was colonised by Britain, but before the period of imperialism, forced migration from Nigeria to the United Kingdom has been in vogue, with the first Nigerians in Britain having arrived as slaves. A famous example among the first slaves was the renowned Olaudah Equiano, also known as Gustavus Vassa who later traced his origins to the Igbo speaking Esaka people of Nigeria (Olaudah, 2003).

The Neolithic tribes known as the Nok people, recorded by archaeologists for their terracotta figures and early use of iron had occupied the area known today as Nigeria before the advent of European explorers (Anonyuo-Nwaenyi, 2009). Also, prominent in this area was a well-established form of administration known as kingdoms and empires, among which were the Kanem-Bornu of the Hausa caliphate,

the Benin kingdoms and Yoruba empires of Oyo and Ife, where the Portuguese made initial contact with Nigeria in the 15th century, before the British came in, four centuries later (Anonyuo-Nwaenyi, 2009). Then as a political entity, Nigeria came into existence as a British colony through the amalgamation law of 1914, which joined the Northern and Southern regions. Hence, a once separate peoples and cultures with three major tribes – Igbo, Hausa, and Yoruba became one nation state – Nigeria (Crowther, 1966).

As Britain took absolute control of the political and economic leadership of the country by way of colonisation, the need for skilled manpower resulted in more Nigerians moving to Britain and America as students (Anonyuo-Nwaenyi, 2009). Also, during this time the population of Nigerians seeking Western education was on the increase with few colleges being able to absorb them. For instance, in 1958, the population of the country was estimated at about 55,000,000 with only one University College able to serve their educational needs (Anonyuo-Nwaenyi, 2009). Consequently, the British administrative control of Nigeria influenced the influx of Nigerians to the UK as students (Ogbaa, 2003). To this effect, the British government granted many scholarships as incentives to lure Nigerians to study in the UK (Anouyuo-Nwaenyi, 2009). However, when Nigeria gained political independence from Britain on October 1, 1960, freedom was truncated by civil unrest - the Biafra War (1966-1970). This conflict resulted in an increased movement of people from Nigeria to Britain and the United States, which included a mixture of refugees, elites, and skilled professionals alike (Anouyuo-Nwaenyi, 2009). Hence, in 2008 the UK Foreign and Commonwealth Office estimated that the number of people of Nigerian origin in the UK was between 800,000 to 3,000,000; including illegal immigrants, British-born people of Nigerian descent and recent immigrants. However, the 2011 census accounting only for non-British born Nigerians puts the figure at 191,000 (ONS, 2011).

The prevailing factors for Nigerians emigrating to the UK and other parts of Europe and America can be summed up in the historical antecedents (involving colonialism, politics, education, and economy); which have implications for religion and culture as well.

2.1.3.2 Politics, Religion, and Culture

Presently, Nigeria's over 250 ethnic groups are spread along the 37 states located within the six geo-political zones of the country: South-East (Abia, Anambra, Ebonyi, Eungu, and Imo), South-South (Akwa-Ibom, Bayelsa, Cross-River, Delta, Edo and Rivers), South-West (Ekiti, Lagos, Ogun, Ondo, Osun, and Oyo), North-East (Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe), North-Central (Benue, Kogi, Kwara, Nasarawa, Niger, Plateau, and Federal Capital Territory- Abuja), and North-West (Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto, and Zamfara) (Ezeani, 2012). The Yoruba and Igbo are the dominant ethnic groups (mainly Christians) in the Southern region and Hausa-Fulani and Kanuri (mainly Muslims) dominate the Northern region (Awolowo, 1947; COI Report, 2014). Presently, The Muslims constituted about 50.4% of the population in 2011, dropping to 50% in 2014; while the Christian population increased from about 40% of the total population in 2001 to 48.2% in 2011 and 50% in 2014; showing a significant growth rate compared to the Muslim population (COI Report, 2013). However, the USSD IRF Report in 2014 puts the population of Muslims at 50% of the total population, and Christians making up 45% while animists or followers of indigenous religious beliefs constituted 5%, a drop from 10% in 2001 (COI Report, 2013). The overall increase in the population of Christians is of particular interest to this PhD, considering the potential influence of religious beliefs and practices on health decisions and increase in preferences for alternative

methods of cure against conventional approaches within the healthcare service (Rudell, Bhui & Priebe, 2008; Jorm, & Griffiths, 2006; Oliver, Pearson, Coe & Gunnell, 2005). This is with special reference to the growth and influence of the Pentecostal denominations within the Christian religion, expressed thus: "The Pentecostals have overtaken the Fundamental churches and have catapulted them into melting pots of the word of God, and the winning of souls for Christ." (Ayuk, 2002, p. 190).

Considering the religio-cultural diversity in Nigeria and a post-modern understanding of culture as a mixture of values, customs and behaviours borrowed from many places (Helman, 1984), the cultural and religious influences on health seeking behaviours among Nigerians cannot be wholly understood without due appreciation of the historical antecedents that shaped them. These historical factors are mainly from colonisation and Christian evangelisation, both of which introduced Western cultures in the continent with far reaching consequences. This highlights the role of education in understanding the impact of Colonisation and Christian Evangelisation on African society. Through the Western education system, Africans were made to imbibe and admire the values of the colonising culture/society. The consequence is a sense of frustration among Africans, such that the continent is viewed as trapped in '…problems with identity crisis and loss of equilibrium in a global society into which it has been irreversibly drawn.' (Anonyuo-Nwaenyi, 2009, p. 94). Therefore, it could be postulated that colonial education for Africans, was not a means of acquiring a balanced knowledge consisting of wisdom, integrity and skills. Instead, it was regarded as an opportunity to acquire a distinguished social status, prestige, and power (Ezeani, 2013). This undesirable outcome could be linked to the misdirected aims of colonial education, one of which was to train Africans to become English/French in their outlooks to life, both morally and intellectually (Betts, 2005;

Macaulay, 1835), while they remained Africans by blood descent. With this radical policy in place, Africans were required to discard their own values in preference to those of the colonisers as education became misinterpreted as mere identification with the exotic, rather than a process of acquiring knowledge for a positive change (Mkabela & Lithuli, 1997).

The educational approach resulted in a lack of mental autonomy, expressed by Fafunwa (1967), as a 'psychological state where the colonised has adapted their intelligence and initiative to that of the ruling power, without any critical questioning or investigation' (p.12). Consequently, the psychological impact readily translates into a feeling of inferiority and dehumanisation among Africans (Azikiwe, 1963; Boahen, 1987; Okoh, 2005). This outcome captures an aspect of the historical antecedents that have psychological impact on the people as it shapes the social capital capacity within which health information and decisions are processed for a desirable well-being. As education is a systematic process of imparting and receiving information or knowledge through instructions, it has a formative role on the recipient; with potentials for maladaptive cognition if it goes wrong. To this effect, Adlin Sinclair (2004) observed that, individuals represent the information they imbibe, which consequently influence their entire behaviour; and to reverse this process towards behaviour change there needs to be a cognitive change. Therefore, in trying to change their circumstances, Africans embarked on reactions that resulted in increased struggle for freedom and cultural revival; with feelings of distrust, anger and hate for anything Western, which eventually culminated in political and religious independence (Ogbaa, 2003). The long-term consequences could be seen in the establishment of a unique form of African Christian religious worship, rooted in African culture and traditional religion and consequently influencing the thinking and lifestyle of the indigenous people (Sanneh,

2004). However, with political independence and enhanced migration, African immigrants experienced further negative treatments abroad, a reflection of unequal power-balance and rejection by both the church and state (Olofinjana, 2010). In the UK for instance, this condition resulted in a further reactionary response by first generation African immigrants who established more African oriented churches like what they had in Nigeria (Olofinjana, 2010).

2.1.3.3 The Impact of Christianity: The African Independent Churches (AIC)

Certainly, in Africa and Asia, during the centuries of Christian evangelisation, political conquest and expansion, missionaries became instrumental in linguistic creation and translation of the bible into local languages for the purposes of transmitting the gospel message and for socio-cultural transformation of peoples (Sanneh, 2004). In Nigeria, this resulted in the emergence of different Churches with unique African characteristics reflecting religio-cultural revival under the banner of 'African Independent Churches (AIC)' (Sanneh). Therefore, to explore the basis for the current illness perception and general health seeking attitudes among Nigerian immigrants in the UK, it is important to understand the emerging religious movements and their use of the Sacred Scripture/Word of God as a theological method for coping with daily life challenges. The African Independent Church was a major outcome of missionary activities in Nigeria - the Niger mission (Ekechi, 1972). This group was characterised by zealous faith rooted in the Scriptures, with unwavering commitment to social and political issues. The outstanding character of this new group was a unique type of 'Christianity' with an African identity representing a symbol of religious and intellectual freedom. It symbolised a struggle, from what could be viewed as the Western way of knowing to what is uniquely African, and from the rationalist approach

of Western Christianity to simple religious conviction (Sanneh, 2004). The consequences are that, the vernacular bible became a powerful instrument to dislodge the prevailing biblical narratives based on Western cultural and intellectual dominance as expressed thus,

> …the Biblicism of protestant missions helped to suppress the transmission of Western cultural presuppositions to indigenous societies. The objection of some Western missionaries that such Biblicism encouraged blockheaded fundamentalism is in part a recognition of the power of the vernacular Scripture to force a serious reckoning on the whole matter of gospel and culture, and to do this without the controls of the Western church. Obviously, excesses will be committed, but they will be indigenous excesses rather than Western ones. (Sanneh, 2004, p. 203)

The "excesses" referred above could have health seeking implications among Nigerians, which is central to this research. It could be argued that past experiences have shaped the Nigerian Christian religious worshippers to acquire from vernacular resources a strengthened determination to develop unique religious methods as a way of finding answers to their problems. However, in the 80s and 90s, this movement took on a new dimension with the wave of independent churches called, the Newer Pentecostal Churches (NPCs).

Pentecostalism is a movement in Christianity (functioning as part of mainline churches or independently) viewed as the prophetic fulfilment of a universal outpouring of God's spirit among his people based on the extraordinary experience of the twelve apostles in the early church as recorded in Acts 2 (The New Jerusalem Bible); which was interpreted as the 'Pentecost' or baptism of the Holy Spirit, hence the name

'Pentecostal' (Kay, 2011). Their fundamental teachings lay emphasis on the work of the Holy Spirit and an experience of God that is unmediated by rituals and liturgical practices (miracles). To partake in this divine experience, one must undergo personal conversion - *Baptism in the Spirit* - characterised by *gifts of the Spirit,* expressed spontaneously in the art of speaking in tongues, prophecy, and faith healing (Brahinsky, 2013). Such spirit-based group within the Catholic Church, is the Catholic Charismatics; a group described as ambivalent because they act like catholics (loyalty to sacramental life) but pray like protestants (speaking in tongues, and faith healing as a gift of the Holy Spirit) (Loustau, 2016). A dualistic approach to health and illness (faith healing) propagated by Pentecostalism is particularly important to the current PhD; which has been expressed by Kay (2011) thus, "Sickness comes from the devil and healing comes from God, and anybody who believes in God should have nothing to do with medicine." (p. 14).

The growing phenomenon of transnational Pentecostal churches from Nigeria, has become a new social force (Burgess, 2014). In his investigations, Burgess noted that, out of the ten mega-churches in Britain, four are Nigerian-initiated, with one of them – the Kingsway International Christian Centre (KICC) reckoned as the largest single congregation in Western Europe; and another – The Redeemed Christian Church – as the fastest growing Pentecostal denomination in Britain. There are over 20 churches in this category, with over 20 branches each in London. For instance, the Winners Chapel has about 3,000 followers in its main church in London and a large congregation in branches throughout the UK (Luton, Manchester, Birmingham, Leeds, Bradford, Liverpool, and Glasgow). Another group worth mentioning is the Christ Embassy which began only in the year 2000, and presently has over 22 church branches in London, and 16 outside London (Olofinjana, 2010). With the proliferation

of this brand of religion, it is not easy to estimate their number as many are unregistered, yet there are no recorded difficulties among Nigerians in accessing them for health and other purposes. Besides, there are other Black Majority Churches (BMCs) in the UK that are accessible to Nigerian immigrants. For instance, in the London Borough of Southwark, there are about 160 BMCs; the London Borough of Lewisham has about 100 BMCs, out of its total number of 275 churches (Olofinjana, 2010).

2.1.3.4 African Christianity: The Healthcare Seeking Implications

In Nigeria, the legacy of Colonisation and Evangelisation has enormous political, economic, religious, social, moral, cultural and educational consequences (Ezeani, 2013). Within this religio-political antecedent is found a mixture of multi-ethnic and religious groups under diverse indigenous and foreign cultural influences. These historical antecedents (religious, cultural, social, educational, economic, and political) are believed to have links with established cosmology (myth and superstition) that define events in a unique way that is comprehensible to the local people, considering the 'meaning-making' element of culture (Cohen, 1997). This interplay within a complex cultural and religious matrix has put Christianity and Islam in a dominant position as agents of character formation and interpretation of life events. Therefore, on a larger scale Nigerians are understood to exhibit a unique health seeking behaviour dominated by a worldview that ascribes diseases/illness and their aetiology to the supernatural, external entities or deities beyond the realm of the physical environment (Iyalomhe & Iyalomhe, 2012).

The reliance on religious coping strategies for health conditions in Nigeria has been facilitated by the natural African worldview and orientation relevant to biblical

narratives; which is mostly propagated by the Pentecostal/Charismatic Movements, and they have recognisable popularity here in the UK as already noted above. These groups hold retreats, religious camping, and deliverance crusades, outreach services or family prayers in individual homes, villages and towns. The basis of these gatherings is to effect healing, citing relevant biblical passages rooted in the metaphor of 'Curses and release from Curses', to effect healing from the root (Healing the Family Root) (Njoku, 1993). From this background, the people are taught that life's problems, sicknesses and other ills befalling them are associated with the sins of their forefathers (Ex. 34:6-7; Deut. 5:9) (The New Jerusalem Bible); and having inherited these curses, these preachers teach the people that they must be exorcised from its effect in order to experience good health and progress. This type of teaching is made to apply to all facets of human daily living and can influence individual and communal health belief, illness perception and health seeking method thus; 'It is not a question of theological opinion. It is God's holy truth revealed. How else can we make the gospel take root in our land and take flesh in our lives, if not by addressing the core of the message, namely: redemption, to every need of our people. *We should meet our people where they are, and make the Gospel speak to them*. There is universal salvation, but we need to apply its effects to every facet of our lives' (Njoku, 1993, p.vi).

The strategy seems to be a repositioning of metaphysical ideas (*nemesis, karma,* or destiny) from African traditional religious viewpoint into the Christian message within which a suitable metaphor is developed to construct meaning and explain life events with possible solutions attached. For instance, the practice of release from curses is based on the principle of repetition of the countering words of the bible as is evident in the African idea of repeated incantations to effect cosmic changes. This approach portrays an outstanding type of liberation theology (Berryman,

1987), that encapsulates an aggressive struggle for political, economic, social and spiritual salvation of the people. Another unique attraction to this religious group is the strong musical orientation involving dancing, which is deemed to be an appropriation of African love for music (Stone, 1998).

Through this form of religious education, there is a systematisation of local illness categories, to find an interface between local and biomedical explanations. In this instance, locally prevalent illnesses and diseases are recognised and assigned specific or general causes, in the form of 'folk illnesses' (Rubel, O'Nell & Collado-Ardon, 1984). Consequently, with the study of malaria in Africa, research shows that 'folk illness' has been a common phenomenon where the symptoms of convulsions were not recognised by the local people, but were attributed to supernatural' agents with unorthodox treatment options such as spiritual and traditional healing methods (Makemba et al., 1996; Mwenesi, 1993;). With the religious healers incorporating salient traditional elements and merging concepts from biomedicine and local beliefs derived from African cosmology, the traditional medicine arguably seems to be losing its place. However, this process of reinterpretation of illness with inclination towards traditional belief is found to be more successful with perceived failure of the biomedical treatment, and where the persons or their families are embroiled in disturbing social conflicts (Hausmann-Muela, Muela Riberia & Tanner, 1998). Hence, the general atmosphere of scriptural reading/interpretation, and its application to existential problems among the clergy and laity, seems to define the unique Nigerian Christian religious history and present day experience. This attitude could be understood as an attempt by Nigerians to translate theological principles into action for solving problems per prevailing circumstances. This method is thought out as a spirituality that transforms beliefs in God into a practical option for solving the people's problems in a

concrete manner (Okuma, 2002). The health implications are quite remarkable among Nigerians; as studies show that faith-based and alternative/complementary approaches to psychological and physical health conditions have been adopted for treating various health conditions besides medical intervention (WHO, 1996).

Meanwhile, observable trends show a proliferation of religious groups with variations in theology and biblical interpretations. These variations include the literalist, liberal approach characterised by unmediated access to God (prevalent among the African Independent Churches and Pentecostal Movements) on the one hand, and the structured, guided, and dogmatic approach typified by rituals and the sacraments (as among the mainstream churches), on the other (Gottlieb & Olson, 1987; Loustau, 2016). These distinctions or divisions along denominational lines are of interest to this research as it could point to specific religious groups with interesting characteristics as a reflexive community. It is also important as it could indicate that religious affiliation and the structural arrangements of a religious community can influence health-seeking behaviours. Since Nigerian immigrants have lived for a long time within their heritage context as described above, it is important to explore their health-seeking behaviours in a new context (UK) characterised by different socio-economic challenges, with a healthcare system - NHS – that is free at the point of delivery and comparatively more accessible. This investigation is vital given the risk factors inherent in consultation/treatment with non-professionals in care as well as the non-recognition of spiritual healing methods (seemingly preferred by Nigerians) within the formal health system; possibly due to the challenges it can present to clinicians (Brown, 2016).

2.1.4 African Religious/Spiritual and Cultural Worldview and Health

The concepts of religion and spirituality are no longer confined to the discipline of theology, which has resulted in long-lasting debates on how to define them as authors are drawn from different disciplines: psychology, philosophy, sociology, history, and anthropology (Downey, 1997; Lundskow, 2008; Mangione, Lyons & DiCello, 2016; Principe, 1983; Sheldrake, 1998). Hence, a precise definition of spirituaity became difficult as it was applied not only to religions, but also to secularists and Marxist ideologies; resulting to its widespread use in the twentieth century to include meditation, nature, or the arts (Bowman, 2004; Garssen, Visser & de Jager Meezenbroek, 2016; Ho & Yin, 2016; Lundskow, 2008; Peteet & Balboni, 2013; Slater, Hall & Edwards, 2001). The word 'spirituality' is a derivative from the Latin word *spiritualitas*, an abstract concept coined in the fifth century to denote the quality of Christian life lived according to the Spirit of God (The Oxford English Dictionary). However, a nontheistic approach to the understanding of spirituality views it as a "striving for and experience of connection with the essence of life" (de Jager Meezenbroek et al., 2012, p. 142), which has three major dimensions: connectedness with oneself, connectedness with others and nature, and connectedness with the transcendence. As spirituality centers on direct attunement to the transcendent, religion on its own aims at achieving the same goal through a system of doctrines expressed in rites and worships within a group (Trevino, Naik & Moye, 2016). Here, the spiritual notion of 'transcendence' may, but not necessarily, refer to 'God', which implies the possibility of an overlap between spirituality and religion (Garssen et al., 2016). For instance, within the African world-view or traditional religion and culture, the essence of religious worship (religiosity) follow from its spiritual benefits through beliefs, belonging, and behaviour, with no distinction between the natural and

supernatural (Aina, 2006; Storm, 2015). This orientation is a vital consideration in dealing with health and wellbeing among African immigrants.

As distinct concepts, religiosity enhances mutual relationship within a community while spirituality aids connection to a 'Higher Power'. As related constructs, both are concerned with the lived experiences related to a person's ultimate purpose in life; and involving also the way people perceive this and live out, within a given historical context, those aspects of their religious values, philosophy of life and ethical considerations that are viewed as most ideal and noblest towards the achievement of the highest ideal (Principe, 1983; Santoro, Suchday, Benkhoukha, Ramanayake & Kapur, 2016). In the same pursuit, spirituality also involves the act of living out a personal 'Faith' or commitment towards the attainment of highest ideals or goals set by an individual; which may necessitate some form of struggle towards spiritual development through religious activities (Hill & Pargament, 2008; Mangione, Lyons & DiCello, 2016). The aspect of spiritual experiences expressed in religious activities within community settings is vital to the context of this PhD and its research population as a reflexive community, because it espouses the process of becoming fully human in relation to life, an individual's search for meaning and purpose involving all actions aimed at corporate wholeness, rather than an individualised type (Noor, Bashir & Earnshaw, 2016). Although as noted earlier, where spirituality is rooted in moral values and ethics, it can be independent of religious beliefs. This means that spirituality can be either embodied or disembodied from religion (Flanagan, 2015), so that it may not necessarily be ordered towards the divine. Yet, among different definitions of spirituality and religion, what is central to both is a sense of the sacred (Hill et al., 2000; Mangione et al., 2016); implying that athough they are potentially distinct, they are

also overlapping, with the possibility that a person can be spiritual without being religious and vice-versa, be both, or neither (Ho & Yin, 2016; Vieten et al., 2013).

However, in contrast to the 'distinct' approach to understanding spirituality (where it may not be ordered towards the divine), another school of thought upholds that its fundamental link with religion is the transcendental dimension, a paramount characteristic of anything that qualifies for the term 'Spirituality' (Trevino, Naik & Moye, 2016). In this case, spirituality is defined as a state of holding a relationship with the divine, regarded as supernatural or transcendent – precisely – it is '…a state of being related to a divine, supernatural, or transcendent order of reality.' (Wuthnow, 2001, p. 307). This contemporary perspective (where invariably spirituality overlaps with religion) has implications for life in society and for salvation of the whole human person – mind, body, and soul; with important consequences for health/well-being and relevant actions for its realisation (health-seeking behaviours). In this regard, many years of research has shown that spirituality/religion has significant influences on health and well-being (Bray, 2010; Corry et al., 2013; Fleming & Evans, 2008; Santoro et al., 2016). The vital component of spirituality that is commonly used to measure this influence is 'spiritual development'; a journey of an individual as part of a community (Wuthnow, 2001). Without underrating the influence of spiritual development or depth of spirituality on health seeking behaviour, the research questions within this PhD focus more on religious activities, and affiliations to institutionalised forms of Christian spirituality (Mainline and Pentecostal religious organisations) as important formative agents in shaping both cognitive and behavioural responses to illnesses/symptoms.

Research on immigrants and health has identified spirituality and religion as useful coping methods (Karekla & Constantinou, 2010; Thune-Boyle, Stygall,

Keshtgar & Newman, 2006). Early research in this area (Jagodzinski & Dobbelaere, 1995) suggested an increase in detachment from religious persuasion, and therefore, concluded that there is a significant disuse of spiritual/religious coping strategies, and these coping responses are less effective or less frequently used by patients (Frick, Riedner, Fegg, Hauf & Borasio, 2006; Zwingmann, 2005). However, other research (Jim, Richardson, Golden-Kreutz & Andersen, 2006) provided evidence of the continued relevance of religion/spirituality as important coping resources among immigrants. Studies on breast cancer (Zwingmann, 2005) found that women employed spiritual practices in coping with diagnosis and survivorship; and the majority said spirituality helped them to find meaning out of the situation, guiding them on appropriate treatment option. Jim et al., (2006) reported religious coping and the benefits of spiritual dimensions of meaning correlated well; thereby concluding that this coping method is both effective and frequent. Finally, Zwingmann et al., (2006), also found that cancer patients relied more on positive religious coping (confident and constructive reliance on religion) than the negative religious coping (religious struggle and doubt), with older women, less educated patients, and women without partners found to have used negative religious coping methods.

With particular reference to Africans, Holt et al., (2009) found religious involvement to be a positive coping strategy, and the idea of God to be important particularly among African Americans. Christians and Jews related their illness to a transcendent power, with few (5 out of 100) relating their illness to biological factors, eating behaviour, or pollution (Kappeli, 2000). In another study by Yanez and colleagues (2009), survivors of life-threatening conditions reported a decrease in depressive symptoms and increase in vitality when using spirituality in coping. A reliance on faith also predicted a temporary increase in depressive symptoms, as well

as a decrease in vitality within the context of low meaning/peace. Among survivors, meaning/peace did not predict adjustment across time, but it was more beneficial than faith in relation to mental health and lower cancer-related distress. Based on level of faith, younger women reported lower meaning/peace than older women, college-educated women reported significant lower faith than less educated women, White women reported lower faith than women of other ethnic groups (Yanez et al., 2009). However, these findings did not predict adjustment across time between meaning/peace and faith among patients and survivors.

Although the studies by Kappeli (2000), reported negative coping among patients suffering from conflict, struggle and doubt, it is not an indication that religion does not serve as a significant coping method, but an indication that several factors should be considered while assessing patients' spiritual and religious coping responses. For instance, a history of harsh religious upbringing could result in reactions and anger towards the 'God' of their belief. Also, groups where the family is regarded as the major source of support can show significant impact on coping approach that can affect research findings, besides the impact of social desirability among religious adherents who may try to appear faithful to their religion (Bourjolly & Hirshmann, 2001). In concluding this debate Dubach and Campiche (1993), note that there is individualisation of religious practice and consequently, less attachment to religious dogma, religious institutions and authorities, such as the authority of the clergy, rather than an absolute secularisation of modern society against religious practices. This conclusion is important regarding Nigerian immigrants, who have deeply religious backgrounds not yet secularised; as noted earlier in this chapter. This can explain part of the reasons that Nigerians in the UK can still express deep religious beliefs, and strongly rely on religious/spiritual healing methods irrespective of the

availability of free healthcare services. Moreover, the discrepancy and lack of a meeting point between the formal (healthcare professionals) and informal (alternative/complementary therapists) health management approaches can also contribute to inadequate healthcare utilisation, which raises such fundamental issues as, the acceptable meaning of the concept of 'health and illness' - what constitutes the state of good health/wellbeing, and what are the best approaches to realising this state? Various attempts have been made to address these questions through psychological theories and principles. The next sub-section explores the major model that is relevant to this thesis – the biopsychosocial model.

2.1.5 Theories and Models of Health and health behaviours

The notion of health has eluded concrete and comprehensive definition, as it has been perceived differently by different people (as discussed in detail in section 2.1.1). Marks et al., (2005), included cultural, psychosocial, economic and spiritual aspects which widened the understanding of health and intervention beyond the biomedical framework to the biopsychosocial framework (Engel, 1977). The biopsychosocial understanding of health has guided the development of research questions and objectives within this thesis; and therefore, deserves special attention.

2.1.5.1The Bio-psychosocial Model

The bio-psychosocial model is an important way of looking at behaviours and health outcomes, which considers the interaction of biological, psychological, and social factors in health and illness. This pioneering work was initiated by George Engel, who explored health intervention through the interplay of biological, psychological, and sociological factors beyond the then simple biomedical model

which had been the basis of Western medicine since the eighteenth century (Crossley, 2000). The biomedical model views diseases as resulting from biological malfunctions, and treatment is sought by putting aright the ailing part of the biological system. A broader theoretical basis for a multi-causal approach to health underlies the necessity for socio-cultural and religious considerations in the design of successful health interventions. On this basis, health research can be extended using a broader framework such as the biopsychosocial framework, to engage other aspects of health (such as social capital analysis) in understanding people's health behaviours using a form of reflexive community. This knowledge base can be useful in health promotion among groups, and communities within a multicultural population (MacLachlan, 2006). The Venn diagram below (Figure 2.1) is the researcher's version of schematic representation of health seeking behaviours to involve a broader perspective of socio-cultural, biopsychological, and religio-spiritual factors.
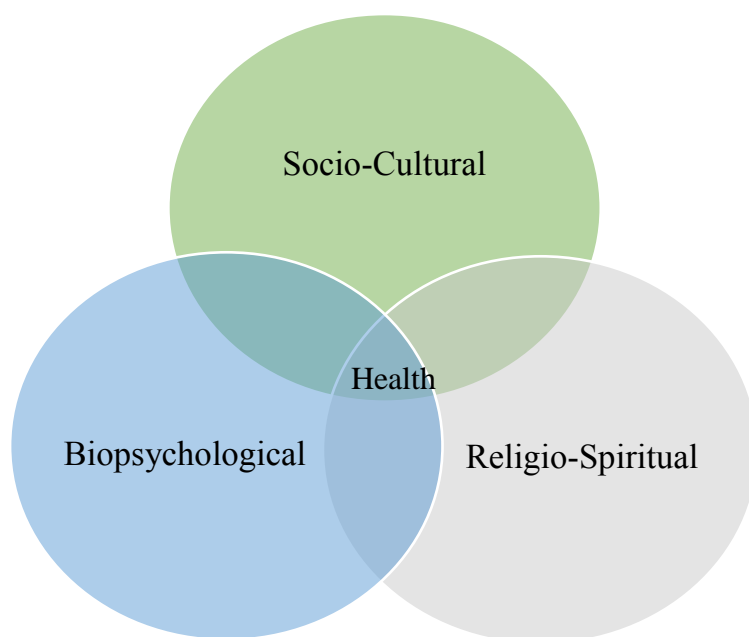
Figure 2.1. Health and illness Venn Diagram: An adaptation

Also, based on new information from the bio-psychosocial and anthropological views of human behaviour, the aetiology, diagnosis, treatment methods, and relationships in consulting were radically reformed. The consequence of this radical change was that patients' circumstances became important in medical decisions, as Mechanic (1978, p. 114) observes "…the doctor, if he is to meet his responsibilities as a physician, must attune himself to the social situation of the patient.' In line with the WHO definition and the biopsychosocial approach to attaining the highest standard of health, much health-related research has become concerned with the study of such issues as health behaviour and health seeking attitudes, applying relevant theories and principles. On this basis, it is important to consider how people of different cultures and social groups understand health and interpret the causes of ill-health with reference to their social circumstances, as well as religio-cultural beliefs and practices. To initiate, promote, and maintain desired attitudes to health and well-being, various theories of behaviour change within a cultural context have been developed following the bio-psychosocial health model. The increase in research on community aspects of health and human behaviour was initiated by the rise in the primary health care (PHC) approach. Also, from a global health perspective, research and training in tropical diseases (TDR) within the social sciences, brought to light various determinants that are important while considering health behaviours among Africans (Hausmann-Muela, Muela Ribera & Nyamongo, 2003). These vital aspects are related to the emphasis placed on religious, socio-cultural, and socio-economic factors in health and illness; as well as their implications for health-seeking behaviours relevant to this thesis.

Moreover, the biopsychosocial health orientation has given rise to most health seeking theories and models used in explaining and predicting behaviours associated with health and illness, health behaviours, and health seeking behaviours. These

theoretical approaches are multi-disciplinary, covering areas in social psychology, cultural and medical anthropology, epidemiology, medical geography and social economy. Through the application of these theories and models, there has been better understanding regarding health care utilisation, identification of important religio-cultural variables in health seeking behavior, better understanding regarding variations in health seeking behavior and the reasons for such variations. Although, a few these biopsychosocial-related models (such as *The Health Belief Model, The Theory of Reasoned Action/Theory of Planned Behaviour, Health Care Utilisation Model, and Decision Making Models*) which are relevant to this thesis are not tested nor applied deductively in the four empirical studies conducted in this project, they assist in the identification of previous research evidence relevant to this thesis. Also, they remain vital guides to the research questions and objectives set within this thesis, and so provide the reference points for the triangulation/integration of all the studies (see 8.1.2 & 8.1.2.3 [i] & [ii]); leading to a proposal for a better integration of the diverging aspects of the study findings – the spiritual and the bio-medical health factors (see 2.2 [viii]) (8.1.2.3 [iii]).

2.2 Explication of some concepts in the thesis

(i) Health behaviours/Health-Seeking Behaviours

For the purposes of this research, the term 'Health behaviour' is used as a broader concept incorporating health seeking behaviours; and refers to personal characteristics and lifestyle behind human actions/inactions that affect health status or well-being (Gochman, 1988). Health seeking behaviour is an aspect of a wider spectrum of the human behaviours exhibited in response to illness/symptoms, and usually aimed at positive actions to prevent diseases, cure illnesses and regain health.

However, Mechanic (1986) referring to similar notions used the term, "Illness behaviour" to include attention to pain and symptomatology, the process of ascribing meaning, and socially labelling symptoms/illnesses. But for the sake of clarity, the term 'health-seeking' is adopted for this research.

(ii) Healthcare utilisation

Healthcare utilisation (professional help-seeking) was viewed as a positive attitude towards the use of medical help. This was the outcome measure used to determine how the forces of acculturation, coping methods, and religion can motivate Nigerian immigrants to seek or avoid professional healthcare. Professional help is considered as access to medical help, such as the use of all treatment approaches within the NHS, as opposed to other treatment methods regarded as complementary and alternative methods (CAM) by providers mostly outside mainstream NHS funding. Hence, the term 'medical help-seeking' as applied to this thesis stands for individual means of finding medical assistance from practitioners within the healthcare system for either preventive or curative intention.

(iii) Religion/Spirituality

Spirituality is used as a holistic human experience of transcendence, personal quest for meaning, or relationship with a higher being, that may or may not have any link with a particular religion. Whereas religion refers to a group of activities involving organised worship, system of beliefs, rituals, and symbols (Otto, R. 1979; Thoresen, 1998); as well as behavioural, social, doctrinal, and denominational dimensions (Armstrong & Crowther, 2002), usually aimed at spiritual benefits. It implies therefore, that where all religious practices are inherently spiritual, not all spiritual exercises are religious. In the African worldview where everything is viewed as functionally connected (Damafing, 2008), religion is believed to be all encompassing with

fundamental links to the cultural, social, and political life of the people, a compendium for morals, norms and mores of society. This vital interconnectedness has led Kamya (1997) to perceive an African's identity as having its roots in the community's identity; hence individuals are viewed as a part or an extension of the environment.

Although a precise definition of 'religion' or 'spirituality' remains elusive and without consensus (Corry, Lewis & Mallett, 2014; McSherry & Cash, 2004), religion has been variously defined as an organised system of beliefs, practices, rituals, and symbols, based on established theological knowledge and aimed at the relationship with a higher being, while spirituality involves a feeling of transcendent relationship with some being, more powerful and external to the perceiver (Thoresen, 1998). This way of perceiving spirituality implies some basic themes found in the literature, such as 'transcendence', 'connectedness', 'higher power' and that which pertains to meaning and purpose in life (Coyle, 2001; Mayers & Johnston, 2008). From another perspective, a consensus document by the National Institute for Healthcare Research (Hill et al., 1998) viewed religion from 3 different ways, that have implications for understanding both religion and spirituality:

(a) the feelings, thoughts, experiences, and behaviours that arise from a search for the sacred…and/or

(b) a search or quest for a non-sacred goal (such as identity, belongingness, meaning, health, or wellness) in a context that has [as] its primary goal the facilitation of (a), and

(c) the means and methods (e.g., rituals or prescribed behaviours) of the search that receive validation and support from within an identifiable group of people. (p. 21)

It is important to note the similarity between religion and spirituality as shown in the consensus document, where the first attempt at defining religion also related to the definition of spirituality thus: 'the feelings, thoughts, experiences, and behaviours that arise from a search for the sacred' (Hill et al., 1998, p. 21). Following the above definitions however, spirituality can be viewed as a transcendental concept, arguably devoid of a non-sacred goal, means, and methods such as rituals, and prescribed behaviours validated from within an identifiable group; while religion encompasses all the above, with spirituality as one of its components and the essence of the religious life (Moberg, 1967). This interactive approach confirms existing findings showing that spirituality can be theistic – (a religious string) either with or without attachment to a personal deity; or could be secular without any reference to a particular religious belief (Shaw, 2005).

Acknowledging that the vastness of terms included within the concept of spirituality (such as New Age spirituality, parapsychology, and astrology) makes it more difficult to arrive at a single definition that is generally acceptable, the term 'religion' has been adopted for this thesis as inclusive of religious beliefs and other spiritual quests. The working definition of spirituality as developed by Johnston and Mayers (2005) gives impetus for this inclusive approach: 'Spirituality can be defined as the search fo meaning and purpose in life, which may or may not be related to a belief in God, or some form of higher power…' (p. 386). Therefore, spirituality and religion are used interchangeably as related to belief in God; to the effect that religion incorporates spirituality. Considering the African religious/cultural worldview of the research population already discussed (2.1.4), such as strong beliefs in a personal God and increase in reigious worship, whether as traditional religionists, Christians, or Muslim converts, the crux of the discussions within this thesis are based on the

concept of religion with African Traditional Religion (ATR) and Christianity as reference points. This religious orientation is different from the current experience in Europe, where church attendance and belief in a personal God is on the decline (Lambert, 2004), as people look for meaning in spiritual experiences outside established religious traditions (Brown, 2007).

(iv) Culture

Various definitions of culture exist; and according to Helman, (1984) it is viewed as a complex phenomenon involving knowledge, beliefs, art, morals, laws, customs, religions and such other capabilities and habits exhibited as a way of belonging to a particular society. These elements deeply determine a person's perception of the world, and how to respond to it in relation to others, their environment and belief in higher being or external forces. Also, culture is defined as a means by which people interact in a group and make the world meaningful to themselves, and vice-versa (Cohen, 1997). Gochman (1988) views it as a unity of language, customs, and signs, with implicit and explicit patterns of behaviour that have deeper values. Based on these definitions, culture and religion are relatively linked together to form important aspects of this thesis.

(v) Acculturation

Acculturation can be viewed from two main theoretical perspectives. First, is the social psychological approach popularised by Berry (1997), which posits that acculturation is the process of learning about and adapting to a new culture (Berry, 1990), with the consequence of cultural change when groups of contrasting cultures 'come into prolonged, continuous, first-hand contact with each other' (Redfield, Linton & Herskovits, 1936, p. 149). Hence, acculturation involves the process of culture learning undergone by those engaged with a new cultural or ethnic group, which

usually occurs as the consequence of migration when individuals from different cultures interact within the same geographical location (Berry, 2003). These cultural changes occur at both personal level (such as values, attitudes, beliefs, perceived identities) and group level (such as social, religious and cultural systems) (Berry, 2003).

The second approach to understanding acculturation follows from the diaspora studies and cultural identity contexts led by Hall (1990, 1997), with further developments from Bhatia and Ram (2001). The historico-political basis for Hall's approach focused on immigrant identity among post-colonial migrants into the UK and US cultures, regarding political positions, found to be based on 'negotiation, dislocation and conflict' (Bhatia & Ram, 2009, p. 143). While recognising the validity of both approaches, with the second approach seeming to relate more to Nigerian immigrants' navigation of their identity, this thesis engages the first approach by Berry. This is because it provides a more analytical framework for exploring different factors involved in acculturation experiences and influences, as well as how they relate to experiences of immigration challenges, acculturative stress and health seeking behaviours; which are among the interests covered within this thesis. Moreover, recent studies confirm that Berry's bi-dimensional approach is the most widely used model for exploring the acculturation process (Ozbek, Bongers, Lobbestael & Van Nieuwenhuizen, 2015). According to Berry's bi-dimensional approach to acculturation, two independent strategies are known to characterise the process – heritage-culture retention and acquisition of the host-culure (Berry, 1997), from which four possible patterns can emerge – assimilation (high involvement with the host culture), separation (high involvement with the heritage culture), marginalisation (low involvement with both cultures), or integration (high involvement with both cultures) (Berry, Phinney,

Sam & Vedder, 2006). These emerging patterns characterise a multi-dimensional aspect of acculturation.

According to Berry's (1980) multi-dimensional approach to the study of acculturation, the ideas of acquiring the culture of the host community and retaining the cultural heritage of the immigrant form two main dimensions within the acculturation spectrum. These aspects interact to create four possible categories exhibited by the immigrant – *assimilation* (preference of the receiving culture above their own culture), *separation* (preference of the heritage culture over the host culture), *integration* (adopting the receiving culture while retaining their heritage culture as well), and *marginalisation* (rejection of both heritage and host cultures) (Schwartz et al., 2010). Whether immigrants become assimilated, separated, integrated, or marginalised, will consequently determine the level of stress experienced due to the emerging gap between the old and the new cultures. Therefore, various studies have identified acculturation as a risk factor for increased stress, including the development of adverse emotional and physical health conditions among African asylum seekers in Israel (Nakash et al., 2015). Also, the relationship between stress (including stress caused by acculturation challenges) and ill health has been identified by stress theorists. However, it is acknowledged that the four patterns of acculturation strategies do not adequately describe all individuals' experiences (Berry et al., 2006).

Considering the concept of acculturation from other dimensions such as antecedent factors, acculturation strategies, and consequences/outcome, this thesis focused on the strategies or acculturation orientation and its consequences on the healthcare seeking behaviours of Nigerians. Here, the acculturation strategies or styles are defined as potentially new attitudes exhibited by Nigerian immigrants in response to their contact with the UK culture (cultural adoption) and in relation to their

original/heritage culture (cultural maintenance) while living in diaspora. An important aspect of the acculturation process is related to the outcome, which can be either psychological (internal adjustment, acculturative stress, well-being) or behavioural adaptation (social, external adjustment) (van Oudenhoven, Judd & Ward, 2008). However, little is known about the extent to which Nigerians in the UK adopt the mainstream culture and/or maintain their heritage culture. Therefore, acculturation is considered within this study as the changes and challenges resulting from the interaction of Nigerian immigrants (coming from a different cultural, social, religious, and historical background) with the host culture in the UK.

(vi) Coping strategy

Coping strategy has been operationalized to involve various skills acquired, and actions taken by Nigerian immigrants in order to avoid stress and regain health/well-being, which can include internal/psychological resources (such as personal beliefs - mediated by religion/culture, self-efficacy, personality trait, self-esteem, etc.) or external/social resources (typified by social support from families, friends, or groups/institutions – which can be voluntary, religious/cultural or professional). Such skills as referred here are found to be predicted by cultural knowledge/education, cultural distance, cultural identity, language proficiency, length of stay in the host culture, and level of contact with hosts (Atcaca & Berry, 2002). This thesis focused more on identifying themes related to active coping skills such as social support from families and institutions (religious or social institutions) relevant to the religio-cultural background of the research population. Social support as an aspect of coping strategies refers to the reliance on certain groups or individuals, such as family members for help during moments of stress, or illnesses/symptoms (Sarason, Levine,

Basham & Sarason, 1983). This could take the form of informal social support that is local from friends, relatives, and peers; or formal support from groups and other formal organisations.

(vii) Social capital

This is simply viewed as social resources, and shared values that link people together in mutual trust to enable them work together through civic participation or fellowship for the development of both human and material resources (Gillies, 1998; Leeder & Dominello, 1999; Loury, 1987; Putman, 1995). The useful asset to this research is this construct's capacity for bonding among members (bonding social capital) and the capacity also to bond across groups (bridging social capital) (Gittell & Vidal, 1998; Narayan, 1999).

(viii) The Theory of Transformative Coping (TTC)

This theory proposed by Corry et al., (2013, 2014) involves a combination of creativity and spirituality that, 'builds resilience which buffers against stressful experiences and can help improve and maintain mental health and wellbeing. It constitutes active cultivation of personal resources while simultaneously reducing deficiencies.' (2014, p.103). With regard to creativity, existing studies (Puig, Lee, Goodwin & Sherrard, 2006) confirm that creative arts therapy has been effective on the emotions, spirituality, and psychological wellbeing of cancer patients. Their study concluded that creativity transformed negative emotions to positive ones to enhance psychological wellbeing. The details of how this programme can become feasible at the grass-root care level are provided at the recommendations section of this thesis (see 8.1.2.3 [iii]).

2.3 Research problems and aims

Research questions

1. What are the socio-cultural and religious determinants of health-seeking approaches employed by Nigerian Christians in the UK during illnesses and symptoms?

2. What is the role of religious affiliation, educational level, professional status, acculturation, and self-efficacy on health services utilization?

3. What important strategy could facilitate the development and sustenance of a culture-context and integrative model for health services utilization among Nigerian migrants in the UK?

Statement of the research problems

The changing face of the UK patient population due to increased migration has resulted in health disparities between minority immigrant groups and their British counterparts. Some reasons adduced for the incidence of poor healthcare utilisation among immigrants was their reliance on other treatment methods based on their religion and culture. To address this situation, it became necessary to adopt changes that can enhance health services utilisation, especially for the hard-to-reach migrant groups, such as the recent reorganisations within the NHS, where it became possible that patients can choose a treatment approach/care method that suits their unique circumstances and cultural beliefs, not necessarily in accord with Western-based biomedical model (Anderson, 1986). To ensure the success of this initiative has necessitated the need to incorporate vital information about immigrants' religious and cultural variations through health guides from among immigrant communities, who can also support people from within their local communities, in their own languages and

cultural orientations. Therefore, four empirical studies were carried out within this PhD to provide information about Nigerian immigrants' health behaviours that can help policy makers to assist other minority immigrant groups in the UK towards improved healthcare utilisation. Consequently, the research problems and aims of the respective studies are presented, and summarised below in the thesis main objectives.

Study 1: (chapter 3).

Research among Nigerians and other people of African descent showed evidence of poor health care utilisation due to religious, cultural and economic factors (Abubakar et al., 2013; Ogunsiji, Wilkes, Peters & Jackson, 2012); known to have also influenced their responses to illnesses in the context of migration as they relied on African traditional medicine and such other alternative therapies (Agbonyitor, 2009). Following this evidence, the WHO (1978) recognised complementary therapies, such as African traditional medicine as a care method, thereby addressing cultural needs in therapy. However, the rising influence of the Pentecostal religious movement in Africa and the diaspora poses a significant challenge to medical help-seeking among Nigerians. For instance, in Nigeria, available evidence shows that the indigenous ways of treating mental health have changed as many Christian converts turn to their spiritual leaders for help rather than the traditional healers or the psychologists (Okafor, 2009). The health implication is that among many Nigerian Christians, immigrants and non-immigrants alike, faith healing ministers have become the popular care approach in alternative to conventional therapists (Adekson, 2003). Despite this trend, little is known about any effort to incorporate the spiritual methods into the formal healthcare system. This lack of attention can only result in poor health outcomes and in most cases harm to the patients, especially for Africans who are known to be highly

religious (Kamya, 1997). To understand various factors responsible for these health inequalities and to meet the religio-cultural needs of the large immigrant populations in the UK, this study was designed to understand the socio-cultural forces within which Nigerians construct meanings and make health-related decisions, which is presently unexplored. The aim of study 1, is therefore, to use in-depth qualitative analysis (Thematic Analysis) to assess various responses to illnesses among adult, male and female Nigerian Christians currently living in the UK, after years of contact as adults born and raised within diverse religious and cultural settings in Nigerian before coming to the UK. This study approached the set objectives from the point of view of service users, so that the data were used to inform the subsequent study (Study 2) on the same phenomenon, but from a different perspective: Nigerian as service provider living and working in Nigeria. This aspect of the triangulation approach (within-study triangulation) ensures a holistic investigation of the research questions and systematically links the two qualitative studies from different points of view.

Study 2: (chapter 4).

Findings from study 1 were expected to show an effect of social, religious, and cultural factors in the choice of treatment methods from the perspective of Nigerians as service users. Although some general studies among care providers have shown that peoples' beliefs and values can influence therapy process and outcomes (Grencavage & Norcross, 1990), little is known in relation to Nigerian care providers and how their treatment approach could be influenced by their work contexts, or their beliefs and values, as well as those of their patients. Also, as little is known about the impact of such psychological and social determinants on health seeking among Nigerians from the perspectives of Nigerian care providers (the clergy, herbalists,

spiritual healers, and health professionals), these aspects of the thesis were explored using a cross-cultural study approach (Studies 2 and 3). Although it was expected that the clergy and health professionals who are well educated would not experience similar religious/cultural barriers to healthcare utilisation due to possible advantages of health awareness, there is a need for research to clarify such relationships. To do this, study 2 was designed as the first part of a cross-cultural study to investigate care providers' perceptions of health-seeking behaviours among Nigerians in their natural/heritage religious/cultural context before migration, how this influenced their attitudes to care provision, and to further explore potentials for collaboration among different care providers. The panoptic view and multi-purpose aim of this study made it useful as it explored both health seeking behaviours of Nigerian patients from the perspectives of their care providers, as well as providers' own illness responses and influences to care provision. It also investigated the potentials for collaboration among different providers towards integrative healthcare services, and the challenges that could face such integration. The aim was to provide basic background information on Nigerian immigrants and their health behaviours before migration. This can also provide the opportunity to better understand any changes in health behaviours due to immigration or acculturative strategies and thereby help policy towards implementing a successful culture-sensitive and integrative method that can make the healthcare services both in Nigeria and the UK (NHS) more effective in addressing the health needs of their patient population. The themes qualitatively derived from this study were inductively analysed using the processes of thematic analysis (TA).

Study 3: (chapter 5).

Following from the findings of study 2, it was expected that more information about the impact of religious and cultural factors of the Nigerian care context was necessary. This study forms the second part of the cross-cultural study already explained. This second part of the study was not intended as a comparative analysis, but aimed to use a cross-cultural approach to replicate the preceding study (study 2) in the context of migration, and possibility of acculturative influences while working in the UK. Therefore, it further explored Nigerian healthcare seeking from the perspectives of Nigerian clergy and health professionals working in the UK; to understand their experiences of medical help-seeking among Nigerians and consequently how social, cultural and religious factors can influence responses to illnesses for patients and care providers alike (especially the clergy and care professionals). Furthermore, it investigated important issues regarding willingness and challenges in collaborative effort among the clergy and health professionals towards an integrative healthcare considering the particular circumstance of the UK healthcare system. The proposal for this part of the study was to qualitatively derive and analyse vital themes than can provide information towards a culture-sensitive and integrative aspect of care that can be compatible to the NHS, through an Interpretative Phenomenological Analysis (IPA). By this, the NHS can be more effective in addressing the religious and cultural needs of a multi-cultural UK.

The issues of validity (honesty, depth, richness, rigor and scope) and reliability (credibility and neutrality) which can diminish the value and contributions of qualitative research were considered through cross-validation of data, using the inter-rater approach. Moreover, the many perspectives and contexts of the phenomenon considred within the three qualitative studies ensured a wide scope of data collected,

and the rigorous processes of data analyses also guaranteed sufficient depth and richness of results derived. Further details are contained in the reflexivity section for each study.

Study 4: (chapter 7).

As the preceding qualitative studies focused on pre-migration and post-migration determinants of health seeking behaviours among Nigerian Christian group, both as health services users and providers, it became pertinent to undertake an investigation that could be generalizable among the Nigerian immigrant population irrespective of religion. Hence, a quantitative research approach was adopted, using well established questionnaires to investigate the interplay between determinants in the uptake of medical/psychological services already identified in the qualitative studies, and other factors related to the context of immigration (such as acculturation orientations) as well as socio-demographic characteristics. The aim of study 4 therefore, was to investigate the roles of acculturation, religion, coping strategies, age, gender, religious affiliation, length of residence in the UK, education, and occupation in predicting medical help-seeking among Nigerian immigrants.

Aims of the research programme described in the following chapters

The themes underlying this research thesis were based on African/Nigerian religio-cultural and socio-political antecedents versus health seeking behaviours; as to what influences health-related behaviours and their construction (formation, sustenance, and variations). By this, health seeking behaviours are considered from a bi-focal perspective: Nigerian immigrants as individuals and as a social unit/social group. The second perspective considers the question - what values are shared among Nigerian

immigrants that bind them together, and which can be harnessed to enhance bonding across other groups while considering the health system and other empowered formal systems in the society towards a smooth integration? The idea is that in a multicultural society like the UK, the traditional cultural system of any migrant group should be considered pivotal in the design and delivery of any effective health intervention. This sensitivity for cultural diversity can enrich policy and produce cost-effective, and quality healthcare system through the different objectives within this thesis as summarised below:

1. To explore the determinants of health-seeking behaviours of Nigerians in the UK; and identify barriers and facilitators to healthcare utilization (Study 1).

2. To use a cross-cultural study approach (studies 2 & 3) to understand social and psychological determinants of health seeking behaviours among Nigerians at home and in the diaspora from the perspectives of clergy, herbalists, spiritual healers, and health workers; and to explore the potentials for clergy-health professional collaboration towards a culture-context and integrative healthcare provision.

3. Understand the roles of acculturation, religion, coping strategies, and some socio-demographic factors in predicting and enhancing positive attitudes towards seeking medical help by Nigerian immigrants in the UK (Study 4).

The aims and objectives set in the studies outlined above were pursued through a well formulated research design incorporating triangulation of methods in a mixed methods approach described in the next sub-section.

2.4 Research Methodology: An Overview

To pursue the objectives described above, this research adopted a mixed methods approach, involving the use of both quantitative and qualitative methods (Greene, Caracelli & Graham, 1998). For quantitative data collection, questionnaires were used to collect numerical and measurable data (Teddlie & Tashakkori, 2009); while semi-structured, in-depth interviews for in-person and focus group discussions were adopted for the exploration of participant experiences through the qualitative approach (Saunders, Lewis & Thornhill, 2007). The mixed methods followed a sequential mixed-designs strand, with three qualitative methods first (studies 1, 2, & 3), followed by one quantitative approach last (study 4) occurring at different stages in chronological order (Teddlie & Tashakkori, 2009). The rationale for this approach is based on the pragmatic value of research objectives, which makes it possible to address diverse aspects of the research phenomenon, which otherwise would be impossible using only one approach tied to its unique methodological and philosophical commitments (May, 2007). It implies therefore, that the selection of a research method could depend on the purposes and circumstances of the research, as much as its 'methodological and philosophical commitments' (May, 2007, p. 297). For instance, research evidence shows the possibility and relevance for this approach by using research questions and hypothesis from quantitative and qualitative studies and drawing upon theoretical propositions (Schulenberg, 2007). Moreover, from the constructivist philosophical viewpoint, it is a better methodological approach to study multi-faceted social phenomena using a multi focal approach such as the mixed methods (Mason, 2006). Hence, as this research incorporates different types of research questions, it is only possible to address each of them using a mixed methods approach, which allows for a diversity of views on the subject and offsets the weaknesses inherent in one research

approach used alone. Here, what is important and adds value to research is to understand the phenomenon under investigation, which can open avenues for further research. For instance, qualitative measures using open-ended questions are expected to yield unanticipated information about the object of research, which has potentials for novel areas of interest suitable for a quantitative investigation (Shaw, 2001). Adopting the mixed methods approach therefore, shows outstanding advantages as an adaptable skill of inquiry compared with either quantitative or qualitative approaches used alone. However, it was acknowledged that employing these methods and their tools among human participants could impact on their well-being; a concern that was addressed by the University Ethics Committee, and noted at the concluding part of this sub-section ([i]). Also, presented within this sub-section (2.4) are the philosophical underpinnings behind the mixed methods design, as well as its practical implications for doing research (2.4.1). This is followed by a discourse on the philosophical underpinnings of the two analytic tools used in the qualitative approach (2.4.2): Interpretative Phenomenological Analysis - IPA (2.4.2.1) and the Thematic Analysis – TA (2.4.2.2). The third aspect presented here is a critical review of literature involved in the process of choosing the three measures (The MASPAD Scale, The Brief COPE Scale, and The Attitudes Toward Seeking Medical Care Scale) used in data collection for the quantitative study (Study 4) (2.4.3). The conclusion of this sub-section highlights the methodological interrelationships between all four studies through graphic representations (Figures 2.4 & 2.5), while specific details on each study designs, with justifications for using each research method, participant information, procedures, outcome measurements and the data analysis have been explained at the presentation of each study in their respective chapters.

(i) Ethical Issues

Although applying the research methodology for this PhD did not involve minors or vulnerable adults, it was anticipated that sensitive and emotional aspects of being an immigrant and in the minority, could affect the participants. Also, the issues associated with illness and needing help/treatment, such as the psychological impact of 'vulnerability' and 'stigma/shame' were expected. These potential adverse effects were managed by adopting a moderate language/terminology during the interviews and for the questionnaires. Moreover, appropriate help-lines were provided for professional advice/care if needed. Satisfaction with other details in this regard were confirmed by the University Ethics Committee before commencing each study.

2.4.1. Philosophical underpinnings of mixed methods

The approach used in this thesis as described above, is also known as triangulation involving both qualitative and quantitative methods to investigate health seeking behaviours among Nigerians in the UK, with a view to providing vital information for an integrative and culture sensitive healthcare system, and therefore, enhancing health services utilisation. However, to understand issues involved in 'mixing' methods, it is pertinent to understand the meaning and nature of the 'mixed methods' approach to research, through the historical and philosophical assumptions behind its development and use as a methodology. As the name implies, and bearing from its methods and design, a 'mixed method' approach involves the use of both quantitative and qualitative methods to conduct a research where data for analysis are represented in numbers and words, hence, its quantitative and qualitative aspects respectively. However, this approach moved from methods approached in definition to a definition based on methodological orientation, where the entire research process could be based on various philosophical positions underpinning both quantitative and

qualitative methodologies and reflected at all phases of research regarding a particular phenomenon. By implication, this involved both ontological issues (what is, and what is knowable), and epistemological issues (what is knowable and how we can come to know it).

From the foregoing, a mixed methods approach has become a unique research framework underlying the process of doing research in an integrative way, by incorporating both qualitative and quantitative approaches into a unified and distinct whole. Ipso facto, this notion rejects the traditional dichotomy between qualitative and quantitative methodologies (Plowright, 2010). By implication this approach is suggestive of a new way of looking at reality and making sense of the social world by unifying the philosophical dichotomy underpinning the qualitative and quantitative methodological approaches to research. However, this unification raises some ontological and epistemological problems that are fundamental to research as they particularly relate to philosophical and axiological issues, which need to be resolved in order to justify the propriety of mixed methods in research.

(i) Philosophical issues

To appreciate the ontological and epistemological issues involved in doing mixed methods research, the issue of paradigm debate is raised dealing with differences and conflicts arising from competing worldviews on how to do research, mainly between positivism/post-positivism on one hand and constructivism/interpretivism on the other (Teddlie &Tashakkori, 2009). This approach is reductionist and deductive by focusing on interrelations between selected variables (Oliver, 2010). This view mostly influences the use of quantitative approach, with hypotheses development and testing. Ontology here is more of a realist ontology,

which assumes that data is numerical and measurable, using such methods as the questionnaire. Constructivism on the other hand, upholds that the meanings of phenomena are constructed through the subjective meanings of participants based on personal experiences and social interactions. These are in turn interpreted by researchers as they understand it. This worldview gives rise to a qualitative approach based on the nominalist ontological view, meaning that phenomenon is less precise and not numerically measurable but descriptive, and interpretive (Oliver, 2010). Hence, the use of such methods as interview or focus group for data collection within the three qualitative studies in this PhD.

Following these philosophical differences, controversies continued over their unification in a 'mixed methods' approach, especially due to the fundamental differences in their paradigms and methods as encapsulated in the 'incompatibility' and 'compatibility' debate (Teddlie & Tashakkori, 2009). However, pragmatism as a philosophical paradigm is pliable to multiple research methods while dealing with a similar research problem, rather than being rigidly fixed to a particular theoretical style (Onwuegbuzie & Leech, 2005). Therefore, adopting a pragmatic worldview gives credence to the use of the mixed methods approach in this project because it upholds that reality is one and many, singular and multiple, as seen from varying perspectives that are not mutually exclusive.

(ii) *Axiological issues*

Another issue arising from the mixed methods approach follows from questioning the uniqueness of its designs and procedures as concrete and practical tools of doing research and question the value it has added to research, above and beyond the qualitative and quantitative approaches used alone. Research evidence

shows that mixed methods assumes a fluid stance through pragmatism so that various philosophical worldviews and research paradigms become adaptable to the research process either individually or in combination, irrespective of differences (Onwuegbuzie & Leech, 2005). Therefore, to attempt a reconciliation of the 'compatibility' and 'incompatibility' debate discussed above, available evidence (May, 2007; Schulenberg, 2007) shows that the driving force for adopting a mixed methods approach was for the pragmatic purpose of addressing diverse aspects of the same research phenomenon, where different angles and questions relating to the phenomenon were examined; which otherwise would have been impossible. This success shows that the connection thought of as an unbreakable umbilical cord between philosophical views and methods, is a mere tendency rather than definitive connection. Therefore, a successful paradigm shift could be achieved if the selection of a method depends '…on the purposes and circumstances of the research, rather than being derived from methodological and philosophical commitments' (May, 2007, p. 297).

Following the multilevel structure of this thesis, it was not possible to intrinsically hinge it upon a specific methodology with an existing theory or model, rather a mixed-methods of an inductive approach was adopted with more qualitative studies (studies 1, 2, & 3) at a micro research level to explore beliefs and attitudes related to illness responses. This is in the hope that findings can help to illuminate the processes of any existing model that can be useful at the macro level stage (study 4), using the quantitative approach (Smith, 1996). Also, because the research population in this thesis was composed of multiple groups that constituted a psychologically meaningful cluster, with potential relationships (between and within groups) that can vary, it was necessary to approach the thesis with due recognition of its hierarchical nature. This

is especially for the quantitative study (study 4), where it was possible to investigate potential group differences and predictions using the hierarchical multiple regression as an analytic tool; which is not possible with other statistical tools such as the ANOVA. The analytic tools employed within the triangulation approach of this thesis are detailed in the next section.

2.4.2 Qualitative research tools relevant to this thesis

2.4.2.1 Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is based on the philosophical and epistemological notions of phenomenology and hermeneutics (Finaly, 2009). Phenomenology is a philosophical idea construed and popularised by some of its leading proponents such as Heidegger (Finaly, 2009), on the basis that we acquire knowledge by subjective experiences, that is, how we experience the world around us; while hermeneutics is concerned with how humans understand and interpret such phenomenon or experiences of the world around them. Applying these principles in research therefore, the researcher interprets the phenomenon of interest (the lived experiences of research participants) from the expressed perspective of the other/subject who was directly engaged with the phenomenon. This tool was adopted for the qualitative analyses in study 3; as it is most suitable for such an initial study among Nigerian care providers (clergy and health professionals) working as immigrants in a socio-cultural and religious context different from their own. This analytic approach was also deemed appropriate as it allowed for the process of 'double hermeneutics' (Smith, 1996), which characterised study 3 because participants tried to interpret their observations of health seeking behaviours among Nigerians based on their own experiences as care providers, while the researcher tried

to coordinate these experiences into a single and meaningful whole. IPA as an analytic tool can be used to develop theories, models, as well as explain observed human behaviours (Fade, 2004). Hence, it is suitable for the thesis presented in this PhD, which is not rooted on any pre-established psychological theory or model, but aims to understand observed phenomenon with the hope that future theories could emerge and findings can make pre-existing models more relevant for future research.

2.4.2.2 Thematic Analysis (TA)

Thematic Analysis (TA) is acknowledged as a distinct and widely used analytic tool, though poorly demarcated from other tools with similar features within psychology, such as the IPA discussed above or grounded theory (Boyatzis, 1998; Braun & Clark, 2006; Roulston, 2001). Due to its fundamental nature in qualitative analysis, the TA aspect of 'thematising meanings' has been viewed as cutting across other methods of analyses (Holloway & Todres, 2003, p.347); and therefore, some researchers have subsumed it as a mere process while using other analytic tools such as the grounded theory (Ryan & Bernard, 2000). However, as rightly proposed by Braun and Clark (2006), TA can be used as an analytic tool on its own as applied in this thesis. Overall, the seeming limitation shown above can be properly understood as the strength of the TA, making it flexible and compatible with other methods and analytic tools. Therefore, the TA was adjudged an adequate tool to analyse data in studies 1 and 2 of this thesis, where both individual interviews and focus group discussions were used.

2.4.3. A Critical Review of Quantitative Measures

The research population in this thesis was composed of multiple groups that constituted a psychologically meaningful cluster, and important variables were derived across different factors with potentials for cross-level interactions. Hence, it was necessary to employ different measures to obtain the needed information for a hierarchical multiple regression analysis. To find questionnaires that met the criteria for this study, several literature searches were carried out using the PsychInfo and Ebsco data bases. The aim was to find appropriate questionnaires or subscales measuring acculturation, coping strategies, African belief systems, and health seeking behaviours. The following scales were identified and assessed for reliability, validity, conciseness, and propriety for the research population:

(i). The MASPAD

Although, researchers have developed generic acculturation scales for use among people of any ethnic group (Ryder, Alden & Paulhus, 2000; Stephenson, 2000), they were not considered fit for this study because each acculturation context and immigrant group is unique (Berry, 2003). Therefore, a suitable scale for this study needed to be relevant to the African immigrants' religio-cultural and historical orientations comparable to those of Nigerian immigrants in the UK. An initial review of literature on existing questionnaires for the measurement of acculturation revealed the availability of many questionnaires, which was narrowed to scales developed for African people, such as the improved and revised versions of the African American Acculturation Scale (AAAS, AAAS-R) (Klonoff & Landrine, 2000), the Vancouver Index of Acculturation (VIA) (Ryder, et al., 2000), and the Measurement of Acculturation Strategies for People of African Decent (MASPAD) by Obasi and Leong (2010).

However, the MASPAD was preferred because it is bi-dimensional, and culture-specific to people of African descent, having good validity and without some objectionable items of the AAAS-R viewed as not representative of African cultures. The MASPAD measure for acculturation was also validated as a reliable, self-reported acculturation scale widely used among African immigrants, with validity test showing Cronbach's α = .82 and reliability test = .87 (Obasi & Leong, 2010).

Other widely validated and reliable acculturation scales found included the African American Acculturation Scale (AAAS-R), which is a 47-item bi-dimensional scale that measures three categories of acculturation in terms of cultural traditions, values, beliefs, assumptions, and practices of the immigrant. These important categories include (1) acculturated: being integrated into the host culture, (2) traditional: immigrants remaining in their own cultural traditions, or (3) bicultural: immigrants being actively involved in both the traditions of their own and of the host society. Other acculturation scales related to African immigrants do exist, such as the Acculuration Scale (AfAAS) by Snowden and Hines (1999). Among these, the MASPAD provides additional advantages over the AAAS-R and the AfAAS, as it is most recent, has fewer items (45 items), and measures all four acculturation categories (traditionalist, integrationist, assimilationist, and marginalist) proposed by Berry (1980). Moreover, it is more culture-specific, as it considers issues of traditional culture from 'various dimensions of African worldview, philosophy, traditions, and cultural practices' and therefore, proven to be better than scales meant for any ethno-cultural group (Obasi & Leong, 2010, p. 527); such as the Vancouver Index of Acculturation (VIA) by Ryder and colleagues (2000). Also, with reference to the AAAS-R, the MASPAD has more items that are representative of acculturation for African immigrants, while the AAAS-R is criticised for containing religious items (such as 'I

believe in the Holy Ghost', 'I am currently a member of the Black church' or 'I used to sing in the church choir'), that presupposes the adoption of Western religion (Christianity) by enslaved and colonised Africans, thereby excluding practices of African or Arab religious/spiritual system (such as Islam, Akan, Ifa, Santeria, Vodun, etc) (Obasi & Leong, 2010). In addition, the MASPAD incorporates some additional subscales that measure some constructs of interest in this study such as *African religious/cultural beliefs* that can particularly influence illness perception/causal attribution among this research population. By incorporating these factors (acculturation and religion) into one scale, it was possible to reduce the number of questionnaires and response items. This approach is likely to enhance participant interest and response rates required for this study, as previous research confirms that shortening the scale while maintaining excellent psychometric value saves time in research protocols (Worthington et al., 2003). The final choice of the MASPAD scale therefore, was based on its propriety, weighting its advantages over other scales commonly used among Africans. However, as the scale developers had granted permission to adapt the scale to the purpose of the present study among immigrants of African descent in the UK (Appendix 4), further analysis was conducted on the scale adapted for the UK population and an acceptable cronbach's alpha for a 6-factor solution was considered an improvement on the multidimensional scoring of the MASPAD. This decision was also based on the orthogonality check on the MASPAD at both bi-dimensional (r = .071 to .246) and multidimensional (r =.032 - .264) levels across three of its original studies, which provided sufficient evidence for an independent assessment of each acculturation strategy (Obasi 2004). Hence, this study adapted and scored the MASPAD as a multi-dimensional scale, with possible overall total scores ranging between 0 – 180; where individual item scores of 1-3 were

regarded as low and 4 to 6 as medium to high scores. The detailed procedure for this is shown in the study chapter – 7 (7.5.2.1).

(ii). The Brief COPE

A search for an appropriate coping scale for this study resulted in three measures: The Wellbeing and Coping Measure (Howard et al., 2003), the Brief Resilient Coping Scale (BRCS) (Sinclair & Wallston, 2004), and the Coping Resources Inventory for Stress - Short Form (CRIS-SF) (Matheny & William, 2010). However, two factors determined suitability of a coping scale; it was necessary that the measure should be short to avoid a too lengthy questionnaire package and high rate of attrition in view of four concepts being measured; and the choice of scale was expected to contain items on religious/cultural coping styles relevant for use among African immigrants. Therefore, a critical review of identified measures focused on the number of items, the target population and their number, as well as scale validity and reliability.

Although the Wellbeing and Coping Measure contained fewer items, it was found to focus on aspects of well-being such as self-blame, self-efficacy and control, which were not expected to be relevant to the current study. The Brief Resilient Coping Scale *(BRCS)* only captures the tendency to cope in adaptive manner, and was adjudged inappropriate as the current study was not interested in participants' resilience in coping. The Coping Resources Inventory for Stress‑Short Form *(CRIS-SF)* (Matheny & William, 2010) is a 70-item scale with high internal consistency reliabilities ranging from .78 to .93, but designed to measure strengths and weaknesses of coping resources in relation to patient's lifestyles rather than identifying the coping resources used by clients. Moreover, it has too many items and was also

rejected. The Daily Religious and Spiritual Coping Scale--Short Form (Keefe et al., 2001) assesses positive and negative religious/spiritual coping but focused on the perceived salience of religion in coping with rheumatoid arthritis pain, a specific health condition not relevant to the current study. Other measures found to contain some items needed for the current study were the List of Coping Strategies by Mena et al., (1987), and Brief COPE Inventory (Carver, 1997); both of which were compared for the most appropriate. The List of Coping Strategies has the advantage of fewer items (9), but was used alongside the SAFE acculturation scale among different generations of US immigrants. Also, it was deemed to be an older scale, and considering that the MASPAD (an acculturation scale) was already part of the questionnaire package this scale was not chosen for the present study. The Brief RCOPE on the other hand was rejected because, while it measured positive and negative patterns of religious coping, it failed to include other aspects of coping such as social support, which is vital in the current study. Therefore, the Brief COPE Inventory was found to be a better alternative, being a widely used and validated scale that measures different aspects of coping with stress, and showed the following Cronbach's α: active coping = 0.68, planning = 0.73, positive reframing = 0.64, acceptance = 0.57, humour = 0.73, religion = 0.82, emotional support = 0.71, instrumental support = 0.64, self-distraction = 0.71, denial = 0.52, venting = 0.50, substance use = 0.90, behavioural disengagement = 0.65, self-blame = 0.69 (Carver, 1997). This scale was chosen for use in the current study because it has the added advantage of adaptation following authors' instructions. Hence, it was adapted for use in the present study with only 16 items from 8 subscales (active coping, religion, emotional support, instrumental support, denial, venting, behavioural disengagement, and self-blame) of the original 14 subscales (2 items per scale), all in straight question format (no reverse item). All items were scored

1- 4 following the Likert response format, with possible total score ranging from 0 - 64. The details of the validation and use of this scale are contained in the study section - chapter 6 (6.5.2.2).

(iii). The Attitudes Toward Seeking Medical Care Scale

Data for *Health seeking behaviour/health services utilisation* was collected using a widely validated and reliable scale called the *Attitudes Toward* Seeking *Medical Care Scale* (Fischer, Dornelas & DiLorenzo, 2013), following a refined search on the most recent and relevant scales. The literature search on health seeking behaviour questionnaires resulted in a number of scales of interest, such as the Medical Information Seeking Scale (Miles & Wardle, 2006), Barriers to Help Seeking Scale (Mansfield, Addis & Courtenay, 2005), Barriers-to-Care Checklist (Vanheusden et al., 2008), Attitudes Towards Seeking Medical Care Scale (Fischer et al., 2013), Help-Seeking Intentions Scale (Dean, Wilson, & Russell, 2007), Help-Seeking Questionnaire (HSQ) (Sabina, Cuevas & Schally, 2012), and Help-Seeking Decisions Measure/Willingness to Engage in Help-Seeking Behaviour Measure (Hammer & Vogel, 2013).

The Medical Information Seeking Scale, has fewer items, it focuses on information seeking rather than actions. The Willingness to Engage in Help-Seeking Behaviour Measure or the Help-Seeking Decisions Measure (Hammer & Vogel, 2013), showed high validity scores and few items, but used the two information-processing pathways (the reasoned pathway and the social reaction pathway) to predict help-seeking decisions on students experiencing psychological distress by using four artificially created help-seeking scenarios. Hence, the actual items were considered unsuitable for the current research population as they were student-focused and

psychological health oriented with suggested scenarios. Also, the Barriers to Help Seeking Scale (Mansfield, Addis & Courtenay, 2005) was found to be gender-based as it was developed to investigate only men's attitude to professional help-seeking. Finally, the Barriers-to-Care Checklist (Vanheusden et al., 2008) with 18 items and two sub-scales to assess practical (cost, time, or geographical availability) and psychological barriers to health-seeking was found to contain some appropriate items. However, it was applied to a population of Dutch adults who admitted mental health problems but who did not seek professional help; and such particular research population did not match the needs of the current study.

The Attitudes Toward Seeking Medical Care Scale (Fischer, Dornelas & DiLorenzo, 2013) was one of the most recently developed scales with 35 items on attitudes toward seeking medical help. The scale comprises four sub-scales: attitudinal factors (pro-action intention), cynicism/fatalism, issues of trust in the medical profession, and procrastination/avoidance actions (using 16 unreversed items and 19 reversed items), with Likert type measure scored 3, 2, 1, 0 for unreversed items and 0, 1, 2, 3 for reversed items. However, as the current study focused on the action/intention of participants towards seeking medical care, a factor-analytically derived 12-item action/intention subscale of this measure was adjudged most appropriate for use. This is because, it not only helped to minimise the growing number of items in the entire questionnaire package, it also addressed the research interest more specifically and adequately. Moreover, the pilot study by the scale developers attested to its predictive validity, with test-retest reliability at $r = 0.91$ (DiLorenzo, Fischer & Dornelas, 2012). Furthermore, a more recent study to validate the association between attitudes and behaviours using the action/intention subscale was replicated by the authors (DiLorenzo, Dornelas & Fischer, 2015) and it was shown to

be internally consistent at r = .82. Therefore, it was concluded that the 12-item action/intention attitude subscale of the Attitudes Toward Seeking Medical Care Scale (Fischer, Dornelas & DiLorenzo, 2013) adequately measured health care utilisation among the research participants, with responses (agree, partly agree, partly disagree, and disagree) scored 3-0 for straight items (S: 2,3,5,6,7,8,9,10,12) and 0-3 for reversed items (R: 1,4,11), with a score ranging between 0-36 (where 0/1 = low scores and 2/3 = high scores). This subscale was adjudged more appropriate than other measures found in the literature, as most of them were designed for specific health conditions, especially mental health conditions, and for particular ethnic groups.

In addition to the factors measured above, some socio-demographic information, such as age, gender, religious affiliation, education, profession, and length of years in the UK were included as the first part of the questionnaire package. The relevance of these variables is based on the methodological requirements of the quantitative study and its research questions as shown in the figures presented below. The next chapter (chapter 3) provides the first empirical study on health seeking behaviours of Nigerians as immigrants in the UK.
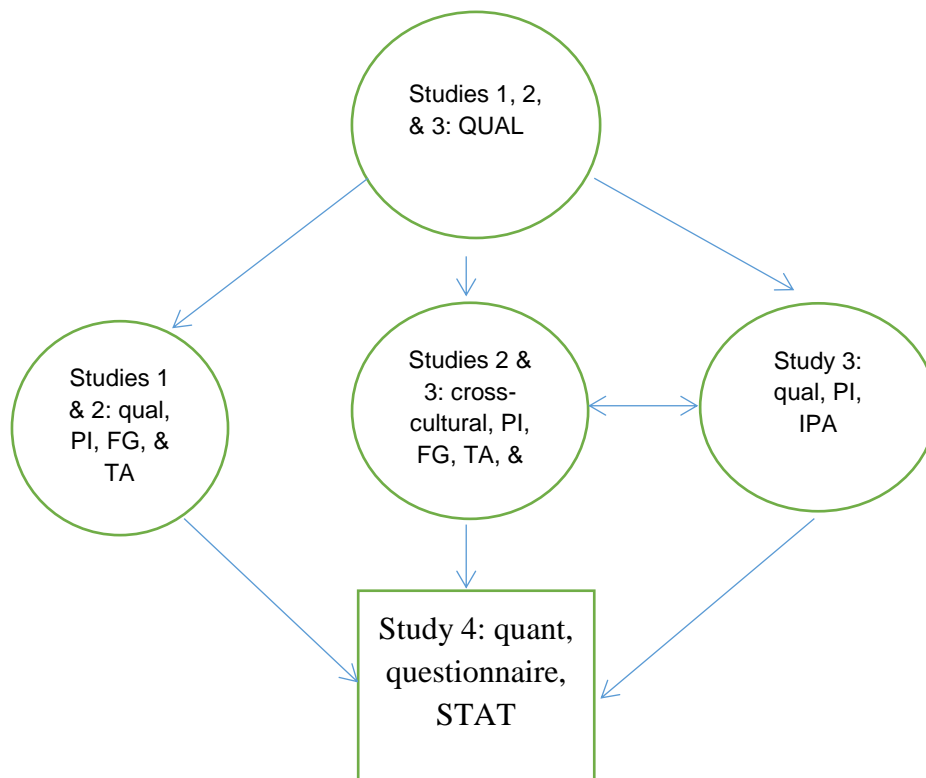
Figure 2.4. Methodological differences and similarities between studies (Qual = qualitative, PI = personal interviews, FG = focus group, TA = thematic analysis, IPA = interpretative phenomenological analysis; Quant = quantitative, STAT = various statistical analysis).
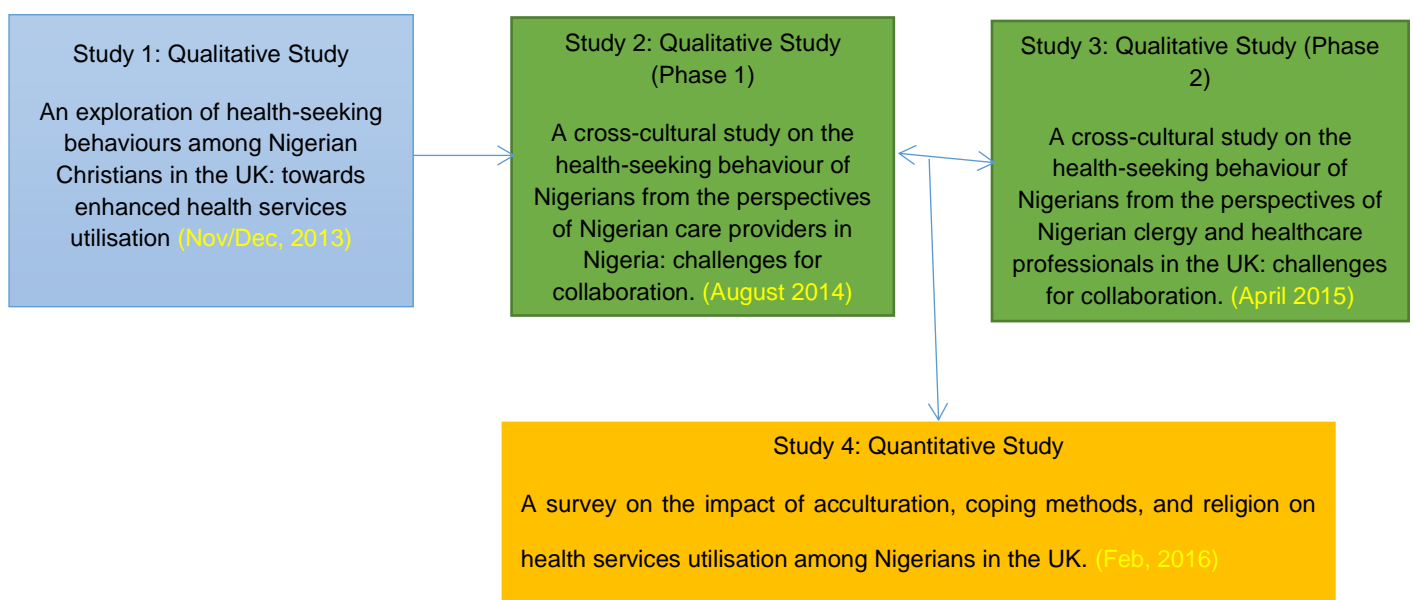
Figure 2.5. The relationships between studies, and how data derived from each of them informed the development of subsequent studies.

CHAPTER THREE

STUDY 1

Title: An exploration of health-seeking behaviours among Nigerian Christians in the UK: towards enhanced health services utilisation

3.1. Introduction

3.1.1 Summary

The previous chapter explained that health is a multidimensional concept involving cultural, psychosocial, economic and spiritual aspects. Consequently, there is a possibility that health-related decisions can have moral implications through which meanings are inferred regarding aetiology, possible treatment approaches and their outcome. It is important that immigrant patient health behaviours need to be contextualised to appreciate their proper meaning and impact (Hausmann Muela & Muela Ribera, 2003). Within the context of immigration, the issue of ethnicity and unequal power relations are vital for a broad consideration of how various determinants influence health seeking behaviours as already discussed (see 2.1.1, 2.1.2). Moreover, the additional acclimatisation challenges that impact immigrants' health and wellbeing, raises the issue of vulnerability and equity in access to available health services (Hausmann-Muela & Muela Riberia, 2003), as well as the promotion of health strategies that strengthen immigrant communities. Research in Africa using this approach has been shown to be successful with a model of health systems aimed at supporting the prevailing lifestyle of the people (Wiese, 2002). The implication for Nigerians living in the UK is that they could face many personal, cultural, and environmental barriers in accessing medical help while adjusting to physical and psychosocial consequences of immigration more due to the weak social capital

prevalent in their country of origin before migration; as revealed in study 2 (see 4.2).

Therefore, there is a need for research to focus not only on immigration-related factors (ethnicity, racism, language, culture and religion, negative stereotypes), but also to extend considerations towards the role of social capital in understanding migrants' health-seeking behaviours and outcomes (Gerrish, Chau, Sobowale & Birks, 2004). To the best of the researchers' knowledge, there is no research evidence on this aspect of healthcare seeking among this research population. The consequence is an improved understanding of this community and how adherence to their religious and cultural tenets can impact their health-seeking behaviour. This chapter contains reports on findings from an empirical qualitative study on the perceptions, attitudes and responses to symptoms/illnesses, of Nigerians in the UK. This is based on data derived from both semi-structured, in-depth interviews and focus group discussions (FGD) (McNeela & Bredin, 2011) towards the realisation of the set objectives; from the point of view of service users, while using the two subsequent empirical studies (Studies 2 & 3) to explore the same phenomenon from the perspectives of Nigerian service providers.

3.1.2 Background to study

The previous chapter dealt with the literature on factors that influence patients' decisions to seeking health-related help. The review acknowledged the complexity of the research evidence and identified a plethora of factors implicated by existing theories and models. Nevertheless, little is known about healthcare seeking behaviours among Nigerian immigrants in the UK. At most, research in Nigeria and other parts of Africa showed evidence of poor health care utilisation due to religious, cultural and economic factors (Abubakar et al., 2013; Ogunsiji, Wilkes, Peters &

Jackson, 2012). These factors are shown to have influenced health seeking behaviours among Africans at home and in the diaspora, toward self-treatment or home management using African traditional medicine, and other alternative means at their disposal (Fawole, Akinboye, Folade, Arulogun & Adeniyi, 2008; Agbonyitor, 2009). Other studies among African immigrants as well as other minority immigrant communities such as African Americans, show a significant rate of health care underutilisation, especially for mental ill health (Cheung & Snowden, 1990; Leong, 1994). This outcome has been attributed to cultural diversity where those from minority ethnic groups are less likely to seek out counselling services, and are more likely to experience misdiagnosis when they do, compared to those of the dominant culture, usually Caucasian; leading to early termination of therapy (Sue & Sue, 2004). The WHO responded positively to the situation through the Alma Ata Declaration of 1978. Hence, the inclusion of complementary therapies (such as African traditional medicine), as a way of addressing the cultural needs of the world's diverse patient population was recognised (WHO, 1978). However, little is known or documented about the interaction between the formal and informal healthcare systems and sparsely so in the developing countries (Anwar, Green, Norris & Bukhari, 2015).

Moreover, the rising trend of the Pentecostal religious movement in Africa and the diaspora poses a significant means of alternative treatments (spiritual or faith-based healing) among Nigerians in preference to African traditional medicine. Available evidence shows that the indigenous ways of treating mental health for instance, in Nigeria, has changed with converts to Christianity now turning to their spiritual leaders/ministers for spiritual healing rather than the traditional healers/diviners of African traditional religion (Okafor, 2009). The health implications are that among many Nigerian Christians, immigrants and non-immigrants, faith

healing ministers have taken the place of conventional "therapists" for their health problems (Adekson, 2003). Agbonyitor (2009) showed that among the Plateau people of Nigeria, a successful home-based intervention for people living with HIV/AIDS (PLWHA) in such endemic region was faith-based (Gospel Health and Development Services). Church-based health programmes for mental health among African-Americans is also shown to have received increased attention as an approach to mental health management (Hankerson & Weissman, 2012; Peterson, Atwood & Yates, 2002; Wells et al., 2004). Despite this, nothing is known about efforts to recognise and incorporate this method into the formal healthcare system. This lack of attention to an emerging trend in healthcare management cannot remain out of research focus. Africans are highly religious and they believe that, belonging to a religious association is a means of expressing self-identity as well as cultural identity (Kamya, 1997); which can contribute to religion-guided health-seeking behaviours.

There is therefore a need for new research to determine what factors impact upon health care seeking behaviours to provide a better understanding of possible relationships between Nigerian immigrants' health behaviours and religio-cultural beliefs. A qualitative research approach was used to consider a broad range of factors that define Nigerian immigrants as a social unit. This approach was preferred as it provides the additional benefit of extending healthcare seeking decisions from the responsibility of the individual, to issues outside the health domain (such as social capital), within which health decisions are embedded. This study therefore, has been designed to understand this immigrant community and the social forces within which they construct meanings and make health-related decisions. An initial study of this kind requires an inductive qualitative research approach to explore how participants make meaning of their experiences (Shaw, 2001). By this, potential barriers and facilitators

to Nigerian immigrants' health-seeking attitudes were explored, and related to their story as a reflexive community.

3.1.3. Aims

This very study aims to explore the experiences of health-seeking among Nigerian Christians in the UK, in order to identify potential barriers and facilitators to health services utilisation.

3.1.4 Research question

How do Nigerian immigrants respond to illnesses/symptoms, and how can this impact on healthcare utilisation?

3.2   Method

3.2.1 Design

This is a qualitative study using semi-structured interviews (One-to-one Interviews and Focus Group Discussion) for primary data collection (Saunders et al., 2007). This was considered suitable for in-depth exploration of participants' processes of meaning-making about their experiences of finding cure during illnesses/symptoms (Ritchie & Spencer, 1994; Brocki & Wearden, 2006; Chapman & Smith, 2002). The interview method was also useful as it best captured participant's subjective experiences, as well as a deeper grasp of the sensitive aspects of their concerns as a minority group. Moreover, this research approach is flexible and interactive, with the possibility of using prompts during interviews in line with participants' chosen way of expressing themselves (Banister, Burman, Parker, Taylor & Tindall, 1999). This opened novel areas of research interest (Shaw, 2001) through the emergence of

unexpectedly rare, but strong themes vital in addressing the research question. This method is person-centred (Rogers, 1942, 1951, 1961), which allows participants freedom to air their views and for the researcher to interpret these views with an open, unbiased mind.   Meanings were derived from emerging themes, and rooted in the data.

The focus group discussion (FGD) was also adopted as it has the potential for utilising the group dynamics inherent in group interviewing to generate results and insights that may otherwise have been missed. This is of particular value to this research as it enhanced discussion and interaction among participants, thereby capturing a wider range of opinions considering the sensitive nature of the topic, and limited time and resources available. This aspect could provide valuable information on participants' collective interpretations of experiences; and demonstrate how cultural identities, social representations, beliefs and shared religio-cultural values contribute to social communication (Burgess et al., 1988). Using the focus group in addition, was also thought to provide rich data on the precise behaviour pattern of Nigerians and how they can influence one another during decision making processes, especially in terms of health decisions.

Qualitative analysis and interpretation of themes was based on the processes of Thematic Analysis (TA). TA was used to identify, analyse, and report themes derived from the dataset (Braun & Clarke, 2006). It was adopted as most suitable for exploring emerging themes during an initial study of this kind, and for interpreting vital aspects of the research question (Boyatzis, 1988). The coding process and write-up was based on a thematic network style of presentation espoused by Attride-Stirling (2001); with the aid of the Nvivio 10 software. This follows a six-step pattern of arriving at themes useful for analysis (see Table 3.2). This aspect also draws on the relationships

between the data set (individual interview = 4 transcripts, and the focus group = 1 transcript), while exploring possible inconsistencies, contradictions, and tensions within and between the data.

3.2.2 Materials

The interview schedule comprised a set of questions designed to tap into cognitive, emotional, behavioural, socio-cultural, environmental, and medical aspects of help-seeking, highlighting - frequency, experiences, reasons for use or disuse, and alternative methods used. This was informed by an extensive literature search on the topic, and a pilot study that was conducted to ensure propriety of questions. The observations and suggestions from the pilot interview as shown later in the Procedure sub-section (3.2.4), resulted in minor adjustments to the final interview questions. The schedule (interview protocol) used open-ended questions to obtain unanticipated information about the research phenomenon with potentials for opening novel areas for future research (Shaw, 2001). Two digital tape recorders were used during the interviews and focus group discussions, which were locked in researcher's personal locker provided by the University. The contents were further stored electronically by the supervisors in their pass-word protected office computers.

3.2.3 Participants

A purposive sampling approach (Willig, 2001) was used to choose participants with similar criteria relevant to the research question. In line with the principles of qualitative research, a relatively small and homogenous sample size was chosen to avoid the loss of vital, salient points during analysis (Brocki & Wearden, 2006). Recruitment was done through local contacts among members of Nigerian ethnic,

religious and cultural organisations in London. Inclusion criteria were based on their homogeneity, which included nationality, religion, place of birth, and immigration status/place of abode, with due consideration for equal gender representation. The exclusion criteria were non-Christian Nigerians, British-born and bred Nigerians, children (Nigerians aged below 18 years), and language (lack of confidence to be interviewed in the English language). Participants were selected from non-institutionalised Nigerian Christians living in London, irrespective of their acquisition of citizenship status from the UK, or any other country. Participants represented various tribes from the 6 geo-political zones of Nigeria. Ten participants (5 females and 5 males) were originally from 4 geo-political zones in Nigeria: North-East, South-East, South-South, and South-West. This distribution was based on availability and willingness to participate; hence it was not possible to find participants from the North-Central and North-West zones, known to be muslim-dominated. Six of the participants formed the focus group and 4 were involved in the face-to-face interviews. The number of years participants had lived in the UK varied from 3 to 40, (mean number of years = 12.6). Other participant characteristics are shown in Table 3.1, including their pseudonyms, and demographic distributions (gender, age ranges, origins, religion, educational qualifications, and occupations).

Table 3.1

Participants and their socio-demographic background

Participants	Gender	Age range	State of origin	SES/Others
1. Hajiya (P/I)	F	41-50	Gombe – North-East	Catholic, nurse, graduate
2. Mekus (P/I)	M	41-50	Cross-River – South-South	Catholic, clergy, post-graduate
3. Lola (P/I)	M	51-60	Oyo – South-West	Pentecostal, post-graduate, insurer
4. Ngene (P/I)	F	41-50	Enugu – South-East	Catholic, graduate, nurse
5. Chyomi (FG)	F	31-40	Akwa-Ibom – South-South	Pentecostal, degree, civil-servant.
6. Chebe (FG)	F	41-50	Imo – South-East	Pentecostal, nurse, degree
7. Ogo (FG)	F	Over 60	Anambra- South-East	Catholic, degree, retired
8. Ujama (FG)	M	41-50	Anambra - South-East	Catholic, graduate, civil servant
9. Ugbo (FG)	M	41-50	Anambra - South-East	Catholic/charismatic, degree, student.
10. Ugochi (FG)	M	41-50	Enugu - South-East	Catholic, postgraduate, teaching assistant

Note: P/I = Personal Interview, FG = Focus Group.

3.2.4 Procedure

Ethical approval was granted by the Department of Psychology, Middlesex University Ethical Committee (Appendix 1). A pilot study was conducted to investigate the feasibility of the study and suitability of the interview questions. For this, five (n = 5) participants were recruited through local contacts from the religious and cultural groups in London. Middlesex University was the scheduled venue, with research questions meant to explore meanings attached to medical help-seeking and corresponding actions taken to get well. This resulted in minor adjustments in the interview protocol (Appendix 5, amendments highlighted). For instance, the demographic information on age was originally specific (Age…), but was later changed to be non-specific as 'Age range' because some participants were not comfortable to disclose their exact age. Also, using the term 'health-seeking' was considered too technical for participants and was avoided in the actual protocol to avoid any confusion or misinterpretation that could potentially affect response. The final question (s/n 8) on participants' opinion was also included to cover possible areas that may be omitted by the interviewer. However, the feasibility checks from the pilot study showed an impending obstacle, as participants raised their concern about the venue – that traveling to the University for Interview could potentially discourage participation due to financial difficulties and logistic constraints. Consequently, the venue was changed from the University laboratory to St. John Fisher Social Club Hall in Bexley. The attention of the Ethics Committee was drawn to this change, with due authorisation to use the new venue (see Appendix 6). To select participants, an informal contact was made with members of some of the ethno-cultural and religious gatherings of Nigerians in London, and a total of 35 individuals were initially contacted through the snowballing process and only 31 individuals indicated their interest. Of the 31 potential

participants, 5 were excluded for various reasons: lack of time commitment (n = 2), non-Christian Nigerians (n = 2), and British-born and bred Nigerians (n = 1), with only 26 left. Then, 7 were later excluded for unavailability and below the age requirement (18 years and above), and 9 withdrew on their own volition (showing lack of confidence to be interviewed in the English language) leaving a total of 10 participants. Two participants indicated a preference for personal interviews, and two confirmed their willingness to participate in the focus group only, while six were willing to take part in either the interviews or the focus group discussion. However, it was necessary to agree on a date that suited all participants for the focus group and only six could make the proposed date. Therefore, the final arrangement was: four participants for the in-person interviews (n = 4) and six for the one focus group discussion (n = 6). Therefore, a total of ten (10) participants completed the study (see Figure 3.1).

Initial Contact: 35

Initial Interest: 31   Excluded: 5

Withdrawal: 9   Unavailable: 7

10 (Personal Interview (P/I) = 4, Focus Group (FG) 6
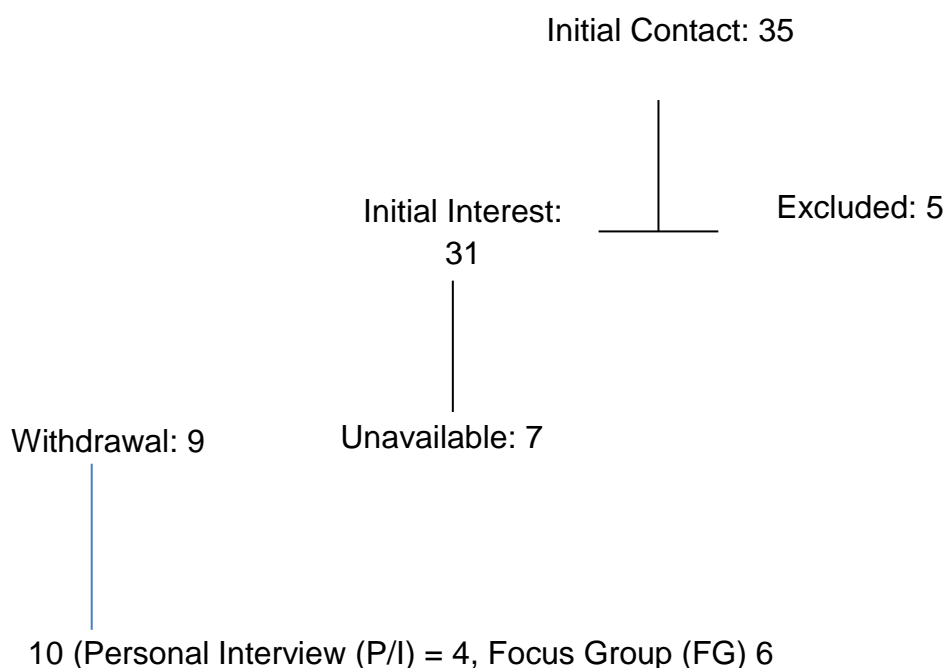
Figure 3.1. Recruitment process

Participants were given the details of the research schedule before the interview: the information sheets for both interview and focus groups with details of the research aims and participants' freedom to participate or withdraw at any time without having to offer any reasons for this; as well as aspects of confidentiality and anonymity. Participants were also informed of the interview procedure, and were assured of debriefing at the end of research (see Appendices 2:1 & 2:2). Two detachable Consent Forms were signed (Appendix 3) by the participants who kept their copies, as well as the Debriefing Forms (Appendix 4), while the researcher retained the duplicates. The choice of language for the entire process was the English language, to avoid misinterpretations that could result from using the vernacular. Nigeria being the most populous country in Africa, with the world's largest population of black people (Ifemesia, 1982), has more than 250 different ethnic/cultural groups and languages (Okafor, 2009). Interviews and focus group discussion were subsequently, conducted and recorded with 2 digital tape-recorders; and later secured in the University private locker provided for the researcher.

Data collection took place between November and December, 2013; with the individual interviews lasting between 50 to 60 minutes each and 2.5 hours for the focus group discussion. Interview recordings were later transcribed verbatim for analysis, with inaudible sentences denoted by ellipsis. Participants were each identified with pseudonyms for the purposes of anonymity and confidentiality, as well as for easy referencing during the analysis (see Table 3.1).

3.2.5 Analytic process

The thematic analytic approach (Braun & Clarke, 2006) adopted for this analysis is the semantic approach (Boyatzis, 1998); which involved the identification of themes

at a descriptive level of simple meaning supported by extracts from the data. Then this was taken further to an interpretative level supported by relevant theories to situate the analysis within broader meanings and interpretations relevant to existing literature (Patton, 1990). This process is guided by meaning making, achieved through a six-stage data coding process:

1) This stage began by transcribing and reading through the data, which was imported into the Nvivio 10 software. By reading through the data, the researcher attempted to make an initial and unfocussed appreciation of the text, to capture the initial impression of participants' expression of their responses to illness as migrants. This is an open unbiased encounter, with short notes recorded about each transcript to capture the general background of participants' responses. This is an initial process of identifying hunches or concepts that will develop into useful codes. This strategy involves data reduction into a more manageable unit, which is a helpful interpretative technique (Lee & Fielding, 1996).

2) The second step was used in making a choice of codes based on recurring issues that provide insight for the overall appreciation of participants' responses, as well as their relevance to answering the research question. Relevant codes were applied to the appropriate segments of the data, so it can be organised into a schematised meaningful and manageable data set for easy analysis (Attride-Stirling, 2001). These basic nodes or subordinate codes formed the basis for the inductive process of deriving higher categories of themes.

3) The third step in this process was to organise similar basic themes around a higher order category of a more distinct nature called the 'organising theme' (Attride-Stirling). This represented all basic themes, dealing in various ways, on the same aspect of participants' expressions of their actions, attitudes and experiences while trying to maintain or regain health. It captured textual meanings, with thematic representations based on the aggregates of all basic codes of the same root/family. This aspect ensured that codes were closely associated with the data/texts, by using some socio-psychological concepts that best represented participants' responses. This aspect was represented in the Nvivo project as 'child nodes.' The initial steps (1 and 2) initiated the development of basic themes from the codes by a careful process of induction.

4) The fourth step involved the cross-checking of themes in relation to hunches and data source from which they were generated. This led to the formation of super-ordinate category of themes by clustering similar basic/organising themes under core concepts that best represented the overarching explanation of participant responses. These concepts served as global themes, represented in the Nvivo project as 'parent nodes.' The 'parent nodes' were identifiable and definable within focused boundaries that make them distinct. From the emerging themes (Table 3.2), a thematic map or tree structure was derived to guide the analysis (Figure 3.2). The Nvivo system used the tree structure to properly ground the 'parent nodes' unto the data, using the organising themes or 'child nodes' as the linking stem through to the basic themes or 'grand-child nodes' that served as the root. This network showed that

the basic nodes were in turn aggregated under their respective 'parent nodes', through the 'child-nodes', and they served as working themes in the description and exploration of the thematic network.

5) The fifth step is the result and analysis stage (see sub-section 3.3) involving the identification of each global theme with their specific stories relating to the research question, using appropriate quotes from the text. At this stage of analysis, only the themes that strongly represented some depth of meaning about the phenomenon of investigation were included for discussion.

6) This stage of analysis is the discussion of results (see sub-section 3.4) representing the reported form of the analysis. This aspect contains few but compelling extracts from the data set, relating to the research question and existing literature. This involved vital interpretations that showed the significance of the thematic pattern to broader meanings of health seeking behaviours and determinants.

Table 3.2

Identification of themes (The result of steps 1, 2, 3, and 4)

Basic themes	Organising themes	Global themes
Financial and environmental difficulties, attempts to cope with challenges through social support (families and groups in the UK and Nigeria), through employment for financial security, and through gaining knowledge/awareness of things to do.	Challenges and coping strategies.	Immigration challenges
Life challenges – physical, psychological, and spiritual view of illness; choice of health-seeking methods to manage these challenges, and negative experiences of using these methods, will power, expectations, illness condition, social and cultural practices, financial aspect, it depends on individuals, self-treatment, prayer (by church group and by self)	Illness perception/beliefs, physical and structural factors, other treatment options, past experiences, financial aspect.	Barriers to health care utilisation.
Health-seeking methods and experiences: medical, spiritual, alternative medicine, self-efficacy, positive experiences, illness condition, structural factors, the environment	Positive experiences, illness condition.	Facilitators to health care utilisation.
Contribution and opinion from participants, needs for improvements, and regulation against abuses, and barriers, collaboration, attitude change needed.	Health improvement needs, health provider collaboration, change in attitude.	Acculturation
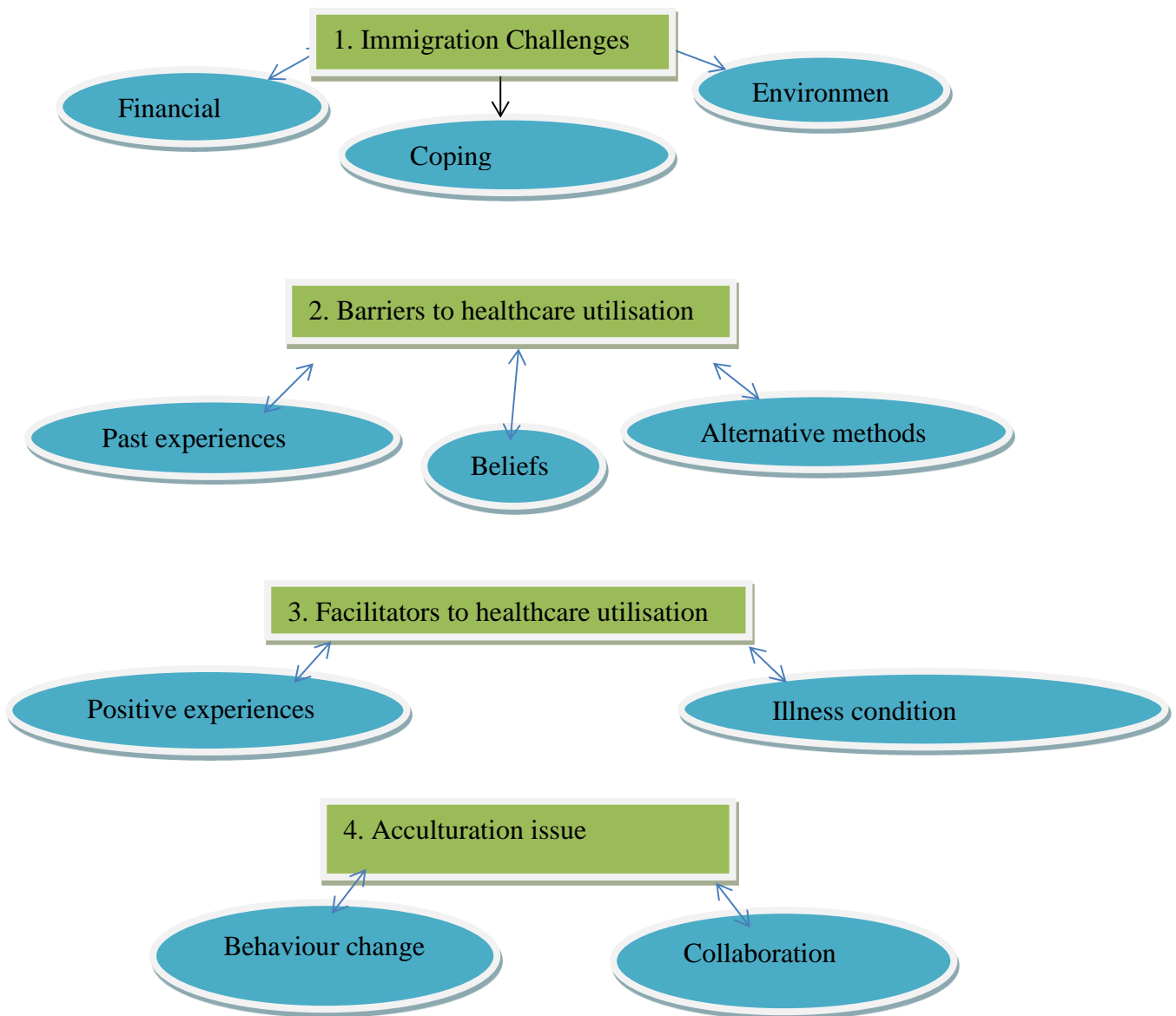
Figure 3.2. A thematic map of four main themes and their sub-themes

3.3 **Results/Analysis**

3.3.1 Immigration Challenges

This theme describes the challenging experiences of Nigerian immigrants in the UK, and their initial responses while trying to adjust to various issues associated with migration, especially as these affected their most basic needs, and in particular, their health needs. For instance, such obvious challenges associated with migration include the pace of cultural change and pressure to adapt to these changes, as well as lack of support to cope with these needed changes are shown to impact seriously on immigrants' health (Nakash, Nagar, Shoshani & Lurie, 2015). Such challenges and consequent responses reported in this study have been summed under the three sub-themes – the *environment*, *financial issues*, and *coping strategies* adopted:

(i) The Environment

Environmental issues consisted of initial difficulties from the socio-cultural and physical environment, such as adverse weather, academic challenges, diminished social status, loneliness, integration and acceptance difficulties/language barrier, disappointments, culture-shock, as well as pressure from families at home as shown in the quote below:

UJAMA: *"The fact that you migrated, and migrated from Nigeria to the UK, is everything both, the environment, the economy, the people, everything seems strange."* (FG: lines 196-198).

The above quote explains a general experience of a considerable number of immigrants from diverse backgrounds, and not particular to Nigerian immigrants. It confirms available evidence that factors such as cultural differences are among the

major challenges encountered by immigrants or international students (LaFeur, 2010). Relevant to this are also financial matters, and the need to adapt to the roles of a new social environment as similar studies among Latino international students also identified the presence of acculturative factors as part of challenging experiences in a new environment (Rodriguez, Morris, Myers & Cardoza, 2000); while Lopez, Ehly and Garcia-Vazquez (2002) also identified acculturation and social support issues as influential factors in the academic performance of Mexican-American students. Although these experiences are common among immigrants from different cultural backgrounds, a study by Constantine and Okazaki (2004) shows that foreign students of African origin, in particular, experience more challenges when compared to their Asian or Latin American counterparts. This can be viewed from the effects of poor social capital in terms of poverty, which has been noted to be more prevalent among immigrants from developing countries of Africa; and can translate into more personal issues that hamper the process of adaptation with more stress and diminished self-esteem, especially where the needed social support is lacking (Friedlander, Reid, Shupak & Cribbie, 2007). In addition to this, with reference to Nigerian immigrants, the added pressure from family members left at home who look up to participants as bread-winners, can become a source of additional stress as seen in the following excerpt from the data:

CHYOMI: *'…and then probably stress from home people because as soon as you come in, they thought maybe the money is just flowing from left and right, not knowing that there is so many things you need to go through before you settle down here. They are calling you or maybe someone is sick or you need to help out and then you are not doing it. So you are not feeling happy that you haven't done what you are supposed*

to do and probably they are not understanding. So, all those things also contribute to stress' (FG: lines 95-101).

Hence, supporting findings from previous studies, as already shown, participants in this study highlighted basic issues regarding their needs, and how their new circumstances impacted on their general health and wellbeing, especially when these were not met.

(ii) Financial issues

The prevailing challenges relating to insufficient funds, questions around employability and actual difficulties getting a job resulted in financial difficulties (perceived and actual sense of poverty). This feeling seemed to run through the entire corpus of the data:

UGOCHI: "*… when I came newly as a student I went to look for work, part time work, I was told that I don't have experience of washing plate...(laughter) no, it was… I was rejected I could not find work. I came to an agency 'what is your reference?' I said, 'how can I have a reference?' if you get a Nigerian reference, they say no, we want your reference.*" (FG: Lines 171-176)

CHEBE: "*Like me when I came in into the country, my own is about money because I didn't come with something reasonable*" (FG: Lines 213-214).

OGO: "*So, what really did help is getting a job and earning some money to keep us going at then, which was really difficult because at that time there wasn't a lot of our people around at that time so it was very difficult…* (FG: lines 67-72).

Prior to migration, among other factors, actual and perceived benefits of using medical services accounted for poor health services utilisation among Africans, especially in cases of mental illness (Agbonyitor, 2009; Nsereko, 2011). However, this factor goes beyond mere lack of money or perceived cost to include precipitating factors for actual poverty before and during migration. For instance, in the study among people living with HIV/AIDS in Nigeria, Agbonyitor, (2009) found that most of them were widows, where widowhood is a challenging condition itself, and carried with it additional financial difficulties. Therefore, considering the issue of poverty, social class inequalities and vulnerability, the ratio of 'cost' for health care utilisation would be higher for immigrants from a developing country compared to non-immigrants or other immigrants from the developed countries due to differences of income per capita (Hausmann-Muela & Muela Ribera, 2003). Therefore, the experience of poverty can readily translate into an overarching influence on Nigerian immigrants' health behaviour (negative attitude, lack of interest, time and money) in view of much needed social security:

UGOCHI: *"Ok. Ya, I wanted to chip in a few things, because, you know there is this trend that is common with migrants from our place even other parts of Africa to UK. Because of this struggle for financial empowerment and all these things…many carry on with working 24 hours, 7 to 7, Monday to Sunday, Monday to Sunday, no weekend no rest…."* (FG: lines 686-693).

A wider picture of cost/perceived benefits for Nigerian immigrants as for other immigrants from Africa can become clearer in the context of African culture of extended family network (cohesive nucleus and extended families), which forms part of their religious obligation bedecked with moral, social and economic responsibilities (Mbiti,

1969). Mbiti expresses this interconnectedness, its implications and attendant pressure thus:

Traditional religions are not primarily for the individual, but for his community of which he is a part. Chapters of African religions are written everywhere in the life of the community and in traditional society there are no irreligious people. To be human is to belong to the whole community, and to do so [belong] involves participating in the beliefs, ceremonies, rituals, and festivals of that community. (Mbiti, 1969, p. 2)

With the overwhelming pressure from different sources, and the accompanying challenges from the new social and physical environment participants resorted to varying forms of coping strategies captured by the next sub-theme.

(iii) Coping Strategies

This theme discussed various responses to the challenges experienced during migration, both from unexpected circumstances from the host environment and from within the individual (such as physical and psychological conditions). As adjusting to the needs of a new environment was challenging in various forms, participants showed recourse to social support and gainful employment among other things. The relevance of social support in coping with adversity among patients of diverse ethnic origin has been reported in previous studies (Meyer-Weitz et al., 2000b). For instance, a study on adherence to medical regimen among Dutch HIV patients (Vervoort et al., 2010) considered social support as relevant among other factors. Consequently, extensive work has been done on the use of religious coping strategies during unfavourable circumstances irrespective of cultural backgrounds or country of origin (Pargament,

1997; Lazarus & Folkman, 1984; Jacobson, Luckhaupt, DeLaney & Tsevat, 2006). Therefore, conforming to findings in previous studies, participants in this study also resorted to social support, a concept which explains emotional and practical support, and could be either informal support (from friends, relatives, and peers) or formal support from the society (Dilorio, Shafer, Letz, Henry & Schomer, 2006) such as formal organisations - church groups, government/non-government charity organisations:

UGBO: *"For instance, when I came into this country my first, my first duty was to look for the charismatic because I used to be a very staunch member of that group back home. So, that was the first thing I ever did, searching for Catholic Church and then charismatic…, and that is actually the, my number one cure for everything that stresses me."* (FG: lines 480-486).

However, where responses from the focus group showed more reliance on formal means of social support, such as religious groups, those engaged in personal interviews reported more informal means of support from families and friends as shown in the quote below:

HAJIA: *"The real thing I think what helped me most was my sister-in-law being in the United Kingdom"* (P/I: Lines 1-2).

MEKUS: *"Ok basically I was just like going in relation to your topic, but nevertheless, in general, what really give me a sort of settlement in UK basically is my other African brothers. Particular my Nigerian people"* (P/I: Lines 18-20).

Such a slight difference could be due to the impact of religious affiliation (Pentecostal/charismatic and mainline Christians) that characterised the focus group,

with diversity of opinion and religious sentiments (triggered by the nature of the focus group interaction). By this, participants may have tried to represent their religious groups in a good light, which was not the case with personal interviews.

From the foregoing, it can be concluded that the factors noted within this analytic framework are not particular to Nigerian immigrants because immigrants from other countries also encounter challenges in varied forms and degrees (Mooren et al., 2001; Nap et al., 2015). However, what is unique to Nigerian immigrants is the amount of effort they needed to overcome these challenges due to their unique circumstances that distinguished them as black minority with unique pre-migration and migration history. The different circumstances of black minorities' immigrants from Africa have been established in previous studies showing remarkable disparity in health outcome. For instance, in their study on the health-related treatment between Black minorities and their White counterparts, Wells and colleagues (2001) reported that African Americans had less access to mental health services, and reported greater unmet needs for their mental health care than whites. Also, findings on the outcome of consultation for HIV testing in London, and other European countries show that migrants from Sub-Sahara Africa report late for diagnosis (Boyd et al., 2005; Chee et al., 2005), which is attributable to many factors within and outside the individual. However, recent studies (Mulvey, 2015; Phillimore, 2011) show that the experiences/treatment from the receiving community (inclusive of the health system) greatly shape immigrant behaviours towards integration and access to services. The consequences of such circumstance were reported in this study as the need for an 'extra mile' to cope, as in the example below:

UGBO: *"For instance, you know in this country you have to go extra mile to be able to make it…"* (FG: lines 108-112)

3.3.2 Barriers to healthcare utilisation

Considering the challenges reflected above, this theme discusses participants' experiences while trying to utilise the healthcare system, in addition to already adopted coping strategies. They encountered considerable barriers, ranging from beliefs (religious, cultural) or faith-based practices that shaped their illness perception, individual preferences, personal or lay opinions about illness (health beliefs), or past experiences of illness management (including negative experiences of using the healthcare system itself). These barriers resulted in immigrants resorting to self-medication and the use of other alternative methods, such as African traditional and Christian spiritual methods consistent with previous studies (Gureje & Lasebikan, 2006). This thematic framework has been discussed further while concentrating on three sub-themes that follow:

(i) Alternative methods

In the process of coping with the health-related conditions in a new environment, participants adopted various non-medical or unorthodox health-seeking approaches viewed as potential barriers to using Western medicine. Participants discussed this aspect as either the use of self-prescribed alternative medicines prepared at home with natural herbs, or the use of already-made medicines (orthodox or herbal), procured over-the-counter. These alternatives showed further developments on what migrants decided to do by themselves based on their lay knowledge, health beliefs, and past experiences of illness. By this, they diagnosed, prescribed, and prepared their own therapies using African herbs, as well as non-conventional therapists:

CHYOMI: *"Then if sometimes, here I do it, sometimes if I feel like am having cough I don't wanna take paracetamol, or Coughlin or all that not, I do on bitter kola, do it and then I drink honey and hot water, you know. So all those stuff help me a lot and I prefer them than going into ... or ginger, garlic all those things."* (FG: lines 790-799).

What is important from this theme is not the availability and use of alternative methods but the preference conferred on it by Nigerian immigrants over and above healthcare utilisation as noted in the above quote from the focus group discussion. Moreover, these alternative therapies are common among Africans at home and in the diaspora, who can easily prepare their local herbs (self-made) or obtain already-made/manufactured medications from gate-keepers, as corroborated by previous research findings (Alem, Araya, Kebede & Kullgren, 1999; Bekele, Flisher, Alem & Bahiretebeb, 2009; Kilonzo & Simmons, 1998; Franklin et al., 1996). These studies confirm that the belief in the efficacy of African traditional healing and church spiritual healing is so strong among Africans that they rely on these methods irrespective of experienced failures in some cases. These researchers also noted that the easy accessibility and availability of traditional alternative methods compared to the conventional Western method, contribute to poor health care utilisation, which is also identified in this study:

HAJIYA: *"There are no obstacles and I find it easy because the church is always open to the public. One can easily go anywhere you know in every community you have churches…I don't think there is any difficulties getting to any spiritual help. They are always available."* (P/I: lines 53-62).

Although the traditional and spiritual methods are prevalent among Africans, this study found no report of consultations with traditional healers, instead they used

African traditional herbs or ingredients on their own and relied more (100%) on Christian spiritual healing:

LOLA: *"Ya, so we believe so much in spiritual healing, ya, especially in the Christian aspect of spiritual healing, because the bible said, 'I am the Lord that healeth thee', so we do strongly believe in spiritual healing."* (P/I: lines 74-75).

This aspect could be explained by the fact that the study was conducted among a sample of Nigerian Christian immigrants only, and in a foreign country outside Africa, where the effects of acculturation could have influenced their behaviours. It is can be of research interest to explore the health-seeking behaviour of non-Christian Nigerian/African immigrants, especially African traditional religionists or Muslims, to compare the level of adherence to African traditional healing in a different context outside Africa. For instance, the existence of multiple response options to illnesses is not particular to Nigeria, but it seems to characterize the health systems in the developing countries. For example, the uses of self-medication, through herbal medicine and spiritual healing, home remedies, homeopathic methods, allopathic medicines were also reported among Pakistani population (Anwar et al., 2015).

(ii) Beliefs

Personal attitudes and prevailing beliefs have been found to influence health behaviour (Bandura, 2004). Among respondents in this study, this theme was used to further explore the role of religious beliefs, health beliefs, and illness perception or culture-based explanatory models regarding the choice of preferred treatment methods (Okello, 2007). This also reflected various ways illnesses were perceived or defined (perceptions of different illnesses, what constituted illness conditions, what

caused them) and consequently what should be done to get cure/healing. This is an important theme in understanding health-seeking behaviour among Africans as strong reliance on spiritual beliefs (witchcraft, evil-spirit, magic/curses, or ancestral spirits) has been reported by existing studies among Africans, especially on mental illness (Nsereko et al., 2011), and another on the cosmological beliefs prevalent among Nigerians conducted by Ogunniyi, which showed "deep belief in witchcraft, magic-medicine, and taboos" (Ogunniyi, 1987, p.110). This study illustrates similar influences as reported in both personal interviews and focus group discussions:

LOLA: *"Our belief is that, every physical sickness has, will always have spiritual undertone. And in most cases the first thing we do is just to pray. And we believe in the power of anointing too, we pray, anoint, and it has always been very effective…. And well, it might sound odd but, considering our background, we do know that for every physical thing, that thing must have happened in the spiritual realm."* (P/I: lines 70-84)

CHYOMI*: "To me it's my belief that help me I don't usually rely on medical treatments, except otherwise, and even if I must see a doctor, before I see the doctor I must have concluded in my mind any bad report he is gonna give me there am not taking it…"* (FG: lines 461-464).

It is important here to observe from the above quotes, how the belief system can translate into maladaptive cognitions, and consequently become a serious barrier to healthcare utilisation. Moreover, the degree of this influence extends to self-diagnosis based on the prevailing religious and cultural explanatory models, consistent with existing literature (Kendall-Taylor et al., 2009). In this, participants reported a

belief in the dichotomy between physical and spiritual perceptions of illness; where illnesses perceived to have strictly a spiritual dimension has accounted for spiritual healing/prayer in the choice of health-seeking approaches. This is also a possible pathway to predicting particular responses to illness, 'folk illnesses' and preferred health-seeking behaviour that can become barriers to health services utilisation. For instance, Nsereko and colleagues in their study on health-seeking and mental health among Ugandan communities reported on the prevalence of 'supernatural theory of disease aetiology' (Nsereko et al., 2011, p. 4) as basis for seeking traditional healing. Similar postulation has been expressed in this study as shown in the quote below:

UGBO: *"There are some illnesses, some sicknesses some problems that could be a purely medical and there are some problems that could be purely spiritual. And if a problem is spiritual and you are using medical, it cannot go, you cannot find a solution to that…"* (FG: lines 473-476).

However, this strict dichotomy between the spiritual and physical became mitigated as some responses were critical of the validity of such explanatory model. This is an indication of differences of opinion based on religious beliefs/affiliation as the study sample was dominated by two main Christian groups – Pentecostal/charismatic group and mainline Christians (Catholics/Anglicans). Based on this distinction, the Pentecostal/charismatic group reported a stricter dichotomy with spiritual emphasis for dealing with health and other problems compared to the mainline group. This is in line with findings that religious groups differ in their level of adherence to religious beliefs and practices in relation to health care utilisation; such as the Jehovah's Witness followers who express strict religious beliefs and practices regarding blood transfusion that has implications for public health (Bodnaruk, Wong &

Thomas, 2004). This aspect is buttressed by the quote below:

LOLA: *"…I mean based on our own faith, we do believe that we don't even have to see anybody to be able to get healed spiritually, because the bible said where 2 or 3 are gathered in my name I am there, and Jesus said 'if two of you shall agree on earth regarding any issue, it will be done'. So, that makes it so easy in the sense that my wife and I, we could pray and address a particular issue right there…"* (P/I: lines 91-99).

However, in addition to the availability and accessibility of alternative methods due to existing belief systems as discussed in the two preceding sub-themes, past experiences of illness management before and during migration, especially the negative experiences and poor access to the NHS seemed to further frustrate and diminish any interest towards health care utilisation as discussed fully under the next sub-theme.

(iii) Past experiences: pre-migration and post-migration.

In addition to the barriers discussed above, this sub-theme reflected the challenges to healthcare utilisation posed by immigrants' past experiences of illnesses and their management. These experiences range from those acquired before migration, and those emanating from the use of available healthcare systems in the host country – in this case the NHS. Previous knowledge is a relevant index as previous studies among immigrants from Africa show poor knowledge of certain illnesses prior to migration (Adanu, 2002; Chokunonga et al., 2003; Ogunsiji, Wilkes, Peters & Jackson, 2013; Sheppard, Christopher & Nwabukwu, 2010), which can impact upon their general health behaviour. For instance, women of African descent

have been noted for low knowledge of cervical and breast cancer-screening services at home and consequently abroad (Weber et al., 2009; Sheppard et al., 2010; Mupepi et al., 2011; Odetola, 2011). Also, in a similar study on cancer screening among West African migrant women in Australia conducted by Ogunsiji and colleagues (2013), participants indicated poor knowledge of cancer in their home countries before migration, and this was mainly due to socio-cultural issues surrounding women's health and taboos, secrecy or the sacred nature of sexuality in Africa. Women immigrants from other countries reported similar poor knowledge of cervical and breast cancer prior to migration, but for different reasons (Kwok et al., 2011; Sheppard et al., 2010; Kawar, 2009). For instance, Russian immigrant women in Israel showed negative attitudes towards breast cancer screening as it was not top on their scale of preference; they would rather accord priority to actual problems rather than potential illnesses (Remennick, 2003).

Furthermore, although this study did not focus on gender or particular illness conditions relating to women, it is important to highlight that health-seeking behaviours among Nigerian immigrant women could be related to culture-relevant experiences they had as women prior to migration. For instance, the cultural practices of female genital mutilation (FGM) common in Nigeria and other African nations has the potential for influencing women's attitudes towards female-related health conditions such as cervical cancer screening in the UK as in other countries (Momoh, 2004; Ogunsiji et al., 2007; Straus et al., 2009). This could be due to the trauma associated from such past experiences. Indicators of the impact of past experiences of illnesses among participants was referred to as 'mentality' by a participant in the focus group, which was understood to mean attitudes acquired from Nigeria:

UJAMA*: "…in Nigeria usually that mentality is still carrying me over here. In Nigeria when we are sick we normally take like paracetamol and observe it, because there it's not like free GP here, there if you go to a doctor/consultant you have to pay like is in America. So, for you to give away that money you have to first of all take cheaper medication and observe your situation then if it persists then you go to the doctor and then pay that money…."* (FG: lines 546-558).

The attitude of delayed health-seeking reported above, although a common experience among Africans and patients from other cultural backgrounds, is vital in understanding responses to illnesses, especially mental illnesses among Africans because it usually leads to the use of complementary methods, such as spiritual healing of the Christian or African tradition (Nsereko et al., 2011). However, for Nigerian immigrants, as for other immigrants of African descent, delayed consultations can translate to a complete preference for alternative methods against medical/psychiatric advice. Consequently, the positive experiences that accompany the use of traditional/spiritual healing can reposition it as a better care option against Western medicine (Leach, 2000; Nuwuha, 2002; Vaahtera et al., 2000). Hence, over a third of West Africans were reported to seek treatment from African traditional healers (Osujih, 1993; Folb, 2000). In the same vein, previous studies show that the experiences of Africans using traditional methods lead them to conclude that it is more effective for most ailments, and their practitioners more humane than health care professionals of orthodox methods (Comoro, Nzimba, Warsame & Tonson, 2003; Fawole, Onadeko & Oyejide, 2001). The overall impact of pre-migration experiences on the current health behaviours of Nigerian immigrants can be properly understood from the factors that characterise the health system in developing countries. For instance, eexisting studies show that developing countries have a more pluralistic

health system than developed countries and can present a greater range of competing options for responding to illnesses and symptoms (Anwar et al, 2015). In Pakistan, homeopaths, traditional and spiritual healers, Greco-Arab healers, herbalists and bonesetters are part of the health care system (Ngokwey, 1995; ICDDR, 2008; Leyva-Florres, Luz Kageyama & Erviti-Erice, 2001; Hakim, 1997; Anwar, Green & Norris, 2012) in addition to the formal public and private health providers. Such is also the case with Nigerian care context (Yusuff & Wassi Sanni, 2011).

In addition to participants' experiences of illnesses and their treatment approaches prior to migration, there were reports of negative experiences of trying to access and use the health services (NHS) in the UK which further complicated the challenges to health care utilisation as noted above. This factor and its implications are further concretised by quotes from both focus group discussions and personal interviews:

UGOCHI: *"My first experience getting medical help in UK was really embarrassing."* (FG: lines 299-300).

NGENE: *"Because it was very very, it was becoming difficult … By the time you do this how many times, how many days, you get fed up, and then you look for another way."* (P/I: lines 51-58).

Across the world over, it is evident that health workers and those intending to utilise the health care systems are faced with competing demands as well as insufficient resources, both in developing and developed countries (Hauck et al., 2003). Therefore, health care systems are faced with the problem of prioritising its services to provide beneficial care to its teeming patient population (Green & Gerard,

2009). This can sometimes result in restrictions and denial of access to effective care (Martin et al., 2003; Ham & Robert, 2003; Newdick, 2005). Where other populations (non-immigrants and migrants from other countries) may have similar experiences of frustration with the health system, yet the same experience for Nigerian immigrants could elicit a different response by turning to readily available and accessible alternatives (African Traditional methods and Faith-based healing) based on their unique illness-response attitude and experiences prior to migration as discussed above. For instance, it is consistent with previous studies (Adogame, 2007), that among most Nigerian Christians, especially within the Pentecostal groups, the effects of negative forces or evil has been expanded to include ill health and any barriers to the realisation of good health and wealth. Hence, with such conditions as delayed recovery, medically unexplained conditions, or conflicting diagnosis, the Nigerian immigrant as other African immigrants, would suspect witchcraft, magic, or evil-spirits, and readily turn to spiritual/alternative therapies; which Adogame (2007) explained thus: "These narratives must be seen as inextricably linked to multiple understandings and translations of poverty and to the dominance of 'prosperity gospel'." (Adogame, 2007, p. 478). This was confirmed in the following quotes during personal interviews:

LOLA: *"What can influence my choices of using…Well, if for example I am unwell or any of my family and we seek medical healing and it seems as if, I mean, I mean, there is no improvement, then we seek spiritual healing in that case"* (P/I: lines 78-80).

HAJIA: *"If it is something you know very acute and needing attention there and then I probably will go for the medical because then I will have relief, but if I have a condition in me I will pray for it I won't go to the hospital I will pray about it."* (P/I: Lines 47-49).

NGENE: *"If I've accessed all medical services and they couldn't, they say oh we can't help you, or we can't find out what is wrong with you and you still feel that you are very ill, you turn to your God and see what He can do. Because if it's unexplained and they can't even find what it is He will be your last resort, ya, your last hope and there is nothing he cannot do".* (P/I: Lines 97-101).

This thematic framework, using the preceding sub-themes highlighted some barriers to healthcare utilisation, and identified factors that could apply to all patients irrespective of culture, country of origin or immigration status, as well as other factors that have particular significance for Nigerian/African immigrants because of their pre-migration experiences of illness management and the health care systems. For instance, the World Health Organisation, WHO (2003) reported on the poor state of the health care system in most developing countries, a situation confirmed in Nigeria because of political, socio-economic, cultural and environmental factors (Green, 2008). Therefore, this can explain why the use of the NHS services could be more challenging for Nigerian immigrants as a new and unfamiliar structure/system, compounded by other immigration challenges noted earlier. Hence, they could easily give up on the system and turn to their comfort zone – the traditional and spiritual alternatives – as already reported. In addition, language proficiency and other skills acquired before migration can contribute to the health seeking behaviours reported in this. Existing studies show that such skill can help in adapting to the new culture and can impact on health and well-being as well as levels of medical care needs. For instance, the role of English language proficiency was reported in a US population study, showing that elderly Asian immigrants with poor levels of English proficiency were more likely to experience mental health needs compared to those with higher language proficiency (Nguyen, 2011). Also, in the study among non-western

(Moroccan, Turkish, and Surinamese) migrants in the Netherlands, it was reported that migrants with more adaptive skills may be better disposed to adopt a more active coping approach towards solving their problems than consult with a doctor (Nap et al., 2015). However, details of such influences on Nigerian immigrants need further investigation. Meanwhile, some barriers reported within this study did not preclude the presence of positive experiences that could facilitate health care utilisation as contained in the next theme.

3.3.3 Facilitators to health care utilisation

This theme identified the strengths of the health care system (NHS) in the UK, which needed to be harnessed for added value and continued use. It also explored the experiences of health services provision and utilization as discussed within two sub-themes of the framework shown below:

(i) Positive experiences of using the NHS

Respondents reported positive experiences that can encourage the use of the medical method, despite some obstacles already mentioned:

MEKUS: *"When I now go for medical health, the first place is to go through your surgery. For me it's so excellent, because it's easy for you to book appointment, even you could stay in your house, call your surgery, book appointment and then you get all you need so easily…So for me it's an excellent system whereby you have somewhere to go to even if you don't have money because you don't go with money to your surgery if you have all that it takes to be in UK."* (P/I: lines 71-83).

The instance cited above seems to support healthcare utilisation, but as discussed in the previous theme participants would use the medical services only as a last resort, especially at the tertiary or secondary level, rather than for preventive purposes at the primary stage. Therefore, it is important to understand the culture-relevant factors involved in decision making for initial healthcare utilisation among Africans/Nigerian immigrants, to encourage such health behaviours as health screening, routine medical checks, health enhancing lifestyles, and other health promotional behaviours. This is because social behaviours are regarded as a product of reasoned process based on vital information relating to the action involved (Ajzen & Fishbein, 1980). More so because adequate health outcomes are based on the dynamic process of reaching a health decision which involves various stages of deliberation before a final decision point is reached (Good, 1987). It is appreciated in this study that the benefits of the NHS cannot be overemphasised, but with reference to Nigerian immigrants, the major problem lies in maladaptive cognitions that can obscure these positive aspects of the NHS (free medical services, prompt emergency response/rapid response unit etc.). The next sub-theme seems to provide a better insight from another perspective.

(ii) Illness condition

In addition to these positive experiences, participants observed that the nature of the illness strongly influenced their health-seeking behaviour. This confirms previous findings (Tuckett, 1976) regarding patients' lay knowledge and experiences of their illness condition, its perceived seriousness and threat posed to the individual:

OGO: *"I think depending on what's wrong with you, on what diagnosis it is, you will be*

forced to go (to the NHS) and forget about the money." (FG: lines 576-577).

The above quote from the focus group is interesting and seemingly convincing. However, as noted during the review in the preceding chapter, Nigerian immigrants in the UK were reported as sourcing spiritual healing as a cure for HIV/AIDS; which casts some doubts as to the degree to which illness severity can compel this immigrant population to use the medical services. For instance, in a personal interview with Hajiya, (a participant living with a heart condition at the time), the motivation for preferring a particular treatment method was to achieve a permanent cure, as is consistent with previous studies (Nsereko et al., 2011) that Africans believe in and prefer African traditional and spiritual healing because they address the root cause of diseases and illness rather than the symptoms:

HAJIYA*: "With me personally now I have a long-standing problem which is high blood pressure. I take tablets that is from the medical aspect of it, but that doesn't stop me praying for God to cure me, because am taking this tablet now for years, I am getting relief from it am not being cured. But I know with prayers God can say, that's it from today your blood pressure will be normal, you will never experience this. So, this is the type of, actually, help that I would rather have, a permanent one, with the father, you know, my lovely father up, God."* (P/I: lines 24-30).

Sequel to the value of experiences explored by the framework above, it is possible that if immigrants should be further integrated into the new culture, with enhanced capabilities to access health-related information through church-based support programmes there can be improved health care utilisation. This has been shown to be a successful intervention in previous studies where church-based health promotional programmes have been used to address health inequalities between

African Americans and their white counterparts (Peterson, Atwood & Yates, 2002; Wells et al., 2004; Agbonyitor, 2009). For instance, most common health conditions with prevalence of disparity against blacks in America have been addressed through The Black Church programmes, such as cancer (Bowie et al., 2008; Holt et al., 2009), diabetes (Dodani et al., 2009; Samuel-Hodge et al., 2009), obesity (Kim et al., 2008; Young & Stewart, 2006) COPD/ hypertension (Yanek et al., 2001; Frank & Grubbs, 2008) and HIV/AIDS (Hatcher, Burley & Lee-Ouga, 2008; Tyrell et al., 2008). Further explorations of participants' opinions on this aspect have been articulated in the next theme. Also in Africa, a successful community-based educational programme was implemented among the Kilifi community in Kenya where shopkeepers were trained to administer adequate over-the-counter medication for malaria as it was the common health-seeking method with malaria patients (Goodman, Mutemi, Baya, Willets & Marsh, 2006; Marsh et al., 2004).

3.3.4 Acculturation issues

The challenges encountered in adjusting to the new environment by Nigerian immigrants slowed the process of their smooth integration; which resulted in this theme on 'acculturation'. It represented participants' opinions on possible actions needed to enhance integration into the larger British culture; as it can help to resolve some of their challenges in the new environment, especially during medical consultation (Das, Olfson, McCurtis & Weissman, 2006). For instance, a participant showed evidence of poor doctor-patient relationships and communication that resulted to difficulties during a consultation, which has implications for effective integration:

CHYOMI: *"…. Because to my own understanding I know, this people here they don't really understand like what am saying if am having cough am going to take bitter kola…. because she was like sceptical, 'what's that' you know. So they don't know all those things."* (FG: lines 872-887).

Consequently, this theme is based on two sub-themes rooted in the data set - 'collaboration' and 'behaviour change', both used to explore further what participants felt about the adjustments needed from the health care system/professionals and the service users respectively:

(i) Collaboration

To address such important issues as doctor-patient relationships and communication, participants suggested improvements that can facilitate the process of integration and consequently, adequate access to healthcare services. These suggestions centred on the need for collaboration – which implied an increased involvement of health workers and other personnel (faith-based) from their own culture as part of the healthcare team:

NGENE: *"Ya, like ours, like us doctors from our area would know, they know how to approach us, they know our needs more than anybody else, they understand us more than anybody else, because any cultural background is got a way they function."* (P/I: lines 193-196).

LOLA: *"Yap, certainly yes, because of our background I think it will help more, because those personnel of course because they are from the same background they will be able to, they will be better informed in addressing Nigerian's health issue."* (P/I: lines 115-128).

The above suggestion is consistent with findings from previous studies regarding the importance of clinician-patient cultural matching in improving health services utilisation (Chinman, Rosenheck & Lam, 2000; Mathews et al., 2002; McKinlay, Lin, Freund & Moskowitz, 2002; LaVeist & Carroll, 2002). In addition to the need to increase the presence of health professionals from the same cultural background, participants highlighted the need for enhanced integration of medical methods of cure with other alternatives, especially the spiritual approach. In this interplay, integration was presented as a dual process where the conventional treatment method can be carefully grafted with the spiritual. This suggestion is in line with a study in Nigeria (Agbonyitor, 2009) where patients relied more on church-based home care, which provided them with the benefits of personalised and culturally appropriate care in a familiar environment (Young et al., 2005) in contrast with the experiences of neglect from government-based health care systems (Folb, 2000; Dossou-Yaro, Amalaman & Carnevale, 2001). By this, the healthcare services (medical and psychological) can be introduced to the potentially excluded group at the grass-root level through their religious organisations:

MEKUS: *"But I was wondering if it was possible even in the spiritual realm to see that they give room that people could have counselling homes or in the churches make it so public counselling homes or counselling hours…."* (P/I: lines 263-269).

This can serve as a pre-treatment programme consistent with previous studies (Lundgren, 1999) known to have improved service use among African Americans. For Nigerian immigrants, this can also serve as a spring-board at an advisory level (pastoral counselling) towards further healthcare utilisation at primary, secondary, and tertiary levels.

(ii) Behaviour change

This sub-theme suggested that a successful collaboration should be a two-way process, involving positive improvements in healthcare provision, as well as attitudinal change on the part of service users. In this case participants suggested that Nigerian immigrants should source vital information that can enhance their integration, adequate health care utilisation, and consequently a better health outcome:

UGBO: *"And the other aspect, it is not about the medical it is overall. I think we could change our method of seeking information."* (FG: lines 902-903).

The lack of information regarding appropriate health behaviour has been identified by existing studies as a determinant of health outcome, not only among Africans as noted earlier, but can also become an environmental barrier to a healthy lifestyle among other communities of different religious and cultural backgrounds (Abbasi, Bewley & van den Akker, 2011). It is interesting that this study among Persian couples of the Islamic religion corroborated a similar way of sourcing information reported by Nigerian Christian immigrants in this study, where participants relied on health information from relatives (both in the UK and in Nigeria) who consequently relied on "traditional advice rather than information supported by science, which may be incorrect or misleading and potentially lead to adverse health outcomes" (Abbasi et al., 2011, p. 9). One respondent summarised this process of adequate information search thus:

UGBO: *"…asking the right questions - 1, asking the right persons - 2, and then having the right answers."* (FG: lines 759-760).

Besides these needs for attitude change, the focus group discussion provided a critical insight to why Nigerian immigrants may not have access to useful health information. The issue was viewed as being shy and unable to speak out:

CHYOMI*: "…and being out as well to say your problems, some are shy, you know, to speak out what their problems are"* (FG: lines 763-764).

This may not be unconnected with shame and stigma as determinants of health seeking behaviour; consistent with previous studies (Baumann, 2007; Botha, Koen & Niehaus, 2006; Corrigan & Watson, 2002; Cooper-Patrick et. al., 1997; Das et al**.**, 2006).

3.4   Discussions

This qualitative study using an applied thematic approach has been useful in providing insight into the different factors useful in investigating health seeking behaviours of Nigerian immigrants before, and during migration to the UK; and identified both barriers and facilitators to health services utilisation in the context of the UK health system (NHS). A biopsychosocial approach to the study of health behaviour was useful in framing the research and interview questions, in order to address the interplay between personal and environmental factors that impacted on participants' lived experiences of responding to illnesses and symptoms. The results of this study yielded four major themes that form aspects of this discussion.

Immigration challenges and health care utilisation

The theme on the challenges from migration reflected both obstacles and motivators to health care utilisation, resulting from the physical and socio-cultural environments, as well as attitudinal differences that consequently influenced the

overall response to western medication when compared between black and white patients (Cooper et al., 2003; Miranda & Cooper, 2004). For instance, employment has remained one key element for successful integration as it accords migrants the needed economic independence, the lack of which impacts on mental health (Bloch, 2000). Unemployment results from emphasis placed upon human capital rather than factors that are within the social structure, as well as other physical, psychological, and social factors, such as discrimination, immigration status, English language proficiency, non-recognition of academic qualifications and work experiences gained outside the UK and EU (Bloch, 2007). These factors were well reported within this study. Hence, aiding language skills acquisition, and bridging communication gaps with the host community has been advocated as a positive means of integration (Bloch, 2000). For instance, Cebulla, Daniel and Zuruman (2010) found an important association between English language acquisition and being employed. A notable factor for integration is also health – which includes access and experiences, as well as pre-existing health conditions (Mulvey, 2015) - that can flourish when immigrants become adequately integrated into the host culture; providing a good link for enhanced healthcare utilisation. A study conducted by Nakash et al., (2012) among first and second-generation irregular young immigrants in Israel showed that those with integrated acculturative patterns reported lower mental health symptoms. These factors combined with other determinants, such as past experiences of illness and its management to influence health-seeking behaviours as reported in this study. Negative information regarding western medicine, for example, could have informed health beliefs held among immigrants before migration. Regarding this, the level of information available to Nigerians prior to migration, especially from unofficial/non-medical sources can become an underlying factor for poor health care utilisation

during migration. This is an area for future research, to explore fully the effects of the sensational reports about western medicine and their side-effects, such as the use of antidepressants and other psychotropic therapies (Das et al., 2006). Strickland et al., (1997) investigated the level of tolerance for psychotropic medications among black and white patients (Strickland, Stein, Lin, Risby & Fong, 1997; Bull et al., 2002). Their findings show that African Americans were poor metabolizers of tricyclic antidepressant compared to their white counterparts, and therefore, experienced higher plasma levels per dose than whites. The consequence was an earlier onset of action, and possibility for more side effects that can result to poor uptake or discontinuation of treatment regimen among African Americans compared to their white counterparts. How this aspect applies to other immigrant populations from Africa, such as Nigeria, is an area for future research.

Coping strategies and health care utilisation

Immigration challenges and health care utilization was relevant to social support from families and religious groups. It is also important to note that Africans rely more on families for health advice, especially the elders and significant others which included family heads and spiritual leaders such as religious ministers (Abubakar et al., 2013). Social support is therefore not only used in coping during illnesses, but it can provide directions in the process of making other important health decisions. The prevailing means of support found in this study were derived from families and friends, as well as religious groups both in the UK and Nigeria. This support became vital in responding to illnesses/symptoms as various challenges in the context of immigration prevented proper integration and adequate use of the medical services. This was compounded by Illness perceptions and belief systems, physical and structural factors,

past experiences, costs/perceived benefits, as well easy access to other treatment options (self-treatment, spiritual healing, and herbal medicines). The interactions between the factors enumerated above brings into focus, the impact of social capital, that is, how the realities of a developing economy and its political system can shape immigrants' illness experiences and beliefs (Burnett & Peel, 2001; Fosu, 1994).

Religious belief and health care utilisation

As confirmed in previous research, the association between beliefs and behaviours can enhance health outcomes through adequate health-seeking behaviours (Taffa & Chepngeno, 2005). However, considering the interplay between illness perceptions, and other barriers experienced among immigrants, beliefs and health seeking behaviours may hinder favourable health outcomes. For example, Petrie and Weinman (1997), showed that patients' illness perceptions influenced their health-related decisions; especially in a pluralistic care context where both formal and informal care providers operate side by side (Anwar et al., 2015). This situation can only encourage indiscriminate use of different treatment options (healer shopping), as evident from previous studies (Hunte & Sultana, 1992; Kundi, Anjum, Mull & Mull, 1993) where patterns of health beliefs make patients change methods because they are not yielding quick results or that a prescribed treatment method is providing a lasting solution where a permanent cure has been the target - as was shown among participants in this study. Where this feeling of doubt in the efficacy of the health system persisted, participants were found to fall back on their past experiences of using African traditional and faith-based methods, which were reported as cheaper and easily accessible in the UK.

As cultural and religious beliefs impact upon health seeking behaviours, it can

provide a deeper insight when considered against such important factors as gender. Although this study did not focus on the role of gender or gender-related health conditions, religio-cultural beliefs in the maternal role of women (child-bearing) within traditional, religious cultures (Sperstad & Werner, 2005) can influence women's particular experiences and responses to illnesses. For instance, in a traditional Muslim culture such as Iran (Abassi et al., 2011), as well as in a traditional African culture such as Nigeria (Iyalomhe & Iyalomhe, 2012; Abioye-Kuteyi et al., 2001), women rely on post-natal care from family members and traditional midwives popularly known as Traditional Birth Attendants (TBA), even though they have no formal, medical training. This can influence health seeking behaviour preference towards self-treatment or traditional/spiritual cure than seeking professional care from women health care services. Therefore, as people's cultural beliefs and identity are related to their perception of the world and related issues such as health beliefs and behaviours (Gardner, 2005), it is vital that this study considered the prevailing norms, values and beliefs that characterised Nigerian immigrants' health-seeking behaviours in the context of an emerging popularity of spiritual/Pentecostal healing approach.

Acculturation/collaboration and health care utilisation

The pre-migration factors noted above did not preclude the quest for acclimatisation and integration into the British culture as necessitated by the need for acculturation and collaboration emanating from the data. The relevance of this came from data of participants' health decisions being influenced by relatives, religious ministers and other important persons both in the UK and in Nigeria. To deal with this, participants suggested a change of attitude towards the sources of health information because the source of health advice can determine the type of advice and

consequently the type of health seeking approach sought (Abubakar et al., 2013). Therefore, families and religious ministers are likely to proffer cultural and spiritual methods as is consistent with available studies cited earlier on why patients relied heavily on traditional and spiritual healers for cure (Abassi et al., 2011). This trend of relying on spiritual healers has conversely influenced the proliferation of Pentecostal and other forms of spiritual healing among Africans as it, 'represents one significant factor for understanding the rapid proliferation, popularity and public relevance of contemporary dimensions of African Christianity (Adogame, 2007, p. 476).

The overall implications are that if Nigerians needed to change their attitudes towards sourcing health information from non-professionals, there is equally the need for enhanced communication with the health professionals who must be perceived as trustworthy and reliable because seeking medical help; especially for such conditions as mental illness among Africans have been found to be compromised for fear and distrust towards the health system and its staff (Freimuth et al., 2001; Howerton et al., 2007; Nsereko et al., 2011). How can this be achieved without proper client-clinician cultural matching? The way forward is that adequate representation should be guaranteed by incorporating gate-keepers and other professional care providers from minority immigrant communities through collaboration. Hence, spiritual leaders could be involved at the initial stage of consultation in the form of community-based care, which is found to be successful among Africans (Summerton, 2006; Wreford, 2005; Uganda Ministry of Health, 2000). This can provide initial counselling and motivation for Nigerian patients towards health care utilisation at other tiers of the formal health system - NHS.

Through this aspect of integrative and culture-sensitive setting, it is expected that Nigerian immigrants can develop trust towards Western medicine. It can

also provide a better context for clinician training that can enhance rapport among all stakeholders; consistent with existing research (Miranda et al., 2003) on the success of providing interventions to deal with such problems through translations and cultural trainings for clinicians. The outcomes of this programme showed that the context of clinician-patient cultural matching provided for minority groups especially African/African-American patients, an opportunity for a better health outcome. The findings conform to wider reports on the effects of (poor) clinician-patient matching with its negative impact on doctor-patient communication (Ademuwagun, 1998). Hence, research needs to identify what it is that could make the NHS attractive to Nigerian immigrants because they are still found to be less satisfied with the NHS, and lagging in healthcare utilisation when compared to their Caucasian counterparts as consistent with other studies among Africans (Borowsky et al., 2000; Dunlop et al., 2003; Fiscella, Franks, Doescher & Saver, 2002; Sussman, Robins & Earls, 1987; Vega, Kolody, Aguilar-Gaxiola & Catalano, 1999).

3.5 Reflexivity

This section contains a reflection on the strengths and weaknesses of this study. Researcher bias is possible as reading the transcripts gave the researcher the impression of dealing with a vulnerable group that should be empowered. This could have resulted from the fact that the researcher is also a Nigerian immigrant. However, this was managed by the researcher dissociating himself from the interpretation of responses as they were respondent's personal experiences; as individuals are unique in their construction of their world and their experiences of events around them. Hence, the researcher tried to understand that these challenges were not particular to Nigerian immigrants alone, rather they were almost inevitable experiences of living in a context

that is new and different.

However, as the researcher was active in the research design, interview schedule, and transcription, and the research supervisors also read the manuscripts and agreed on the themes for the analysis, some potential weaknesses that are characteristic of qualitative methods were mitigated. Another source of influence on the results relates to 'power' between researcher and participants (Banister et al., 1999). The researcher could have been positioned at a vantage position over participants, who were aware of researcher's social status. This is a potential source of social desirability bias as participants may have tried to give expected responses, or tried to avoid responses that have attached stigma or were considered shameful. Also, the use of the English language may have affected participants' expressions of meanings, as they were speakers of the English language as a second language. Hence, there is yet the possibility of a covert translation, where thought processes were based on the native language, while expressions were based on the English language, with the possibility that some meaning were taken for granted (Temple, 1997). However, this shortfall was cushioned because the researcher was actively involved in the interview schedule, and observed participants' body language, which may have enriched the analytic process.

Also, considering that participants have been in the UK for many years with potentials for some level of integration, most of the responses in this study reflected broad experiences of immigration irrespective of country of origin. However, some specific cognitive and behavioural determinants were reported as distinguishing them from other immigrants, especially those from non-African countries. Therefore, the researcher acknowledges that not all quotes are particular to Nigerian immigrants, although responses or reactions to similar stimuli could be country or culture specific.

To deal with this, the researcher focused on the research question and interview questions, which were based on an exploratory approach to their overall experiences of migration and responses to illness, with a view to deducting their relevance to health services utilisation in the UK. Regarding the vulnerability of participants, research rigour and credibility was ensured by constantly assuring participants of their confidentiality and anonymity, with the use of virtual/pseudo names; they were assured of debriefing and research rigour was improved by using the inter-rater process to ensure reliability.

Considering the research design, employing both interviews and focus group discussions to avail of the benefits of both approaches could have yielded some difficulties in the choice of the most appropriate analytic tool to use - the IPA was deemed most suitable for interviews or discourse analysis (DA) associated as best for focus group. Moreover, the use of a focus group had the challenge for participants' ability to discuss their personal experiences in the presence of other group members (Smith, 2004); but the researcher was convinced that participants could do this freely as the research focus was based on general discussion about Nigerians in the UK, which indirectly included the participants. While the focus group approach has been methodologically linked to discourse analysis (DA) as the most appropriate analytic tool (Smith, Flowers & Larkin, 2009), it also presents the challenge of assessing phenomenology in this particular setting where personal interviews were also used. Therefore, the thematic approach was deemed appropriate for the data from a combination of interviews and focus group discussions. Hence, the study used a qualitative research approach (Thematic Analysis); not meant for generalisations, but for in-depth explorations of personal experiences. Qualitative research is meant to capture reasonable quality and not quantity of research question (Breakwell,

Hammond, Fife-Schaw & Smith, 2006; Smith, 2004), thereby creating an opportunity for further research that could be used for generalisations. The implication however, is that this report cannot be used to make generalisations about the overall experiences of all Nigerian immigrants in the UK. This observation is especially vital as this study is not a disease-specific study to yield more specific results about a particular patient population (Kendall-Taylor, 2008, 2009; Nwanesi, 1995).

3.6.   Recommendations and Conclusion

Irrespective of some limitations noted above, this study has provided important information regarding the research population. It was found that participants' experiences of health care seeking were like those of other immigrants, but they also differed in some instances. For instance, for them African traditional religion cast in a Christian (Pentecostal) mould, has formed a unique religo-cultural mix; using the Bible as the basis of interpreting the world and events that consequently influenced their health seeking behaviour (see sub-section 2.1.3.4). Based on the emerging themes, this study captured some obstacles to health care utilisation among Nigerian Christians in the UK. These factors were especially found among service users in relation to health care practitioners, such as poor understanding due to cultural differences (culture clash and shock), or doctor-patient relationships; ignorance, language differences, religious and cultural beliefs, as well as past experiences relative to illness type, cultural context and the particular population under study. The results derived from the emerging themes showed that Nigerian immigrants in London encountered many personal, cultural, and environmental barriers towards accessing adequate professional health care. If this is not addressed, this condition could result in further constrains in using available healthcare services in the future. However, if

these factors are well managed, they could become vital for successful access and adherence to medical advice among ethnic minorities. Therefore, further research is needed to understand this process from the health care provider's perspectives, especially Nigerian clergy and health professionals who are at the frontline of providing care for Nigerians. This has informed the second study within this PhD; which proposes to use important themes from the present study to investigate the processes of collaboration among different care providers in the face of a reorganised NHS.

CHAPTER FOUR

4.1 INTRODUCING STUDIES 2 & 3: A TWO-PHASE CROSS-CULTURAL STUDY

(A cross-cultural study on the health-seeking behaviours of Nigerians from the

perspectives of Nigerian care providers in Nigeria and the UK: challenges for

collaboration).

4.1.1 Summary

The first study (Study 1) within this PhD explored the health-seeking behaviours

among Nigerian immigrants from their own perspectives as service users. This was

because existing research confirms that the attitudes and opinions of service users

strongly affect the utilisation and success of services provided (Grencavage &

Norcross, 1990). From this initial study, participants reported a profound use of

religious, spiritual/faith-based treatment methods, with a combination of orthodox and

unorthodox approaches to cure. However, it was reported that obstacles for easy

access to and use of health services (orthodox methods) involved poor service

provision, which included negative experiences from service providers that can be

linked to the diversities already discussed (see subsection 2.1.2). It is therefore,

concluded that religion and culture form the basis for the prevailing healthcare seeking

approach among this group, and has consequences for their poor health services

utilisation. This diversity in patient population and the lack of awareness regarding

their religious and cultural sensitivities is consistent with existing research evidence

(Damafing, 2008), showing that adequate understanding of patients' culture by the

clinician is a factor in successful therapeutic outcomes, and that patient-clinician

cultural matching also influences service use and outcome (Chinman, Rosenheck &

Lam, 2000; McKinlay, Lin, Freund & Moskowitz, 2002; LaVeist & Carroll, 2002). If this

situation is not addressed in research, policy and practice, it can only increase the

existing health disparity in the general UK population. Therefore, there was a need to explore the experiences and values/beliefs of Nigerian care providers (medical and spiritual) working among Nigerian patients to better understand the interplay between therapist-patient cultural matching and observable health behaviours among Nigerians; specifically, the health-related services provided by Nigerian clergy.

To achieve this objective, a two-phased cross-cultural study was designed, using the term 'two-cohort studies' at the ethical application stage to mean a 'unit of studies'; to obtain approval for both phases of the study through a single application to the University Ethical Committee (see Appendix 7). The first phase of the study reported in this chapter (section 4.2) consisted of Nigerian care providers (clergy, alternative/complementary therapists, and healthcare professionals) living and working in Nigeria, while the second phase reported in chapter 5, comprised Nigerian clergy and health professionals living/working in the UK. The study within the Nigerian context provides a particularly important prospect as there has been growing research attention to illness responses and the process of help-seeking in developing countries (Aziato, Odai & Omenyo, 2016; ICDDR, 2008; Leyva-Flores, Luz Kageyama & Erviti-Erice, 2001; Ngokwey, 1995). Both study groups have a shared discursive chapter (Chapter 6), which contains more detailed cross-referencing between studies in the thesis and, to the literature identified in the introductory chapter (Chapter 2). Hence, this combined chapter provided the avenue to understand the convergences and divergences of themes from both study contexts. For both phases of the study, two digital tape recorders were used during the focus group discussions and interviews respectively. The tapes were locked in researcher's personal locker in the University, while the contents were copied electronically to the supervisory team for safe keeping in their pass-word protected office computers.

4.1.2 Background to studies

This study focus was motivated by research evidence showing that Christian religious leaders play important roles in patients' spirituality in health care (Aziato et al., 2016), although some religious leaders may not be well equipped with the necessary skills to deal with severe health issues (Leavey, Loewenthal & King, 2007). Also, the most influential of Black Minority Churches (BMC) in the UK have Nigerian origins (Olofinjana, 2010), and Nigerian immigrants mostly utilise their services as was reported in study 1. Similarly, existing research evidence shows that health care professionals may lack the required knowledge to deal with issues of spirituality, religion and culture; and may find their own religious/spiritual values contrary to those presented by patients during consultations (Herschkopf & Peteet, 2016; Smiley, 2001). This professional shortcoming could be the result of a specific omission within clinical procedures during training or unnecessary tensions between clinicians and clients who do not fully understand each other, which consequently results in unsatisfactory therapeutic outcomes. Within the psychological profession, for instance, attention is drawn to such differences and risk factors, as the Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) states:

> In considering therapeutic goals, psychologists must ensure that they do not unreasonably impose their own values nor those of the institution in which care is being provided to clients or their carers'…. (Professional Practice Guidelines, 1995, p.13).

The above guideline presupposes that clinician's beliefs and values can equally influence patients and their carers; as well as the therapeutic process. Based on this interaction and mutual influence, it is important to investigate the health-seeking

behaviours of Nigerian immigrants from the perspectives of their most likely care providers before and during migration. By doing this, a holistic understanding of the health behaviours of Nigerians can be gained from diverse and distinct religious-cultural contexts provided in Nigeria and the UK.

The entire approach has provided an opportunity to investigate Nigerian care providers' perceptions of various responses to illness/symptoms among Nigerians in both Nigeria and the UK. By this, it was particularly possible to investigate the attitudes and roles of Nigerian care providers in relation to optimal health services utilisation achievable through clergy-health worker collaboration. However, the potential challenges and pitfalls towards clergy-health professionals' collaboration were considered against the backdrop of the successful, but problematic collaboration between culturally accepted traditional healers and health professionals (WHO, 2002). From this study, it is hoped that findings can inspire a further investigation on the factors relevant to the understanding of the health-seeking behaviours that can be generalised among Nigerians, with particular reference to those who live in the UK. This aspect can further help policy makers in the UK, towards understanding immigrant religious and cultural circumstances, and thereby addressing the health needs of its culturally and religiously diverse patient population.

4.1.3 Reseach objectives

- Explore various responses to illness/symptoms by Nigerians from the perspectives of Nigerian care providers in Nigeria and the UK.

- Understand potential barriers and facilitators to healthcare utilisation from the perspective of Nigerian care providers (clergy and health workers) in the UK and Nigeria.

- Explore possibilities for clergy-health professional collaboration towards an integrative coping model to improve health care utilisation.

- Draw conclusions that can inform a quantitative study on wider determinants of health-seeking behaviour and healthcare utilisation among Nigerians in the UK; which can be useful to health care professionals, policy makers, and integration workers.

4.1.4 Research question

The two parts of this study were guided by the research question regarding the extent to which Nigerian care providers' socio-cultural, religious, and environmental factors match with those of Nigerian patients to impact on their attitudes toward healthcare utilisation; as perceived by the care providers themselves: How do Nigerian care providers perceive the attitudes to health-seeking among Nigerians, and what are the potentials for collaboration towards a culture-sensitive healthcare provision?

4.2   Study 2: The Nigerian Group (Phase 1)

Title: A cross-cultural study on the health-seeking behaviours of Nigerians from the perspectives of Nigerian care providers in Nigeria: challenges for collaboration - A Thematic Analysis.

Following the study summary provided above, this section provides a report of findings on the research question based on the first part of the cross-cultural study conducted in Nigeria; which is the second empirical study wthin this PhD.

4.2.1   **Method**

4.2.1.1 Design

This is an inductive qualitative study using focus group discussions (FGDs) for primary data collection (Saunders et al., 2007). The semi-structured FGDs method was used as it proved an easier means of data collection from a larger number of the research population in Nigeria (Wilkinson, 1999). Also, it offers the added advantage of taking place in a more natural context closer to everyday conversation of the research population, with richer and more articulated discussion (Wilkinson, 1998). Moreover, this approach has other advantages already discussed in study 1 (3.2.1). Thematic Analysis (Boyatzis, 1998; Braun & Clarke, 2006) was used for data interpretation as in study 1 (see 2.4.2.2).

4.2.1.2 Materials

Participants were provided with forms for the interview/discussion schedule; informing them about the aims and purposes of the research, aspects of confidentiality, anonymity, and freedom to participate or withdraw at any time without having to offer any reasons clearly expressed. These forms included the Information Sheet, Consent Form, Debriefing Sheet, and Interview Protocol, used to facilitate the three FG discussions (see Appendices 8, 9, 10:1, & 11 respectivey). A letter of permission to use the venue at Ofu-Obi Africa Centre in Nigeria, was obtained to gain access to the venue (Appendix 12:1). Two tape recorders were used in recording the focus group discussions.

4.2.1.3 Participants

Participants were made up of Nigerians who live and work in the South-Eastern geopolitical zone of Nigeria. The participants had to be adults actively engaged as qualified care providers (Clergy, complementary/alternative care providers, and healthcare professionals). This research adopted a 'purposive sampling' approach (Willig, 2001, p. 58) by choosing a homogenous sample size (Brocki & Wearden, 2006) as employed in study 1 (3.2.3). Homogeneity was based on Nigerian nationality, with care provision as professional status, and place of abode to be in Nigeria. The exclusion criteria were for intending participants who were Nigerians but not qualified as care providers, nor engaged at the frontline in providing such services. Also, those aged below 18 years were regarded as minors, and therefore, were excluded. A total of eighteen participants from different professions and religious backgrounds were recruited for the 3 focus groups (FG1: n = 6, FG2: n = 6, FG3: n = 6); and were represented by virtual names to protect their identity (See Table 4.1).

4.2.1.4 Procedure

Data collection was based on 3 Focus Group discussions while recruitment of participants was done through the snowballing process by contacting leading clergy/pastors of various Christian denominations, and healthcare professionals in Nigeria who helped to recruit their colleagues. For the initial focus group discussion (FG 1), 6 participants were recruited for the first focus group discussion through an initial personal contact with two care providers (clergy n = 1, medical doctor n = 1) who made initial contact with eleven persons. Out of the eleven care providers, one was excluded, and three opted out on their volition (3 females and 1 male). Therefore, seven were confirmed, but one person (a female) later discontinued due to family

bereavement; resulting in a low female representation in the first focus group (female = 1, males 5).

To recruit for the next two FGs (FGs 2 & 3), twenty new participants were contacted through a letter of invitation; and eighteen of them declared their intentions to participate, but two (hospital administrative staff) were excluded for not being in the frontline to engage with patients. Then sixteen participants who met the inclusion criteria were provided with the protocol package including the consent form to sign. Of the sixteen persons included, two later declined for lack of sustained interest and fourteen confirmed their interest to continue. However, two of them withdrew later without any reasons leaving a total of twelve participants who concluded the study. These participants were provided with the interview protocol and a request to choose their participation in either of the two discussion groups scheduled on different dates. This arrangement was for their convenience, availability, and a fair distribution/representation in each group. Potential participants who were available on both dates were advised to join any group that had lesser participants at the time, which resulted in a balanced representation of 6 participants for each group (FG2: n = females: 3 and Males: 3; FG3: n = females: 5 and male: 1).

The three focus group sessions were conducted in the English language at *The Ofu Obi Africa Centre Enugu,* on different occasions. Each session lasted for about 2.5 hours and tape recorded, which were later transcribed by the researcher for analysis. The discussants were informed of their freedom to discontinue at any time if they felt uncomfortable during the FG's. They were also informed of focus group protocol and that the researcher would sometimes interrupt or guide the conversations if a participant dominated the discussion or conversations veered too far from the topic guide. As participants were informed of their freedom to withdraw without having to

give reasons, those who withdrew had met the inclusion criteria like those who participated, but those who were excluded were different from the sample for not satisfying the inclusion criteria. Based on purposive sampling technique, and the inclusion/exclusion criteria of the research sample, the withdrawal of two males (clerics) for the FG3 before completing the consent form, only affected equal gender representation in the group, but did not affect the overall gender representation in the study (Females: n = 9, Males: n = 9); nor did it affect the homogeneity and representativeness of the sample. Although, the withdrawals resulted in poor clergy representation for the particular focus group (FG3: Clerics, n = 1) (see Table 4.1).

Table 4.1

Socio-demographic background for the Nigerian focus groups.

FG/Participants and states of origin	Age range	Gender	Profession/Religious affiliation	Number of years in the profession
FG1				
Amana: Anambra state	41-50	M	Anglican clergy	25
Ika: Enugu state	51-60	M	Herbalist, no denomination	12
Kine: Imo state	31-40	F	Clinical psychologist/Pentecostal	7
Buolu: Abia state	31-40	M	Pentecostal clergy	4
Okwe: Abia state	31-40	M	Catholic clergy	7
Uchie: Enugu state	41-50	M	Medical doctor/Catholic	13
FG2				
Nene: Imo state	41-50	F	Charismatic/Medical Radiographer	12
Uka: Enugu state	31-40	M	Catholic clergy	2
Chy: Enugu state	31-40	F	Catholic Nurse/psychologist	12
Ogom: Anambra state	51-60	F	Spiritualist/CAM Provider	8
Ikem: Enugu state	51-60	M	Health educator	20
Bodi: Delta state	41-50	M	Pentecostal Clergy/ complementary health	15
FG3				
Ukamma: Imo state	41-50	F	Catholic Nun/medical doctor	6
Chigo: Imo state	31-40	F	Anglican/Pentecostal, Nurse/psychologist	9
Noye: Imo state	18-30	F	Catholic, Nurse.	3
Ogeme: Anambra state	51-60	F	Non-denominational cleric/spiritual healer.	10
Edu: Imo state	31-40	M	Medical Doctor	2
Abomi: Enugu state	31-40	F	Catholic Nurse	6

4.2.2   **Results/Analysis**

The process of thematic analysis advocated by Boyatzis (1998) was adopted for this part of the cross-cultural study as already used and described in Study 1 (see 3.2.5). In this study, participants' responses were captured as hunches (Willig, 2001); such as, 'methods of health seeking', 'experiences of providing care', 'illness perception', 'beliefs', 'barriers', 'collaboration', 'integration of methods', 'challenges to collaboration', 'referrals', 'health seeking determinants', etc. A colour coding method was used to differentiate individual hunches within each transcript and showed their similarities across transcripts. All themes emerging from this group were marked with 'FG' in the Nvivo tree structure to distinguish them from the UK interview group marked as 'Interview' for the second part of the study (Study 3). From the emerging themes (Table 4.2), a thematic map or tree structure (Figure 4.1) was derived to guide the analysis. This network also showed a colour coding that distinguished 3 global themes and their respective sub-themes. This result and analysis section contains more and lengthier quotes to cater for the three focus group discussions involved; and therefore, has less literature referencing as well as between-study and within-study cross-referencing; which was reserved for the discursive synergy section (Chapter 6) as already mentioned (see 4.1.1).

Table 4.2

Identification of themes (The results from steps 1, 2, 3, and 4)

Basic themes	Organising themes	Global themes
1. Experiences of health care in Nigeria; Methods of help-seeking during illness - medical, spiritual, alternative medicine; determinants of healthcare utilisation - illness conditions, cost, structural and environmental factors; determinants of health seeking methods in Nigeria: Illness perception/beliefs; stigma, accessibility, suggestions on improving healthcare utilisation in Nigeria.	Influences of cultural/health beliefs, Health beliefs formed by lay beliefs, influences of provider's beliefs in shaping care, Choice of treatment by illness condition, the role of cost in healthcare, Stigma and accessibility of healthcare, Providers health beliefs in providing care.	Providers' perceptions of health-seeking behaviours in Nigeria.
2. Experiences of providing care in Nigeria; integration of different treatment approaches, experiences of integration and challenges, opinions on the attitudes and practices of care providers, referrals among care providers.	Willingness for collaboration, Multidimensional referral pathway in Nigerian healthcare	Contexts for collaboration among care providers in Nigeria.
3. Experiences of difficulties in integrating diverse methods.	People's trust in herbal or faith healers, Conflict in underlying principles of healing across methods, Poor legislation and regulation, Trust between professionals	Challenges to collaboration in Nigeria

Note: Table 4.2 shows the three global themes emerging from the analytic process (following steps 1, 2, 3, and 4), with their organising themes and basic themes grounding theme to the dataset.
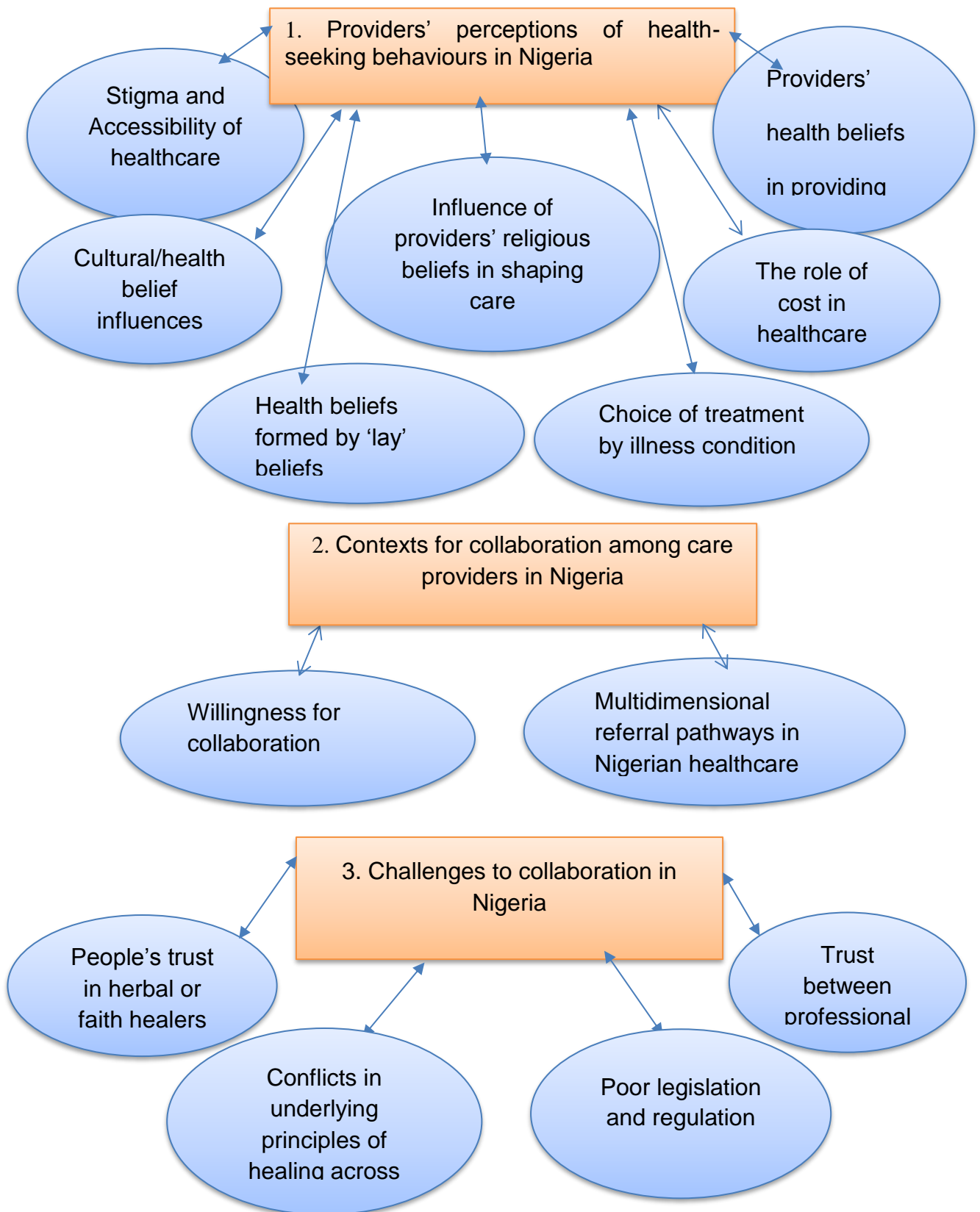
Figure 4.1. A thematic map showing three global themes and their sub-themes

Following from the Nvivo process, the 8 categories emerging from the data are as follows: 1) Health seeking methods used by native Nigerians, 2). Experiences and challenges of providing care in Nigeria, 3). Integration of treatment approaches, 4). Opinions about care provision and the challenges, 5). Determinants of Nigerians' health seeking methods, 6). Collaboration among care providers and the challenges, 7). Improving healthcare utilization, and 8). General contributions from participants. From the categories already cited above, some codes within the dataset were identified as strongly related to the research question: 'perceptions of health seeking behaviours in Nigeria', 'suggestions on improving healthcare utilisation in Nigeria', 'experiences of integrating different treatment approaches', 'opinions on the attitudes and practices of care providers in Nigeria', 'illness perceptions and beliefs', and 'determinants of healthcare seeking methods in Nigeria' in no particular order. These global themes and their constituent themes are subsequently analysed:

4.2.2.1. Global Theme 1: *Providers' perceptions of health-seeking behaviours in Nigeria*

This master theme emerged in view of describing how the clergy and health workers in Nigeria perceived health-seeking behaviours exhibited by Nigerian as part of their experiences of providing care within the Nigerian socio-religious and cultural contexts. This discussion focused on exploring the methods used by Nigerian patients to regain health, what factors influenced such choices and how these choices were relevant to healthcare utilisation. From the evidence provided by participants, Nigerians adopted both orthodox (modern and scientific) and unorthodox (spiritual and traditional) means of cure, but would mostly utilise spiritual and traditional methods; consistent with findings in study 1 (3.3.2)

UCHIE (Medic): *'…Mostly Nigerians favour visiting priests, traditional healers….'* (FG1: LINES 9-14).

IKEM (Health educator): *'…more or less you will look for the herbalist who will give you some…drugs believing because there are leaves and roots around you'.* (FG2: LINES 13-14).

CHY (Nurse): *'…And so they resort to either prayers, they keep on praying, or they will go to the traditionalist, and most times they report to the hospital very late…'* (FG2: LINES 38-42)

NENE (Medical radiographer): '*The first thing, most times, like most of them seek traditional care. Then, the next step, if it doesn't work out, they go to hospital to seek for health care.*'* (FG2: LINES 6-8).

The above quote on the prominence of traditional/herbal and spiritual methods was explained as a consequence of the societal shift towards more spiritual emphasis in the interpretation of life events. This shifting trend has particular relevance to the current upsurge in Christian Pentecostalism as an organised body reputed with mass healing programmes known as 'crusades' as shown in the literature (2.1.3), and evidenced in the data presented below.

OKWE (Catholic clergy): *'…before the recent civilisation and education that is coming up, most Nigerians depend so much on the herbal, they always go for herbal treatment; but recently now, is like there is a shift. People are more on… something*

like 'crusade programme', healing is going to come up, people tend to go there because they believe that God is going to heal them there' (FG1: LINES 22-27).

In addition to the impact of the religious leaders (the clergy and other alternative care providers), the role of unqualified medicine dealers as a risk factor associated with self-medication also featured in the discussions within this theme;

UKAMMA (Medic): '*In addition to that some might equally decide to you know, handle their problem on their own. They may decide to go and meet patent medicine dealers to mix some concoction for them, or they on their own may decide to go and buy drug which they feel might be of help to them.*' (FG3: LINES 14-17).

OGEME (Non-denominational clergy/spiritual healer): '*Here in Nigeria we have more chemists than hospitals. ….. A woman's child was ill she now sent the daughter to go to a chemist, 'jee gwa Nnamdi ka o mix elu m ogwu' (go and tell Nnamdi to mix up some drugs for me). It was expired medicine, the child died…'* (FG3: LINES 670-673).

With reference to the above health-seeking approaches adopted by Nigerians, cutting across medical, faith-based and herbal methods there seemed to be some relationship between religious/cultural beliefs and preferences for the spiritual healing method, which needed further exploration. Also, the reported risk factors associated with self-medication and other treatment choices are important in understanding health behaviours and their relevance for health outcome in Nigeria. These aspects have necessitated an in-depth exploration of the reasons for making these choices, with a view to explaining how these choices could become barriers to healthcare utilisation as discussed in the next theme.

(i) Cultural/health belief influences

This sub-theme discussed participants' experiences and perceptions of various health behaviours among Nigerians in relation to socio-cultural and environmental determinants conditioned mostly by individual religio-cultural beliefs and practices. These determining factors invariably constituted dimensions of barriers to health services utilisation as they facilitated the use of alternative treatment methods. Prominent among these factors were reported as health beliefs and illness perceptions held among the people. Of interest to this study is the report that these health beliefs were deeply rooted in the religious and cultural belief/practices prevalent in the region. For instance, beliefs in witchcraft or voodoo were reported, where patients perceived illnesses to be a spell cast on the sufferer by an enemy or a wicked neighbour, which was motivation for seeking traditional and spiritual healing;

AMANA (Anglican clergy): *'…we have old women and men coming to you, coming to us to complain of somebody dropping something for them and that their legs are now swollen. Aha, they call it 'ehure' in Igbo language and that they needed prayers to be said on it. And sometimes a woman will come and say, 'well, last year I used to trek from so so and so, this year I can't trek again, I think my enemies are after me'. Sometimes is a problem of childlessness, somebody must have done that.'* (FG1: LINES 212-217).

UKAMMA (Medic): *'Can you imagine? Even a ninety/hundred years old man or woman with, be with one chronic illness, when he or she dies, see our people some of them believing that somebody in the village must have killed the man…, that he had quarrel with one man in the village, and am sure it is because of that quarrel; that is*

why the man now sent stroke from somewhere and you know, sent it across to him in the hospital….' (FG3: LINES 567-573).

BODI (Pentecostal clergy/alternative medicine dealer): '*From the herbalist way, maybe they will begin to suspect maybe this is poison or this is somebody bewitching them or who is against their health.'* (FG2: LINES 25-26)

EDU (Medic): *'…conditions like that people always believe that it is being done by others, by the wicked one. So they might prefer to follow it traditionally'*. (FG3: LINES 43-45).

Similarly, some religious and cultural beliefs led them to attribute illnesses to divine curse or diabolic afflictions from the devil (Satan), that needed spiritual intervention rather than medical treatment,

UKA (Catholic clergy): *'…our people 80% will always believe that the devil exists in every place'* (FG2: LINES 154-155)

CHY (Nurse): *'…when it is medical cases like this Blood Pressure (BP), stroke, most times they attribute it to a curse; maybe this particular problem or this particular person.'* (FG2: LINES 173-174)

Consequently, some religious teachings uphold some narratives that can become barriers to healthcare utilisation, such as the Jehovah's Witness teaching that abhors blood transfusion as experienced by one medical participant;

UKAMMA (Medic): '*So I ordered for the blood, the woman said, 'no I am a Jehovah's*

Witness we don't take blood we don't take blood.' I said 'Ah, but actually you've lost quite good quantity of blood I need to transfuse you now'. I even called the husband, the husband said, 'sister' that she is here so that she actually the church members they don't allow them to or rather it is against their, this thing to receive blood.' (FG3: LINES 308-312)

(ii) Health beliefs formed by 'lay' beliefs

In addition to the mixture of religious and cultural beliefs cited above, the issue of lay beliefs about illnesses were also reported as vital factors underpinning various health beliefs that determined the choices of health seeking methods sought by patients as experienced by one medical practitioner;

UCHIE (Medic): *'I also had a patient that came with this ganglion, foot ganglion - ulcer, which eventually led to ganglion…. he said that, ada agbakwa ehuere ogwu…you know that, "you don't give injection to this condition". That if you give it, the person will die'* (FG1: LINES 846-849)

IKEM (Health educator): *'Some believe, they will just give you that information, 'if you take orthodox medicine, is going to form a stone in your body, why not take this alternative to medicine method'.* (FG2: LINES 419-421)

The common beliefs held among the people as authentic information about medicine and its side effects or dangers can become effective in promoting the use of complementary/spiritual healing methods while deterring patients from using available healthcare services. For instance, the aversion for using prescribed drugs in the hospital was the experience reported by a participating psychologist,

KINE (Clinical psychologist): *'…like when I was in Orthopaedic hospital, some patients will tell you 'I want that doctor that doesn't give drugs.' Before they take any drug, they must see me, 'I want that doctor that doesn't give drugs'; because I go on my lab-coat so they think am a medical doctor….'* (FG1: LINES 942-945).

The above discussions concentrated on the experiences of providing care for Nigerian patients who clearly held strong beliefs about the origins of ill health and the effects of different treatments, and providers' own perception of how religious and cultural beliefs, coupled with various health beliefs influenced patients' health behaviours.

(iii) Influence of providers' religious beliefs in shaping care

The above discussions provided an opportunity to explore care providers' own beliefs and attitudes to care. This aspect was useful while considering the general impact of belief systems as determinants for health behaviours and in particular, as barriers to overall healthcare provision and utilisation within the Nigerian context. These attitudes and beliefs were expressed through participants' discussions of their experiences and challenges of care provision in relation to practical solutions and information offered to patients, advice or suggestions provided, as well as the motivations underlying provider intentions and actions that might have impacted on the therapy process and outcome. Therefore, perceived illness perceptions for care providers alike were also explored within this theme, with particular reference to the ways provider's personal and professional lives were affected by religious and cultural beliefs and how this could have impacted on healthcare utilisation;

EDU (Medic): *'…the health provider might still have his own belief and even your belief to an extent might also alter…the way you reason or approach of your reasoning….'* (FG3: LINES 413-415).

For instance, the expressions of religious beliefs held by providers have relevance for their understanding of illness aetiology and diagnosis;

IKA (Herbalist): *'You find out that at times, most of the people are not adhering to the laws of God. When one falters the laws, may be one thing or the other starts happening they start looking for where to get himself healed.'* (FG1: LINES 40-42)

OKWE (Catholic clergy): *'…what I see kind of influences me a lot…. That if I as a priest could give out time to pray, and people believe that what you are doing to somebody and it happens, then trusting in God that Christ is the same yesterday, the same today and the same forever, so whenever we call upon him he will always be there for us….'* (FG1: LINES 289-293).

Following from the believed illness causation, treatment options are usually recommended by care providers as expressed by some of the clergy who use spiritual healing thus,

BUOLU (Pentecostal clergy): *'The truth is that whether anybody believes it or not, anybody can actually choose to differ in opinion, but there are conditions that are spiritually mastermind, ok. So, there is, there is an evil let loose on this plane of existence, you know, and to that extent we can only recourse to high power, positive power in this regard, to dealing with such situations.'* (FG1: LINES 508-512)

OKWE (Catholic clergy): '*I do sometimes give psalms to people just like doctors prescribe drugs during hours. And there are some certain times you give them Psalms to pray in the morning, and even sometimes midnight psalms, like those who have this difficulty in sleeping and all that; or who feel that some witches are around their houses every night. And then tell them to confront them around midnight with certain Psalms, Psalm 35 and some other psalms. And you see them after that, they go in and sleep well.*' (FG1: LINES 346-354).

However, the preceding beliefs seemed to be contradicted by a contrary opinion held by the herbalist, thereby introducing some important tension that helped in better understanding of the variations in providers' beliefs and how these can impact on patients' health seeking behaviours,

IKA (Herbalist): '*So as a homeopath from personal experiences I realise that nobody cause illness to anybody except the individual self who is suffering it, he generated it.…*' (FG1: LINES 142-144)

(iv) Providers' health beliefs in providing care.

In addition to the influences from religious and cultural beliefs, providers also discussed their health beliefs as underlying their illness perceptions and treatment procedures;

OGOM (Spiritualist/CAM Provider): '*What we eat also contribute to our health problems. And so many things we neglect are very vital to our health, good health, especially these our natural food, they are very, very good. And this thing called 'water', is very good. And they should know that any cold, very cold water you drink*

seizes your heart for nine hours before it starts functioning again' (FG2: LINES 740-746)

IKA (Herbalist): '*Certain illnesses cannot be detected in the lab, you can only find it out when you ask God which way on this individual person. The issue is this, you that is giving out things to help mankind, what is your state of mind, are you really doing those things that God asked you to do? Are you working with these laws that God has given us, especially the laws of love which is given to everybody unconditionally?*' (FG1: LINES 144-190).

(v) Choice of treatment by illness condition

From the foregoing results, it is evident that providers varied in their opinions as to the causes of illnesses and treatment options according to their professions, ranging from the health professionals, the clergy, the herbalists and other alternative medicine providers. These beliefs and attitudes emanating from care providers were considered as indirect factors that could determine treatment choices among patients. Besides, it was necessary to consider those factors that directly determined patient' responses towards getting cure, such as illness conditions;

UKAMMA (Medic): *'I also discover as a medical practitioner that the nature of the illness, we have some chronic diseases that the person might have been battling with for many years. You know, at a time some of them seem to lose hope….'* (FG3: LINES 211-217).

On this aspect, patients were reported as consulting traditional and mainly spiritual healing centres for such illness conditions perceived as unexplainable or incurable described thus,

BUOLU (Pentecostal clergy): *'…conditions that have defied orthodox therapy or that are increasingly unaffordable to procure. Those are the instances, where such individuals would probably recourse to more spiritual, have more spiritual recourse otherwise they find their way around it.'* (FG1: LINES 88-91)

OKWE (Catholic clergy): '*Most of the time, as a priest I encounter more things that people have tried as much as possible to, to deal with medically…. So people come with illnesses they have seen that medically they have spent so much but he's not seen any effect on it and they believe that going to God will do it. And that faith they have sometimes clears it all.'* (FG1: LINES 95-105; 138-140).

In the same vein, a medical practitioner while sharing his experiences of providing care through the medical process confirmed that illness conditions that defied medical solutions made patients to opt for alternative approaches;

UCHIE (Medic): *'But sometimes if it defies physical method or psychological method then you find that the patient might you know, filter into other aspects of alternative treatment.'* (FG1: LINES 375-378)

(vi) The role of cost in healthcare

Further to the exploration on health seeking determinants in the Nigerian context, it is not surprising that the cost/benefit factor was evidently reported as a

barrier to healthcare utilisation considering the poor social capital in Nigeria, as was reflected in study 1 (3.3.2, [iii]). Hence, poverty in monetary terms was well reported among the predominant factors in this study, with medical services also reported as neither free nor affordable,

EDU (Medic): *'I think there are some other challenges which include poverty, 1. Level of poverty in our society which exposes or prevents our people from getting good health care. They end up in the hands of quakes who have no skills and we lose a lot of people through that means.'* (FG3: LINES 402-404).

BUOLU (Pentecostal clergy): *'Primarily is their social background…. if you are dealing with an impoverished individual there are a lot of things that can happen….'* (FG1: LINES 469-471)

CHIGO (Nurse/psychologist): '*The first one is poverty as we have already said, it is poverty because some may really check… 'When I go to hospital I will spend this, I will spend that, but when I go to spiritual man he will just direct me or pray for me and I will be healed.' For some of them, poverty is number one. Secondly, is educational ground some people don't know anything. They didn't even know that there is something like going to hospital….'* (FG3: LINES 447-452).

Similarly, the issue of poverty as a determining factor was extended to factors associate with the healthcare facilities as well as lack of adequate information/education needed for the early and easy access to available facilities and effective cure as already reported above by Chigo. The culminating effects have important consequences for health outcome in Nigeria;

UCHIE (Medic): '*From my own experience... most Nigerian patients come to the hospital as a last result … when you now, you interview them they will now tell you that it's because hospital is too costly, you know…. Then again, is 'ignorance'. Some of them are not well informed. Then generally the availability of health facilities, you know. Some of them are living in the rural areas and they don't have the facilities close to their door steps.*' (FG1: LINES 662-671).

The issue of poverty was broadened to reflect its impact on care provision were social capital can influence policies on the quality and quantity of health facilities available for patients,

EDU (Medic): *Then on poverty also, am now taking the burden aspect to the side of the health provider. Because of lack of funds, due to the level of poverty in the region, we lack good equipment that will actually provide the best care to these patients.*' (FG3: LINES 438-440).

The notion of poverty is discussed from a broader perspective regarding its systemic impact on poor healthcare provision. An important source of the poor social capital identified in Nigeria was associated with the level of corruption, which has impacted on the core infrastructures of the country such as the healthcare system,

AMANA (Anglican clergy): '*There is also the challenge of corruption, you know. We know that in Nigeria today and in most African countries, the government our governments are grossly corrupt and as a result of that, it leads to…., one institutions or the other going on strike. Like the doctors in Nigeria just came back from their strike as a result of what, poor remuneration*' (FG1: LINES 640-643).

IKA (Herbalist): '*This we said, 'corruption', 'selfishness', you want to make it only you alone, it is not possible.*' (FG1: LINES 1015-1016)

UKAMMA (Medic): *'I will also like to add; you know our drugs too. I don't know it's just a pity in our country at times, the kind of drugs we produce in our country here. Some of them will I say… they are fake if I put it that way. And you see some of the good pharmaceutical companies that produce good drugs, some of them are quite expensive.'* (FG3: LINES 420-423).

The combination of the aforementioned factors, provided some insight to the relationships between poverty and educational acquisition, with due recognition that mere formal education (being lettered) may not necessarily imply the acquisition of adequate health behaviours needed for the expected health services utilisation as discussed in the following quote,

BUOLU (Pentecostal clergy): '*People that are more lettered would naturally want to have medical recourse before any other thing. People that are more impoverished would recourse to spiritual means before any other thing. And then now in spite of the extremes they also tend to find a middle ground because the educated elite when the medical has failed him, he would resort to the spiritual. And for the more impoverished one, when the spiritual remedy hasn't quite worked out like the medical expert said, they would resort to the medical and sometimes probably at the tail end of the manifestation of whatever condition they may be suffering from.*' (FG1: LINE 960-968).

The issue of educational training and awareness was stressed as an important gateway to better health decisions,

CHY (Nurse/psychologist): *'Another thing that also influence their choice of treatment is their educational status. Some people that are enlightened and have varied knowledge about health issues, when they get sick, irrespective of their financial status, they still resort to medical services. Even though, some people that are wealthy, but, because of maybe their educational status, they still believe in all these superstitious beliefs that will lead them to maybe traditionalist or religious.'* (FG2: LINES 409-414)

IKEM (Health educator): *'…if Nigeria can make education to be cheap so that people will be educated because if you become educated, you become informed, you come out of the cocoon, you can now move further.'* (FG2: LINES 703-705)

KINE (Clinical psychologist): *'…there is a kind of illness one will have, the best thing is to go for a psychological intervention where the psychologists use psychotherapy…, but in Nigeria here patients hardly go to psychologists, may be because they're ignorant of it, because there is no enough awareness.'* (FG1: LINES 80-82).

(vii) Stigma and Accessibility of healthcare

Other remote factors militating against the use of healthcare services include perceived or real experiences of stigma by patients, as well as the physical challenges accessing the health facility. For instance, if patients are stigmatised for their illness conditions and also no guaranteed confidentiality, they can become evasive towards healthcare utilisation,

BUOLU (Pentecostal clergy): '*I think for our context, the most challenge I find is that of confidentiality and stigmatisation you know. In our African, in our local context because quite often people living with certain conditions they don't want to confide in you because they don't want to be stigmatised, they are afraid you would judge them and then if the information filters out they will be stigmatised*' (FG1: LINES 572-575).

OKWE (Catholic clergy): *'One of the great challenges I see is what I call, 'Trust' because of a lot of fake around, and people have come to hardly even trust doctors.'* (FG1: LINES 584-585).

Understandably, health services utilisation will be at its lowest ebb where there is lack of trust in care providers, and can be compounded by difficulties accessing the healthcare facilities,

NOYE (Nurse): *'Sometimes you just found that, especially in these rural areas, you just find that health facility is far from these patients. If they think of the transport they are going to spend to go there, and may even end up not even getting that care they are looking for. They will have no other option than to just seek for these local herbalists…'.* (FG3: LINES 486-490).

Considering the interplay between the factors discussed above, a seeming consequence of the dynamics was presented as general apathy towards medical health seeking. On this point, patients were perceived as compelled to devising personal coping mechanisms by adapting to the illness condition, which culminate in other reasons for not using available healthcare services while in Nigerian and while in the diaspora as articulated a participating doctor thus,

EDU (Medic): *'I found out that the major problem we have, our people have with, in seeking health care even here and there in UK or abroad is lack of patience…, we don't usually like going to hospital where we will follow procedures….'* (FG3: LINES 630-638).

Although participants expressed some religious beliefs like their patients that could influence their attitudes and practices in care provision, the health professionals in particular, who work within the medical setting seemed to be more critical of the negative influences of these belief systems. However, they expressed a compelling pressure that constrained them towards adhering to patients' beliefs in order to establish a cordial patient-clinician relationship that can enhance therapy outcome. Therefore, while participants discussed a remarkable disapproval of any type of abuse or excesses either on the part of providers or patients, they accepted the inevitability of integrating the traditional and spiritual healing methods by advocating a balance between the spiritual needs of the patients and genuine, professional care practices;

UKAMMA (Medic): *'…we all have our belief system. You can equally incorporate, you know, the spiritual aspect of it, letting them know that look, 'tell God about this problem and also take your drug they all work together' because God equally uses all these care givers to achieve what he wants…'* (FG3: LINES 134-137).

Considering the shift towards alternative care methods, especially the spiritual healing approach in view of the challenges encountered in utilising the health services, this study explored possible dialogue among care providers towards efficient and integrative care. This is in the hope that a successful collaboration among different care providers can complement their services, curb excesses, and achieve a better healthcare service through integration. This was the source of the next global theme:

'Contexts for collaboration among care providers in Nigeria', with 2 sub-themes that discussed the experiences of willingness among providers to collaborate (*Willingness for collaboration*) and the referral pathways in place that can aid this process (*Multidimensional referral pathways in Nigerian healthcare*).

4.2.2.2 Global Theme 2: Contexts for collaboration among care providers in Nigeria

As the role of religious/spiritual leaders and other complementary therapists have been discussed in the context of care provision in Nigeria, it becomes necessary to address their influences on the health seeking behaviours of Nigerians as it represents an important factor for improved healthcare utilisation. Hence, this global theme and its sub-themes were used to discuss issues emerging from participants' experiences of adopting an integrative care approach through referrals/cross-referrals of patients while being sensitive to the religious and cultural demands of the Nigerian context;

EDU (Medic): *'Most often, you can't just do without it because of…. the society we found ourselves or the part of the world we find ourselves in. Here we are, we have this, we hold unto the spiritual beliefs. So, for you to get the patients …you must put yourself in this person's shoe and you can't do that if you don't bring in spiritual aspect because this is the number one….'* (FG3: LINES 165-180).

CHY (Nurse): *'I have experienced where a particular patient has undergone, had undergone so many investigations, MRI, CT Scan, where the cost of treatments are a problem, and at the end of it, when nothing could be found out and she was still having*

problem, she was advised to meet a priest for prayers. So that's where I know that I would direct somebody to another way of treatment other than medical services.' (FG2: LINES 331-335).

Although, participants discussed various aspects of working together in diagnosis and treatment of illnesses, it was necessary to explore the drive for this collaborative enterprise using the next theme.

(i) Willingness for collaboration

This theme discussed the atmosphere of receptivity among different care providers to collaborate for the purposes of complementarity towards an integrative method that can benefit the service users,

IKA (Herbalist): '*As pastor has just said, that a lady that has HIV positive refused to take any drug is a challenge to the pastor. He was able to talk it into her for her to accept to take the drug.*' (FG1: LINES 546-547).

For any successful collaboration to take place there needs to be a willingness among providers to translate intentions into action. Therefore, this theme reported on the existence of a positive attitude and practical acts towards collaboration among providers as one of the clergy affirmed;

BUOLU (Pentecostal clergy): *'Well, sometime medical referrals are paramount. Sometimes people come with purely clinical conditions and then your highest recourse is, you know, to refer them accordingly. And then for the most times also em, people require some spiritual guidance to dissuade their minds from certain beliefs that may*

have brought them into that condition in the first instance. And then of course there is counselling also, you know, giving an all- round spectrum.' (FG1: LINES 339-344).

OKWE (Catholic clergy): '*I would think that that counselling is very important. When you do counselling, you get to know the person more and the person opens up the more, you know, both medical, psychological and both spiritual.*' (FG1: LINES 437-439)

IKA (Herbalist): '*I accommodate a doctor at Aba who uses my drugs; and he will like to know the formulae I use. I told him, 'this drug is for this, the other one is for the other thing, the other one is for the other thing, fine-tune your own formulae for your patients.*' (FG1: LINES 754-756)

UCHIE (Medic): '*A priest…doesn't hesitate in sending his wards or anybody that needs his help to the hospital. He doesn't keep them praying for miracles. He sends them to the hospital and also settles their hospital bills. He does that regularly.*' (FG1: LINES 908-911).

From the above expressions of willingness and existing practices of cross-referrals from the clergy, alternative medicine providers/herbalists to health professionals, there seems to be an indication of a positive attitude towards mutual interaction that can provide better care for patients. In particular, collaboration with the clergy was represented as crucial and inevitable based on the depth of religious beliefs and practices already prevailing in the region, which accords the religious leaders an important position in the grand scheme of care provision in Nigeria.

(ii) Multidimensional referral pathways in Nigerian healthcare

From the foregoing flow of referrals from the clergy and complementary care providers to the health professionals (unidirectional flow), it became vital to explore any corresponding practise of cross-referrals from health professionals to complementary/spiritual care providers to represent a more balanced referral process (multidimensional pathway), which was summed up by a psychologist in the quote,

KINE (Clinical psychologist): '*So in most cases you find medical doctors who in as much as they are medical doctors, they also believe or sometimes use spiritual methods to help patients out.*' (FG1: LINES 722-723)

UCHIE (Medic): '*…you might be able to find a patient that have some problems that are not really physical. So, in that kind of case, you advise the patient you know, that it is good to look for a priest and that would pull through.*' (FG1: LINES 386-391).

KINE (Clinical psychologist): '*…knowing the belief of the patients, and knowing that it will help the patient, as a child of God as a Christian I deviate. In fact, most of the times, when I see that is the only way I can help a patient, I deviate, you know, through prayers…. if the patient believes in God I will drop my psychology and become a pastor; and you see them believing in you and getting well.*' (FG1: LINES 416-431)

IKEM (Health educator): '*There are some hospitals that are owned by pastors so such ones, if you will pray, they will not quarrel with you….*' (FG2: LINES 499-500).

UKAMMA (Medic): '*Yes I think I have already mentioned part of it by trying to channel the attention of patients to spiritual area. Some of these things you can tell them, look*

you can talk to God about this problem believing that God will answer your prayer; and also taking the drugs too. You can equally, some of them might equally need a psychologist which you can equally refer them to go and see if you feel it is a psychological problem….' (FG3: LINES 141-147).

Beyond a unidirectional referral process mainly from the clergy to the health workers the Nigerian experiences equally showed a multidirectional flow of referral, with the spiritual healing method regarded as central to treatment options adopted for both physical and mental health conditions. However, irrespective of the general indication of willingness and practices towards collaboration, there seemed to be a consensus of concern about the emphasis placed in faith-based healing methods. The next emerging global theme was used to further explore the challenges and barriers that could impede the smooth process of collaboration.

4.2.2.3. Global theme 3: Challenges to collaboration in Nigeria

From the foregoing themes, the compelling religio-cultural context in Nigeria made it possible for the practice of a multidimensional referral pathway, yet it was important to explore the challenges anticipated by care providers. Therefore, under this theme were discussions about some anticipated challenges that might arise from the collaboration process considering patients' beliefs as well as providers' personal and professional beliefs and practices as summed in the quotes below;

ABOMI (Nurse): *'There are some challenges I have noticed, because I know of a patient she is going to a spiritual place and she is coming to hospital also. Then at a time she stopped taking her drug telling me that she went to that man of God and he*

told her not to take that drug again, that that drug is the major thing that is causing her problems….' (FG3: LINES 372-375)

KINE (Clinical psychologist): '*When one is a, for example a medical doctor and then a Christian. Now you've studied medicine, and you have the theories you have things to make me well, and then you go to church and the pastor tells you that God can also make you well. There is what we call 'cognitive dissonance' if that doctor doesn't match both of them together, you will have cognitive dissonance in you.'* (FG 1: LINES 717-721)

(i) People's trust in herbal or faith healers

The challenges and barriers to collaboration were mainly because of differences in care providers' beliefs. These health beliefs (reflected in religious, cultural or professional basis of illness perceptions and opposing treatment procedures or methodologies) influenced patients' health seeking choices as communicated by care providers. For instance, the patients' choice and trust in using unorthodox methods were shown to be commanded by complementary/spiritual care providers in the quote,

UKAMMA (Medic): *'…we also have some challenges we face with these our; you know, brothers and sisters in those areas. At times, they kind of…they try to make these people feel in some instances that you know, this thing is just purely spiritual there is no need disturbing yourself going to a doctor you know. And this, at times our people, depending on their level of understanding, seem to trust them absolutely.'* (FG3: LINES 237-243).

(ii) Conflicts in underlying principles of healing across methods

Further to this, health professionals (medical and psychological) expressed their strong belief and reliance on the scientific/empirical methods with caution towards the acclaimed success in the use of herbal and spiritual remedies; as the clergy and other alternative care providers described their methods (unorthodox) as popular and much sought after as shown in the quotes below, depicting differences between medical, psychological, and spiritual/complementary options. This situation became more apparent where medicine was shown to be unable to cure an illness while the spiritual was reported as the only effective panacea;

EDU (Medic): *'I as a doctor am a scientist, and seeing, just like my colleague said, seeing someone that provides one concoction and named up to ten to twenty different sicknesses that, that concoction will take care of. For me that person is the risk factor that I must eliminate where my patient is.'* (FG3: LINES 521-524)

KINE (Clinical psychologist): *'So we give them assertive training…of course we don't believe in chemotherapy, we believe purely in psychotherapy we talk them into reality and then you see them get well again.'* (FG1: LINES 232-234)

OGEME (Spiritualist): *'In this very aspect there are some illness, I know of a lady she's been ill she's been to all different types of hospitals even taking …the herbal to be well…her doctor now called her, 'please go and meet a spiritual director, or a spiritualist' that this is not ordinary. All the tests negative, so she got healed in the prayer house through a special blessing…'* (LINES 457-461).

These opposing standpoints between providers can introduce some challenging tension that can affect the collaboration process as each provider hold fast unto their authenticity and success against the others, especially were there exists poor regulations and their enforcement as discussed in the next theme.

(iii) Poor legislation and regulation

The above discrepancies and conflicts in principles of cure seemed to be overshadowed by the pressure experienced by health professionals who endorse informal referrals to alternative methods in response to patients' cultural and religious beliefs. Hence, medical professionals were left with no better options than to collaborate with spiritual healers, which did not go without reported risk factors and challenges, especially where the process remained informal and unorganised. For instance, the lack of regulations and standardization within the spiritual and herbal methods were reported as one of the major difficulties integrating such methods within the formal medical setting much as is the case in the UK health setting;

UCHIE (Medic): *'There should be a proper regulation and there should be also standardisation so that for instance the herbal medicine could be put through tests and find out the chemicals that are involved; and be able to know also what are the side effects and also be able to get out the quantity, dose the patient can be taking…. These things should be well regulated like I said, so that we don't do substandard practice….'* (FG1: LINES 972-980).

Further to this challenge, it was interesting to note the reported improvements regarding poor standards levelled against the alternative means of cure. This context of improvement can ameliorate the challenges observed above and further the

process of collaboration. To buttress this positive atmosphere, two medical professionals agreed on observable improvements in the herbal therapy procedures as well as good practices among faith-based healers, especially with most of them presently qualifying as medical doctors gaining adequate skills in both methods;

UKAMMA (Medic): *'So we cannot overlook the fact that our herbal medicine is also good, is also an alternative. And am sure the awareness has been on for some time now and I believe there is also some level of improvements in the way they are manufactured and processed.'* (FG3: LINES 495-499).

UCHIE (Medic): *'These days, most doctors are becoming Canons, Reverends. So, I think in their practice they might also be incorporating spiritual healing as well as their scientific basis.'* (FG1: LINES 731-732)

(iv) Trust between professionals

However, the discussion on differences in the objectives and philosophies underlying care procedures was developed from another perspective that considered the lack of common interest as militating against mutual trust among care providers. Hence, the issue of 'dodgy' practices among providers were reported as potential influence on patients' health seeking choices, which can enunciate mutual distrust among providers and constitute further challenges to the collaboration process;

IKEM (Health educator): '*But sorry, religious men and women, they are causing more confusion with patients….'* (FG2: LINES 367-369).

EDU (Medic): '*I think in that aspect I will say that it's more challenging the relationship between the health providers and the clergy men….because sometimes, just like doctor has said, the type of hope I am trying not to use the word 'false hope', but I think I must say it. The false hope that is being given to these patients is somehow, not necessary.*' (FG3: LINES 271-274)

OKWE (Catholic clergy): '*Now everybody is now, capitalises on the fake of others and there is no trust again, both medical and those who are giving spiritual. The challenge is the trust…,*' (FG1: LINES 600-602).

Apparently, the lack of trust among professionals was further observed to filter within and between professional groups based on divergent points of interest. Other discordant tones were observed from discrepancies due to power-struggle and 'superiority complex' expressed among practitioners. Hence, there was evidence of lack of trust among different care providers regarding their methods, which participants perceived as a barrier to collaboration;

IKEM (Health educator): '*I think the major challenge, is just what I can call 'superiority complex…. some people believe just like you rightly said, that they know it all…. Some of them are just in their own sects, trying to say we are better than the other person.*' (FG2: LINES 617-623).

A typical instance of intra-group discord as a challenge to collaboration was expressed by a clergy, considering the vastness of religious beliefs and intricacies of the spiritual spectrum,

OKWE (Catholic clergy): *'So for me, there are certain kind of collaboration we cannot accept. The ones coming from unknown sources, I will not accept it. This is where I believe Jesus Christ that he is the one that can set you free, and I do that.'* (FG1: LINES 874-878).

The diversities of opinion, interests and practices were not confined to the complementary realm alone, as the healthcare professionals reported similar disagreements within its ranks,

CHY (Nurse): '*Sometimes there is disagreement between even medical health workers…. For example, like medical doctors, they even have problem with psychologists, like in UNTH and even in psychiatrist hospital. They are supposed to have a psychologist there but you find out that the doctors, they even try to internalize psychology in their own medicine. They call it Psychological Medicine, thereby trying to shift away psychologists…'* (FG2: LINES 565; 570-574).

4.2.3.   A summary of the study

The themes emerging from this phase of the study were used to describe the experiences of providing care within the Nigerian socio-religious and cultural contexts by different care providers in Nigeria; as well as their perceptions of health-seeking behaviours exhibited by Nigerian patients. This discussion used three main themes with thirteen sub-themes (see Table 4.2 & Figure 4.1) to explore the choices made in responding to illnesses and symptoms and various factors that influenced these choices, which can become barriers to bio-medic al healthcare utilisation. Also, themes explored the potentials for collaboration among care providers as well as challenges that can be anticipated in the process. In this case, participants were

unanimous in appraising the unorthodox methods as the foremost cure method, with the spiritual approach being prominent in recent times due to the dominance of the Christian-based spiritual centres. Arriving at this conclusion can be considered reliable and not because of clergy bias as the sample showed a better representation of health workers and complementary health providers in relation to the clergy who were rather underrepresented at the ratio of 6:12.

Furthermore, the treatment choices based on religious and cultural beliefs/practices were shown to be dominant within the care context. These were also reported to have dominated participants' experiences of care and consequently conditioned their care provision/advice, which facilitated the use of alternative treatment methods. These beliefs informed patients' and providers' perceptions of illnesses; with health beliefs deeply rooted in the religion and culture of the people becoming important references to the causes of illnesses and how they could be cured. However, although the medical practitioners seemed to concede to pressure from patients' reliance on non-medical cure means and compromises in some cases, they equally expressed the need to correct the anomaly through education/health awareness. The issue of clinician-patient cultural matching is taken for granted in the Nigerian context, as health professionals seem to understand the religio-cultural motivations towards spiritual and alternative therapies (and may possibly uphold similar beliefs at a different degree). Hence, the seeming compromise reported in some instances.

Apart from the religious and cultural determinants many of which were echoed to those reported in the UK study (presented in the next chapter), other factors such as poverty and ignorance not reported in the UK study were identified as prevalent within the Nigerian context. This outcome is not surprising considering that previous

studies on barriers within primary healthcare in developing countries have identified social capital context of a country as an important factor (Gerrish, Chau, Sobowale & Birks, 2004). For instance, in developing countries with poor social capital such as Nigeria, medical services were reported as unavailable, inadequate, expensive and unaffordable. To this extent, it was concluded that the interplay between these militating factors in the dynamics of healthcare seeking choices represented a general apathy towards medical health seeking in Nigeria and consequently in the diaspora, especially taking cognisance of free services at the point of entry within the NHS in the UK. This situation reaffirmed the prominent role of religious/spiritual leaders and other complementary therapists in the context of care provision in Nigeria, which necessitated the need for an efficient, integrative care approach through collaboration among care providers to improve healthcare utilisation (Meylink & Gorsuch, 1988). This aspect gave rise to serious considerations for collaboration among care providers in terms of their willingness to integrate while considering the potential challenges. The next chapter explores the beliefs, experiences and expectations of similarly qualified Nigerian clergy and health professionals practicing in the UK to determine the factors influencing their fellow Nigerian immigrants' approaches to illness and health care as patients; and possibly their approaches to care provision as well as their own responses to illnesses/symptoms as care providers.

CHAPTER FIVE

Study 3: The UK Group – An IPA

5.1   Title: A cross-cultural study on the health-seeking behaviours of Nigerians from the perspectives of Nigerian care providers in the UK: challenges for collaboration - An Interpretative Phenomenological Analysis (IPA)

The findings from the first phase of this study (Study 2) reported in chapter 4, showed there were needs for further exploration of the research questions among immigrant Nigerians. Themes specific to native Nigerians such as poverty and ignorance, as well as poor/ineffective regulations within the health system, need to be investigated further to see how they impact on Nigerians in the context of an advanced healthcare setting such as the NHS in the UK. Also, it is important to understand the effects of religious and cultural beliefs on Nigerians at home and abroad, where heritage culture and religion in the Nigerian context were found to be strong and influential on the attitudes to health care seeking (both for service providers and users alike). How would the aftermath of Nigerian heritage cultural and religious beliefs (pre-migration) impact upon Nigerian patients and care providers as immigrants in a western-oriented context (post-migration), with a different socio-cultural and religious approach to health issues? Consequently, it is vital to understand if any differences existed in the health-care seeking attitudes of Nigerian migrants as well as service provision by Nigerian care providers in the UK, due to differences in regulatory aspects of health service provision: does cultural-matching among service providers and their patients' impact on healthcare services utilisation? Also, the question: 'Is there in place a better forum for collaboration among care providers towards an integrative care

system in the UK?' needs to be addressed. Overall, it is expected that some themes in the Nigerian study group are likely to be integral to Nigerian immigrants who have moved to the UK, such as religious and cultural determinants of health care seeking behaviours.

Therefore, this chapter presents the second part of care providers' study conducted in the UK. The two perspectives of investigating healthcare seeking behaviours among Nigerians from the clergy and health professionals' experiences and perceptions helped in illuminating the research question from 'more than one perspective' (Smith et al., 2009, p. 49); using a synergy of analysis to draw the two datasets together at the discussion and conclusions section (6.1). Although this process of synthesising data is not a common research approach, it is supported by a growing number of published studies (Dunn, 2012; Georgiadou, 2015; Larkin, Clifton & De Visser, 2009; Larkin & Griffiths, 2004).

5.2   Method

5.2.1. Design

This is a qualitative study using semi-structured interviews for primary data collection (Saunders, Lewis & Thornhill, 2007). The semi-structured one-to-one interview approach was adopted here as in study 1 (3.2.1). It was considered better to vary the research methods (data collection and analytic tool) employed in the two phases of the study (using Interviews and IPA in this case), as IPA is deemed more suitable with interviews where personal experiences can be better expressed without group influences as in FGD. The aspect of privacy and personal reservations has relevance to the individualistic culture which is part of the British society while the Nigerian context of communalism was amenable to group discussions (FG) employed

in the first part of the study (study 2). These socio-cultural differences based on individualism and collectivism between the West and most African peoples is consistent with reports in previous studies (Schwartz et al., 2010). Therefore, the interview approach was adjudged most suitable for data collection in an in-depth exploration of participants' personal experiences allowing for a more private interview on their sensitive experiences as immigrants; and, allowing for an open and critical discussion as participants freely discuss their perceptions of the world around them. Moreover, the use of interviews in the present study was for convenience sake, as it was found more challenging for participants to agree on a specific time and place necessary for the FGD.

5.2.2. Materials

The interview schedule provided to participants followed a similar pattern used for the first part of this cohor-group study as discussed in sub-section 4.2.1.2; which included the same information sheet (Appendix 8), and consent form (Appendix 9) as in study 2, but a unique debriefing sheet specific to the UK context was provided (Appendix 10:2), while retaining the interview protocol as in study 2 (Appendix 11). Two tape recorders were used in recording the interviews for onward storage in a personal locker. A letter of authorisation to ensure a safe use of the interview venue in this study context was obtained (see Appendix 12:2)

5.2.3. Participants

Participants were drawn from a Christian population of Nigerian-born clergy and health professionals. The participants had to be adults, actively engaged as qualified Christian clergy and or healthcare professionals who are first generation UK immigrant

from Nigerian (those who live and work in the UK). This study adopted a 'purposive sampling' approach (Willig, 2001, p. 58) by choosing participants with similar experiences relevant to the research question - a homogenous sample (see also Chapters 3 & 4 [3.2.3, 4.2.1.3]). Homogeneity was ensured by observing the following inclusion criteria: Nigerian nationality, clergy and health professional status, and place of abode designated as London in the UK, with due consideration for gender mainstreaming. The exclusion criteria were: Nigerian non-clergy and non-healthcare professionals or those who are clergy and healthcare workers but not practically engaged in providing such services, or those aged below 18 years, and those who lacked fluency or confidence to be interviewed in the English language. Participants were selected based on availability and free choice, and are represented in this study with pseudonyms for the purposes of anonymity and confidentiality. Choice of participants that satisfied the study requirements were based on experiences and evenly spread demographic backgrounds. A total of six participants were recruited for the study (Interviews: n = 6). Participant demographic information detailing their age, gender, religion, education, profession etc. are reported in Table 5.1.

5.2.4. Procedure

Data collection was based on in-person interviews. Recruitment of participants was done through the snowballing process by contacting leading clergy/pastors of various Christian denominations, and healthcare professionals in the UK, who helped to recruit their colleagues. This was done through initial contact with two health professionals and one clergy (health professionals: n = 2, clergy: n = 1; see figure 5.1).

```
┌─────────────────────────────────┐
│     Initial Contact: 3 (Health  │
│ professionals: n = 2, Clergy: n = 1) │
└─────────────────────────────────┘
```

```
┌──────────────────────────┐          ┌──────────────────────────┐
│   Snowballing result:    │          │      Snowballing         │
│  Health professional n = │          │   result: Clergy n =     │
└──────────────────────────┘          └──────────────────────────┘
```

```
┌──────────────────────────┐
│    Snowballing result:   │
│   Health professional n  │
└──────────────────────────┘
```

```
┌──────────────────────────┐
│    Total number of       │
│   participants: n = 6    │
└──────────────────────────┘
```
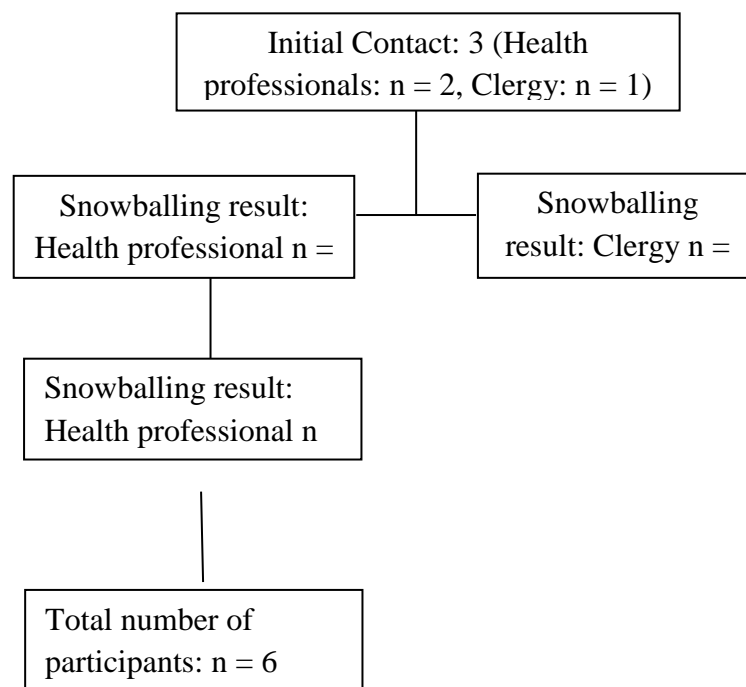
Figure 5.1. Recruitment process

Ethical requirements were fulfilled, and permission was granted by the University Ethical Committee. Interviews were conducted in a safe environment at The Youth Club Hall of St. John Fisher Church, in the London Borough of Bexley on different days of each participant's availability. A total of 6 participants took part in the study, who were provided with the interview protocol containing details of the research schedule regarding aims and purposes of the research, aspects of confidentiality, anonymity, and freedom to participate or withdraw at any time without having to offer any reasons as already shown in the Appendices provided above (5.2.2). The interviews were based upon the same topic guide as was used in Study 2, described in Chapter 4 (section 4.2.1.2); and were conducted in the English language and audio-taped. The interviewees were informed they could stop the interview at any time if they felt uncomfortable, and that the researcher could sometimes interrupt or guide the conversations if conversations veer too far from the topics on the topic guide. The

interviews lasted for between 80 to 90 minutes, which were later transcribed verbatim and prepared by the researcher for analysis.

5.3 Analytic process

The analyses of results followed the processes of Interpretative Phenomenological Analysis (IPA), (Smith et al., 2009), based on the philosophical and epistemological notions of phenomenology and hermeneutics (Gorgi, 1985 as cited in Finaly, 2009), described in Chapter 2 (2.4.3.1). By these principles, participants try to make meaning of their experience (of a phenomenon) as it is concretely lived, while the researcher attempts to give meaning to these experiences through interpretation (Heidegger, 1927, 1962 as cited in Finlay, 2009; Smith, 2004). These tools were adopted as they proved most suitable for initial studies aimed at in-depth exploration of the processes by which participants make meaning of their particular experiences and contexts (Brocki & Wearden, 2006; Chapman & Smith, 2002). Through Interpretative Phenomenological Analysis (IPA), each of the interview transcripts in this study was analysed using themes emerging from the Nvivo 10 software (Table 5.3). This process attempted to make meaning of participants' general ideas of health-seeking among Nigerians in the UK, as well as the potentials and challenges for collaboration among diverse care providers. This is aimed at directing policy and integration efforts towards providing a culture-sensitive and integrative healthcare system that can enhance healthcare utilisation among immigrants. This process allowed participants freedom to express their views and for the researcher to interpret these views inductively, with an open approach unbiased by existing theories. Furthermore, the analysis attempted to go beyond participants' subjective experiences, while considering environmental and external forces of their culture and

sub-cultures (Shaw, 2001); while avoiding detailed comparative analysis between the

two groups.

Table 5.1

Participants' socio-demographic background

Participant pseudo names	State of origin	Age range	Gender	SES, Religious affiliation, Professional status,	Number of years in the UK	Number of years in the profession
Sule	Kaduna State: North-West Nigeria	41-50	M	Catholic Clergy	2	22
Moyi	Ogun State: South-West Nigeria	61-70	M	Pentecostal, Medical doctor	35	38
Fatima	Plateau State: North-Central Nigeria	51-60	F	Catholic, Nurse	20	12
Uju	Anambra State: South-East Nigeria	41-50	F	Catholic, Medical doctor	10	20
Eni	Ogun State: South-West Nigeria	41-50	M	Pentecostal Clergy, Chartered Accountant.	24	10
Fifi	Edo State: South-South Nigeria	40-50	F	Catholic, Medical doctor	18	19

The recorded interviews were prepared for analysis through a verbatim transcription using a truncated form of the Jefferson method - the Jefferson-Lite system (Clerk, Kitzinger & Potter, 2004). This version was adopted to highlight certain behavioural aspects of the interviews that might add to the verbal content to enrich the analytic process. The next step commenced with an open and unbiased encounter with the dataset (Willig, 2001). These served as the summary of the unfocused thoughts regarding important issues raised in each transcript. These were recorded on the right margin of transcripts with the corresponding quotes imported from the dataset unto the Nvivio 10 node structure where reference numbers were automatically generated for each quote, which represented the basic themes from all 6 participants. The second step was the identification of themes that best represented the meanings shared among these basic themes from various sections of each transcript. These basic themes were represented as psychological concepts that captured textual meanings of participant experiences, and these were assigned to relevant references for each participant within the Nvivo. These were written out in an organised form beside each participant's references and highlighted in yellow for easy identification (Appendix 19).

The third step involved the linking of these basic themes (grand-child nodes) within each script into clusters according to their similarity in expressing participants' thoughts and meanings. This initial process of integration resulted to fewer basic themes that best represented the meaning espoused by similar themes within each cluster. For each participant, these themes were organised with more specific labels using the Nvivo generated reference numbers as identifiers, and thereby grounded them to each data script (see Appendix 19).

The fourth step involved the generation of a summary table for all the clustered themes from each script. Similar themes from each script were integrated into a more concrete and representative theme known as the constituent theme (child node), also using relevant identifiers/quotes to ground them to the dataset. Only themes that strongly represented enough depth of meaning in addressing the research question were included in this cluster as shown in Table 5.2.

The fifth step is the final stage aimed at integrating all similar constituent themes, while considering the contents of all the basic themes generated within each cluster. These final themes (superordinate/master themes or parent nodes) were assigned a more global concept that represented specific points of view that could be used to offer an overarching interpretation of participants' experiences during analysis. This process resulted in three super-ordinate themes, with corresponding constituent themes and identifiers that are representative of a more concrete understanding of participants' perception of health seeking among Nigerians in the UK (Table 5.3).

Table 5.2

General clustering of themes - identifying the constituent themes

Participants	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5	Cluster 6
Eni	Acts of help-seeking (Ref. 1, 20)	Influences and Barriers (Ref. 2, 3, 4, 8, 11, 12, 23	provider's personal beliefs (Ref.15)	Potentials for Integration (Ref. 9, 13b, 16, 17, 19, 21)	Challenges (Ref. 10, 13a, 14, 18, 22)	healthcare practices (Ref. 5, 6, 7
Fatima	Acts of help-seeking (Ref. 1, 20)	Influences and Barriers (Ref. 2, 3, 4, 8, 11, 12, 23,	provider's personal beliefs (Ref.15)	Potentials for Integration (Ref. 9, 13b, 16, 17, 19, 21)	Challenges (Ref. 10, 13a, 14, 18, 22)	healthcare practices (Ref. 5, 6, 7)
Fifi	Acts of help-seeking (Ref. 1)	Influences and Barriers (Ref. 2, 3, 4, 6, 7, 22, 23, 24, 25, 26, 27, 41, 44)	provider's personal beliefs (Ref. 5, 9 11, 12, 13a, 15, 20)	Potentials for Integration (Ref. 44b, 43, 39, 38, 37, 36, 34, 31, 30b, 29, 21b, 19, 18, 10)	Challenges (Ref. 8, 13b, 14, 16, 17, 21, 35, 40, 42, 45, 46, 47, 48)	
Moyi	Acts of help-seeking (Ref. 1)	Influences and Barriers (Ref. 3, 4, 7, 16, 18, 19, 29, 39)	provider's personal beliefs (Ref. 2, 5, 6a, 26, 27, 28)	Potentials for Integration (Ref. 6b, 9, 11, 12, 13, 14b, 15, 23, 24,30b, 31, 33, 37, 38, 40)	Collaboration challenges (Ref. 8, 10, 14a, 16, 17, 20, 21, 22, 25, 30a, 32, 34, 35, 36)	
Sule	Acts of help-seeking (Ref. 1, 2, 8)	Influences and Barriers (Ref.3, 4, 5, 7, 12, 23, 24, 25, 33, 34, 35)		Potentials for Integration (Ref. 6, 9, 13, 15, 20b, 32)	Collaboration challenges (Ref. 10, 14, 17, 19, 20a, 22, 23, 24, 25, 28)	
Uju	Acts of help-seeking (Ref. 1a, 2a)	Influences and Barriers (Ref. 1b, 2b, 3, 5, 6, 11, 12a, 12b)		Potentials for Integration (Ref. 4, 7, 8, 10a, 13, 16, 19, 21a)	Collaboration challenges (Ref. 9, 10b, 14, 15, 17, 18, 20, 21b)	
Constituent Themes	Health-seeking behaviours	Barriers to healthcare	Clergy/health worker beliefs	Openness to collaboration	Challenges to collaboration	Interface for integration

Note: This is a table of emerging constituent themes derived from step 4 (see appendix 19 for details)

5.4   Results/Analysis

The analytic process resulted in some important themes (see Table 5.3) derived from the integration of cases - emerging constituent themes, and a further integration of a range of similar themes and data under the 'Master Themes' at the preceding step 4 (see Table 5.2). These final themes (Master themes from different basic nodes) and their constituent themes formed the basis of research analysis and discussions in the next sections. However, the researcher upholds that results derived from this process are a joint venture between personal preconceptions as an interpreter and the expressed experiences of research participants. This implies that participants' real or perceived experiences have been mediated by language (of expression and interpretation), as well as researcher's effort to make meanings relevant to the research questions and objectives; which are further discussed in exploring the notions of 'reliability' and 'validity' of this study at the discussion section.

5.4.1. Master Theme 1*: Providers' perceptions of barriers to health-seeking behaviours*

This master theme emerged in view of describing how Christian clerics and health workers from Nigeria perceived health-seeking behaviours exhibited by Nigerian immigrants in the UK. This discussion involved the choices made in responding to illnesses and symptoms, factors responsible for such choices and how they impacted on the use of available healthcare services. Nigerian care providers have been adjudged suitable in providing such information as Nigerian patients were shown to prefer consulting with them evidenced by the quote from a participating doctor/GP,

MOYI (Medic): *'…in any practice even where you have Nigerians, Caucasians, Asians, the chances are that Nigerians would like to see Nigerian doctors: (1). It may be because of the language; you know…. So, Nigerians would be more comfortable when they speak, I mean when they see a doctor who they think belong to their own group.'* (Lines 292-302)

Table 5.3

A summary of master themes, constituent themes & identifiers from dataset

Master Themes	Constituent Themes	Identifiers from dataset.
1. Providers' perceptions of barriers to health-seeking behaviours	Support from the Church/God first (Cluster 1)	**Fifi (Medic)**. In my experience they use faith-based methods, **Uju (Medic):** '…most of the Nigerians that go to Pentecostal churches especially their long term medical problems would tend to put most of their faith in their church leaders or pastors; **Eni (Clergy):** '..the first thing the Nigerian will think of when they are sick is prayers; **Moyi (Medic)**: 'Nigerian Christians, you know, will go a long way using their faith; **Fatima (Nurse)**. 'Few methods that Nigerian Christians usually use is, first of all most of them go to God in prayers; **Sule (Clergy**: 'they tend to turn to the church first, '
	Providers' perceptions on determinants for healthcare utilisation (clusters 2 & 3)	**Fifi (Medic)**: 'Every illness is down to some spiritual intervention.'; **Uju (Medic)**: 'I think a lot of time they see it as a curse; **Fifi (Medic)**: 'my faith, my spirituality underlies everything I do.' **Moyi (Medic)**: 'I mean I believe in the power of prayer. **Eni (Clergy**. 'I believe strongly in the power of God to heal
2. Issues in collaboration	Openness to collaboration (Cluster 4)	**Fifi (Medic)**: 'I believe that there is a place for the spiritual support **Uju (Medic)**: '…the spiritual healer I suppose can give them faith or counsel them **Moyi (Medic)**: 'I sometimes will advise about using the power of prayer **Fatima (Nurse)**: 'So you could see that people under the ministers, it is good to work with them; **Sule (Clergy)**: 'So whichever way, cross experiences I think I can only encourage it, that is very important.'
	Personal and professional Challenges (Cluster 5)	**Fifi (Medic)**: 'conflict of interest, or conflicts of methodology is the big worry. **Uju (Medic)**: there should be education there really of the minister.' **Eni (Clergy**: 'So it is just the belief from both ends; **Moyi (Medic)**: '…you cannot force any doctor to practice, to practice Christianity; **Fatima (Nurse)**: I don't believe in that so I hardly do that; **Sule (Clergy**: 'So, so there is little bit of that challenge of misunderstanding
	Institutional and personal barriers (Cluster 5)	**Fifi (Medic)**; 'if you can get in touch with the spiritual healers, and gain their confidence'; **Uju (Medic)**: 'there are so many different standards of spiritual healing I would assume and so it is a difficult one to standardise; **Eni (Clergy**: 'The spiritual level of many people here now is so low and then their belief in God is so low; **Moyi (Medic):** 'I think is all based on money you know; **Fatima (Nurse)**. 'I don't think this is allowed in the United Kingdom; **Sule (Clergy;** 'Then if it is about the ignorance or the illiteracy of the minister himself'.
3. Contexts for integration.	Interface for spirituality and health (Clusters 4 & 6)	**Fifi (Medic)**; I believe that there is a place for the spiritual in healing; **Uju (Medic)**: 'I think that they can help in the sense of you know, people that have problems causing a lot of anxiety; **Fifi (Medic)**: 'There is recognition certainly in mental health that the spiritual is important; **Eni (Clergy**: '…we still refer people, believers and members that come to us; **Moyi (Medic)**: '…there are people who present with various problems which you cannot explain, you know medically or physically for that matter; **Fatima (Nurse)**: 'some medical professional that could be worshipping in that ministry and if they could like set up something like first aid; **Sule (Clergy**: 'I may be in a parish you find medical professionals in the parish… helped a great deal in saving a lot of people.'

Note: The identifiers/quotations show how themes are rooted in the dataset

This main theme also explored the ways in which provider's personal and professional lives were affected by religious and cultural beliefs within the community. Hence, two constituent themes: 'Support from the Church/God comes first' and 'Providers' perceptions on determinants for healthcare utilisation' were used to ground this major theme to the dataset as follows:

(i) Support from the Church/God comes first

This sub-theme discussed participants' experiences and perceptions of various actions taken by Nigerian immigrants in response to illnesses and symptoms for all kinds of health conditions; as conditioned by individual beliefs (religious/cultural) and illness perceptions. Despite confirming that Nigerians utilised both the health services and alternative methods participants' talk was centred around the use of spiritual or faith-based methods as the first choice as supported in these reports from two health workers;

FIFI (Medic): *'In my experience they use faith-based methods, their religion is very important especially at times of sickness and vulnerability'*. (Lines 4-6)

FATIMA (Nurse): '*Few methods that Nigerian Christians usually use is, first of all most of them go to God in prayers. First is the prayers and they access the hospitals as well.'* (Lines 3-5).

There was an agreement on the above from all six participants independently; an outcome that could be explained on the basis that all participants were Christians, and may have attracted more Christian patents to their practices. However, the evidence is plausible considering that the religious affiliation of health workers is not

always disclosed and generally, the choice of consulting a particular health worker may not be open to the patient. Therefore, the importance attached to this theme is based on the degree of precedence it occupies among participants' order of health seeking preferences, given the availability of a free NHS. For instance, the two clerics stated that religious/spiritual help methods served as the first approach to cure;

ENI (Pentecostal clergy): *'...the first thing the Nigerian will think of, when they are sick is prayers'* (Lines 4-5)

SULE (Catholic clergy): *'…great majority of people when they get sick, especially back home, given my apostolate back home they tend to turn to the church first, and the second, next level would be probably; instead of the church I think the next remedy is self-medication.'* (Lines 9-11).

Further to the methods identified above, one participant (a GP), while reporting the use of medical services prior to other approaches, observed that illness conditions, pre-existing background, and religious affiliations determined the preferred choice of therapy. This quote confirmed the influence of the 'New Age' Pentecostal group among Nigerians, as was subsequently buttressed by one of its participating clergy;

UJU (Medic): '*Em, well most Nigerian Christians, I would say most of them would normally seek medical help. But I think this also depends on what the illness is, what their background is and what type of Christian denomination they are…., most of the Nigerians that go to Pentecostal churches especially their long term medical problems would tend to put most of their faith in their… church leaders or pastors.'* (Lines 4-10).

[The behaviour exhibited by this participant (Uju) can be interpreted as one of a conflict between her conviction about the dominance of the religious cure methods among Nigerians, and a compulsion to defend her professional practice (as a medical doctor). Hence, she hesitated, before offering more information on the church-based cure than the medical help].

ENI (Pentecostal clergy): *'…If you have influence on your members or people coming to you they basically will listen to you and follow what you are saying.'* (Lines 11-14).

Such reliance on the spiritual methods of cure and consequently on the religious leaders could accord the Nigerian clergy a vantage position towards making health-related decisions, especially for members of the Christian Pentecostal denomination as reported above. Therefore, if religious leaders are trusted with such an important responsibility, they can exert a reasonable amount of influence on the service users during their moments of illness and help-seeking decision. The level and direction of such influence can subsequently be determined by personal dispositions of the religious leaders, ranging from socio-psychological, religious, cultural, and cognitive factors (such as religious affiliation/beliefs, cultural beliefs, health beliefs, level of education, level of acculturation, etc.). These and other determinants of healthcare utilisation form the focus of the next constituent theme.

(ii) Providers' Perceptions on determinants for healthcare utilisation

This constituent theme focused on various barriers to health services utilisation such as factors that facilitated the use of alternative treatment methods besides conventional medical/psychological approaches. Participants speaking from

providers' perspectives observed that the influences emanate from behavioural, cognitive, and environmental factors related to both service users and care providers alike. For instance, culture-based explanations of illness/diseases and preferred treatment methods (Okello, 2007) prevalent within the community were reported to determine health seeking behaviours. The common illness aetiology highlighted in this case was based on spiritual/supernatural causes as explained in the following quotes;

UJU (Medic): *'I think a lot of time they see it as a curse; you know it's a curse, either themselves or somebody has done something wrong in the past and this is the punishment they are getting for it.'* (Lines 37-39)

FIFI (Medic): '*Absolutely, I mean only yesterday I met up with a friend who was saying to me that her husband was not feeling very well. And his sister had telephoned that she was having dreams that he's under some spiritual attack, they can see 'early death' for him, and that is so typical of the Nigerian way of thinking. Every illness is down to some spiritual intervention'* (Lines 40-43)

MOYI (Medic): *'And you have people, you have Nigerians who believe in this traditional medicine, you know. What we call 'juju' in Yoruba land you know.'* (Lines 151-152).

As participants were also part of the Nigerian socio-cultural and religious milieu, the influence of African religious and cultural worldviews shaped their belief systems which they reported as important in their personal and professional lives as well. It is vital to note that this influence also impacted on Nigerian providers' perceptions and explanations of illnesses, and inadvertently could have determined the manner of

health-related help or advice they offered to patients. For instance, the medical doctors in this study reported on the impact of their beliefs in the few quotes below;

FIFI (Medic): '*But for me from a personal point of view, my faith, my spirituality underlies everything I do. But that is personal to me. I don't know if you understand what am saying? So that I do my work as a professional, but take away with me that work, come home, I speak, seek spiritual help and guidance for me and my patients.*' (Lines 73-76).

[Following the body language shown by Fifi, she feels enthusiastic about her experiences of healthcare seeking among Nigerians, both formally and informally. She had many things to say and was convinced about such incidents that she seemed torn between the constraints of her medical practice (strickt regulations) and her beliefs. Hence she professed such conviction in her faith at a personal level distinct from her as a healthcare professional. This could also explain the variation in experiences based on the borough where participants lived and worked (she live and worked in the South East, dominated by Nigerian immigrants)]

MOYI (Medic): '*…. I mean there are people who believe that prayers can cure them and I believe that prayers can cure.*' (Lines 19-21).

Although most participants expressed similar religious beliefs as Nigerian service users, it is important to remark that providers reported a remarkable difference in their attitudes towards religious cure and medical treatment as they tried to maintain a balance between their religious-cultural beliefs and professional practices;

MOYI (Medic): '*I mean I believe in the power of prayer and I also believe yes, if you are unwell you should be able to use medication.*' (Lines 34-35)

[Besides the verbal contents of the interview with Moyi, there was also an observed vascilation between personal beliefs in the traditional and spiritual methods versus the medical approach. This can be explained by the facts that he is a medical doctor as well as a member of the Pentecostal group known for their unique expression of beliefs as rooted in the African Independence Church (AIC) already discussed in chapter 2 (2.1.3.3). However, he seemed to be struggling to remain loyal to his professional practice/regulations as well.]

FATIMA (Nurse): '*… I never, never, believe in traditional or spiritual things. If I don't go to the hospital, I pray to God; put everything in prayer, and I still follow it up with going to the hospital anyway. So that has influenced my…profession as well….*' (Lines 153-157).

[Although, Fatima seemed to have expressed a definitive 'no' to 'traditional or spiritual things', a record of her behavioural expressions revealed that she could be a very religious person who has aversion only to things like the 'witch-doctor' or 'voodoo' in traditional practices, but with a genuine belief in the spiritual approach; hence, she conceded to praying to God and to 'put everything in prayer'. This seeming confusion or misinterpretation regarding the concept of spirituality underscores the definitional problems already discussed (2.2).]

From the foregoing quotations, this constituent theme reaffirms the important role of religious and cultural beliefs among Nigerian immigrants as perceived by Nigerian service providers, who seemed to have imbibed more western views of health without rejecting their religious and cultural beliefs. Hence, this understanding confirms the need for cultural training among health workers as relevant in addressing the health behaviours of ethnic immigrants. For instance, as care providers were viewed as trusted custodians of vital health information that can encourage healthcare utilisation, there is a need for client-patient cultural-matching to understand the religious and cultural orientations of service users to enhance service provision as one of the participating doctors reported below;

UJU (Medic): *'But without exploring what the patient perceives as the problem and perceives as the cause of the problem, it might just, it might just be futile trying to treat it.'* (Lines 53-54).

Through the two constituent themes above, this theme has explored the health providers' (clergy and health workers) perceptions of health seeking behaviours among Nigerian immigrants, and highlighted the most common barriers to seeking professional medical help. The roles of faith/beliefs and its relationship with health beliefs were also shown to impact on both service users and service providers alike. Since the health professionals could feel free to express their beliefs outside their work environments (devoid of the demands of professional regulations/codes of conduct or work ethics), and the clergy were usually sought after for help, both providers seem to occupy the vital position of the 'important other' in the decision-making process of patients as noted in previous quote by a clergy (see Eni, Lines 11-14).

With this common interest, religious leaders and health workers can provide the basis for collaboration towards improved and integrative healthcare services. This aspect forms the focus for the next master theme.

5.4.2. Master Theme 2: Issues in collaboration

This major theme considered various ways of harnessing the roles of religious leaders and health workers towards influencing health decisions among Nigerian immigrants for improved healthcare utilisation. As discussed in the literature reviewed in Chapter 2, some studies have explored the process of collaboration with the aim of improving health outcomes (Meylink & Gorsuch, 1988), as well as the challenges and barriers encountered in this process, resulting from differences in beliefs and practices among care providers (Leavey, 2010). In the present study, issues raised within this master theme were viewed from three perspectives: (1) the readiness among various health professionals to accommodate each other, (2) the anticipated challenges, and (3) barriers experienced. These three aspects gave rise to the three constituent themes: 'openness to collaboration', 'personal and professional challenges', and 'institutional and personal barriers', respectively:

(i) Openness to collaboration

This sub-theme considered the potentials for collaboration between the clergy and health professionals as a means of complementing each other for the benefits of service users. This discussion considered the extent to which providers were prepared to collaborate within the context of the important position they hold among the people, and the similarity of religious/cultural beliefs they share with patients. This aspect is

considered important towards an integrative healthcare provision, while considering the particular circumstances of Nigerian immigrants;

ENI (Pentecostal clergy): *'…an average Nigerian believes in God. And so, an average Nigerian also believes in, you know, taking herbs or taking medicine. So, working together to treat Nigerian patients in that regard is not so difficult.'* (Lines 121-123).

These influences were further explored through the rate of referrals/cross-referrals between the clergy and health professionals. So, what do the clergy and health professionals think of finding a common ground for mutual interaction towards patients' care? As reported below, all three participating medical doctors expressed their intentions and actions already taken to incorporate the spiritual methods despite the experiences of personal and professional challenges;

MOYI (Medic): '*If at the end of the day I find out that the person is a practising Christian, I sometimes will advise about using the power of prayer, you know, to pray.*' (Lines 89-92)

FIFI (Medic): *'Em, not so far, not so far. Although sometime you are thinking that spiritual healing would be helpful here…. My opinion! I believe that there is a place for the spiritual in healing.'* (Lines 132-136)

UJU (Medic): *'I suppose you could explore the patient's beliefs and they could, you know, go and have a chat or talk with the spiritual leaders or healers. But then that*

means the spiritual healer I suppose can give them faith or counsel them to have

faith in the medical profession.' (Lines 142-146).

Furthermore, one of the doctors pointed out that the fundamental reason for incorporating the spiritual approach was the need to complement shortfalls in the medical profession, which is consistent with existing studies on lack of skills needed to understand patient's spiritual/religious and cultural orientations during consultations (Smiley, 2001), which can result in misdiagnosis during medical help seeking (Sue & Sue, 2004);

MOYI (Medic): '*I mean, the main influence is, I mean there are people who present with various problems which you cannot explain, you know, medically or physically for that matter. And you reckon that you may well be able to go through the Christian way which may well further on counselling'* (Lines 97-100).

In this regard, a participating nurse confirmed that the need to collaborate with the clergy was based on the vital position they occupy within this community; as 'doctors' whom their followers relied upon in the dynamic process of decision making;

FATIMA (Nurse): '*I think it is good because ministers (clergy) they deal with… people and the medical they deal with people as well…sure it is good to work with them because their congregation sees them as their own, you know, doctors or something. So, we need to work with them.'* (Lines 198-202).

The clergy also supported the practise of cross-referrals so that patients could be provided with an integrative health service as shown in the first two quotes below, and confirmed by a doctor (Moyi) in the next;

SULE (Catholic clergy): *'So whichever way, cross experiences I think I can only encourage it, that is very important.'* (Lines 344- 352)

ENI (Pentecostal clergy): '*Well like I said earlier, we still refer people, believers and members that come to us, parishioners and say, 'look, we've prayed, but go to the hospital and get checked and the experiences has, combining both has been quite encouraging.'* (Lines 102-104).

[The expression observed at this point with Eni seemed to conflict with the actual contents of the interview; as could portray a social desirability bias. He seemed to have gained an opportunity to score a point and impress the researcher by showing that religious leaders or faith-based methods do not restrain/misdirect patients from accessing the healthcare services.]

MOYI (Medic): *'But the patients do have, you know, the chance to go to chapels or speak to the Reverend, they may need prayers, you know. Even in the hospital where they don't have Mosques they do, they can arrange for an Imam to come through…'* (Lines 247-250).

Based on the foregoing discussions, this study has reported a positive move towards collaboration from the clergy. On the other hand, the health workers felt constrained from cross-referrals to spiritual healer/clergy, but will rather refer to allied professions;

FIFI (Medic): *'Interesting! Do I have those options? The way the practice is and because I am a specialist I do not have those options unfortunately…. Em, not so far,*

not so far; although sometime you are thinking that spiritual healing would be helpful here.' (Lines 121-133)

MOYI (Medic): *'I mean, I don't. We are not allowed to refer. I mean, we have strict guidelines when making referral, you know. So, you cannot, you cannot really make a referral to any other body apart from a medical organisation.'* (Lines 261-263)

FATIMA (Nurse): *'I don't think this is allowed in the United Kingdom so, and I have my profession. I go by my code of conduct of my profession which is NSC. So, I follow that guideline in giving anybody, you know, advice'* (Lines 89-91).

The clergy's willingness to refer to medical practitioners compared to the constraints in corresponding referrals from health workers confirms the findings of an existing study on referrals between psychologists and clergy (Meylink & Gorsuch, 1988), which also reported the flow of referrals to be in one direction (un-idirectional) - from the clergy who were only regarded as 'gatekeepers' within the mental health system. However, considering clergy's expression of willingness to collaborate, there seems in this study, to be a divergence of opinion between them. For instance, there seemed to be some tension between the views expressed among the two clerics interviewed. Where the Pentecostal clergy expressed emphasis on the spiritual perspective and blamed the barriers to total integration of the spiritual within therapeutic process on lack of spirituality among the people, the catholic clergy was cautious of absolute spiritualisation of health matters as shown in their respective quotes below;

ENI (Pentecostal clergy): *'…. The spiritual level of many people here now is so low and then their belief in God is so low and so the willingness to incorporate spiritual healing is…. at its lowest ebb.'* (Lines 85-90).

SULE (Catholic clergy): '*Ya, as I said, here you permit me to make a distinction with due respect to every denomination. I think this can also be based on two factors. The denomination of the person, and secondly the level of enlightenment, the level of literacy matters a lot. So, what do I mean by denomination because you find some like the Pentecostals who believe that look, they can cure, so whatever it is, 'bring him to me, bring her to me I will pray for her, it will be cured…'* (Lines 256-264).

The differences in opinion due to religious affiliation has been shown in previous studies (McMinn, Vogel, & Heyne, 2010), with Pentecostal Christians preferring total integration of spirituality with therapeutic approaches, while more traditional Christians such as Catholics and Anglicans express a more liberal attitude with no difficulties applying secular and spiritual methods independently; as noted in Chapter 2 (2.1.1.3). Regarding the absolute integration of faith in the therapeutic process, the Catholic cleric in this study was more cautious about potential risk factors associated with misguided theological interpretation of life events, which can become an added barrier to healthcare utilisation. This finding is consistent with previous research by Leavey (2008), which distinguished the approach taken by mainstream Christian clergy and Pentecostal clergy while helping patients. According to Leavey's study, mainstream Christians (such as Catholics) placed adequate value on healthcare services and viewed religious intervention as a reasonable substitute, which is reflected in the attitude of the catholic clergy in the quote;

SULE (Catholic clergy): *'I for one, I've always been a realistic person that there is what God can do and there is what science can do and God is not stupid when he gave us science. He gave us science so why don't we explore what he has given to us…. There is what prayer can do and what, and when you pray God is to direct you, he may not easily come to bring you healing. When you pray because you are sick, God may decide ok, he supplies 'Mister B', or 'Doctor A' to supply you with money to go to the hospital.'* (Lines 41-48).

[Sule seemed to show some strong emotions in expressing his discontentment with certain abuses and comorbidity associated with spiritual cure practices, being a religious leader himself. Hence he felt the need to desociate himself from the wrongs with a strong appeal to the researcher's attention.].

From this constituent theme, it is evident that both the clergy and health professionals agreed about the need to collaborate, but there were noted discrepancies in the mode and degree to which participants were prepared to collaborate, especially with regard to incorporating the spiritual method,

UJU (Medic): *'Em, thinking about it now it is interesting because if we're to incorporate it, it would be, 'how do we incorporate it?'* (Lines 142-143).

This uneasiness and mutual suspicion was mainly based on differences in personal, religious, and professional beliefs/practices. These concerns were viewed as challenges and barriers as to how to fit religion and spiritual healing into professional healthcare, which formed the focus of the next two constituent themes.

(ii) Personal and professional challenges

This theme discussed some potential challenges arising from participants' subjective experiences of their religious, cultural, social and professional contexts. These contexts are laced with belief systems that can impact differently upon providers' personal lives and consequently reflect in the ways they carry out their duties of care. For instance, one of the doctors who reported his belief in the spiritual approach and had directed patients to access it also shows a strong orientation in African traditional medicine as quoted below;

MOYI (Medic): '*My great grandfather, my grandfather was a herbalist and I have some of my uncles you know, did practice these alternative medicine like…like herbalists you know. And I have come to see some of the powers they possess you know.*' (Lines 200-202).

[The non-verbal expressions noted about Moyi earlier continued to show here, as one who had a dual allegiance to both religious and medical cure. First for religious cure based on belief and heritage cultural experiences, then for the medical cure because he is involved in it as a medic].

The risk factor associated with such views is that health care providers could effectively impose their beliefs on therapeutic processes or health-related advice without recourse to the regulations provided by their regulatory bodies; such as when they offer help outside the confines of their official duty. There is also the possibility of professionals giving personal medical advice, or referrals to non-medical and unorthodox procedures as reported below by two doctors while responding to their

practice of referrals to other providers outside the medical field or the possibility of their giving non-medical advice;

MOYI (Medic): *'We do the referrals, but these are, these are done privately and then we take it from there, you know'*. (Lines 273-274).

Moyi in his characteristic body language, showed that he meant more things than he said; and with a facial expression I understood to mean, 'these things take place, despite the strict regulations.'

FIFI (Medic): *'…. Very often it is a relative who comes and says, 'look am bothered by this, this is what is happening to this person and then you give advice. Yes, I do get that.'* (Lines 33-37).

Based upon the data provided above, this sub-theme further discussed the experiences of participants' personal attitudes (impacted by religious and professional beliefs, the level of commitment to these beliefs, level of awareness and skills needed in helping the patients, personal interest, etc.), in relation to their being members of a broader cultural group that can directly or indirectly influence them. The issues of 'beliefs' and 'interests' continued to resonate among participants as represented by the few quotes below;

ENI (Pentecostal clergy): *'Ya, it is just the belief. The two parties should understand that they are all working towards the betterment of the person involved. So it is just the belief from both end… if there is no common ground there will not be any result.'* (Lines 130-133)

FIFI (Medic): '*Well, conflict of…, is it conflict of interest or conflicts of methodology is the big worry. Therefore, if they are going to work together everybody must know their limitation.'* (Lines 232-239).

The limitation being referred above seems to allude to both subjective personal limitations, and constraints arising from operational boundaries set by professional bodies that can impact on both personal and professional lives of members. The second aspect of these factors has been discussed within the next constituent theme as actual barriers.

(iii) Institutional and personal barriers

Here, the barriers to collaboration were discussed as conditions or legislations that are more objective and structured within religious and health institutions, which can modulate providers' personal and professional practices and consequently impact on the process of collaboration;

FIFI (Medic): *'As a medical practitioner in this society it is not my place to bring religion in. In fact, it is against the law'* (Lines 110-111)

MOYI (Medic): '*I mean, I don't, we are not allowed to refer, I mean, we have strict guidelines when making referral, you know. So, you cannot, you cannot really make a referral to any other body apart from a medical organisation.*' (Lines 261-263).

In this regard, participants reported on the mutual suspicion about underlying principles of care and consequent lack of trust among health providers which reflects on differences in the objectives, underlying motivations and philosophies that define religious and medical approaches to cure. With particular reference to spiritual healing,

a participant (medical doctor) reported on the lack of standardised methodology as its main bane and hence a barrier to collaboration; with the healthcare system reckoned to be better regulated under established codes;

UJU (Medic): *'…there are so many different standards of spiritual healing I would assume and so it is a difficult one to standardise*; (Lines 201-202)

FIFI (Medic): *'…I am a medical professional and that is on the basis on which people come to me and that is how I treat them… And we have code of professional conduct practising in this country, which means that that is the remit under which you treat your patients.'* (Lines 70-73).

In addition to the institutional factors noted above, monetary and organisation interest emerged as a more salient factor consistent with previous studies (Sperry & Shafranske, 2005), when one of the doctors briefly explained the entire controversy over the full integration of other methods within the formal health system as based on monetary or eco-political interest;

MOYI (Medic): '*I think is all based on money you know, it is all based on money and the belief by some powers to be; that these herbal medicines don't work*.' (Lines 264-268).

In this regard, a Pentecostal clergy viewed the main barrier to collaboration as the impact of secularism in the UK; an ideology that can have a negative influence on the general spirituality and level of religious expression as he reported below;

ENI (Pentecostal pastor): '*Well I don't know now, maybe it's changing in both because of the spiritual level of the country we are in the UK. The spiritual level of many people here now is so low and then their belief in God is so low and so the willingness to incorporate spiritual healing is…. at its lowest ebb'* (Lines 85-90).

The above notion is consistent with reports from previous studies, discussed in Chapter 2 (2.1.3.3) showing that Christians represent a significant minority in the UK whose spirituality may be of relevance to their mental health while the only Christian denomination with record growth in England is the Pentecostal group due to the influence of black majority churches (British Religion in Numbers, 2011). What is basic to this constituent theme is that regulations embedded within providers' institutions could become barriers in the process of collaboration. This is with particular reference to a well-structured UK healthcare system that makes it impossible for health workers to operate beyond its confines. However, despite these challenges and barriers, participants noted that some areas of health practices were amenable to integration with the spiritual method of cure. To explore this proposed field of better integration the next master theme emerged as, 'Contexts for integration'.

5.4.3. Master Theme 3: Contexts for integration

Within this theme, participants expressed hope in clergy-health workers' collaboration irrespective of potential challenges and barriers, but they suggested that this could be better achieved within the spirituality-psychologist context. Hence, there was high confidence that spiritual healing was more appropriate in dealing with psychological conditions than more severe medical conditions;

FIFI (Medic): '*There is recognition certainly in mental health that the spiritual is important, that the spiritual plays a role in the healing of the mind.*' (Lines 199-200)

UJU (Medic): '*… I think it depends on what the problem is. To be very honest, if it is a medical problem…. the Christian clergy may not necessary be equipped to provide cure…. I suppose it depends on what context you put the cure in. I think that they can help in the sense of you know, people that have problems causing a lot of anxiety, and a lot of you know, that is affecting perhaps family, they can intervene and provide some counselling.*' (Lines 81- 85).

The above quote supports existing studies (Wang et al., 2003) that the clergy might not be well equipped to handle severe health conditions as cited previously (2.1.1.3), but may be helpful in managing the underlying psychological symptoms. The implication is that collaboration may be more successful between the clergy and psychologists/mental health workers. Therefore, to further explore this master theme, there was need to understand the interface between spirituality and health which gave rise to one constituent theme - 'Interface for spirituality and health.'

(i) Interface for spirituality and health

As reported in this study, there is more opportunity and willingness on the part of the spiritual healers to refer patients officially to health services (psychologists and medical doctors), but the health practitioners could only refer to their professional colleagues in medicine or psychology) as supported by the quotes from a clergy and medical doctor respectively;

FIFI (Medic): '*…yes there are patients who come in with physical symptoms and you*

can see they are troubled. The physical symptom is just an underlying, an expression of what is underneath. They need psychological help. So yes, in that situation, I make referrals to the psychologist.' (Lines 123-128)

ENI (Pentecostal pastor): *'Well like I said earlier, we still refer people, believers and members that come to us, parishioners and say, 'look, we've prayed, but go to the hospital and get checked and the experiences has, combining both has been quite encouraging.'* (Lines 102-104).

Consequently, all health professionals in this study suggested that ideally a more convenient collaboration is possible between spiritual healing and psychological services rather than medicine as the current structure of the NHS constrains them from such practices;

FIFI (Medic): *'Well, medicine is going to be medicine…am sure that the profession is going to say, 'let us do our thing, keep the spiritual out of this'. When it comes to end of life care, that is the palliative care where the spiritual is really important, and I think that's an area where, yes there will be good collaboration, there will be pulling together for the benefit of the patient. But em ya, those are the areas - mental health, end of life care, the palliative….'* (Lines 200-213).

From the foregoing, it can be concluded that the meeting point between spirituality and medicine occurs at the psychological level, because the clergy are willing to refer to both doctors and psychologists, and the doctors are willing to refer to the psychologists and vice versa. In practice, however, approaches to the bidirectional model of referral have become prominent (Meylink & Gorsuch, 1986; Gorsuch & Meylink, 1988) so that psychologists can also interact with faith-based

practitioners. For instance, this initiative has led to more interest in collaborative relationships whereby psychologists could form part of supervisory teams for pastoral counsellors and vice versa (Coyle, 2010). This form of collaboration between faith-based groups and health professionals at the grassroots level was the experience and suggestion of participants in the present study, confirmed in the following quotes;

FATIMA (Nurse): *'….if they can like have in the ministry, may be like they have medical, medical set-up in a ministry where I know there are some medical professional that could be worshipping in that ministry and if they could like set up something like first aid…Ya, first treatment and then be manned by this medical within the, within the ministry. If people like they have minor injuries, minor illness so that government can medically provide help before the ministry now transfer to the hospitals. Like primary health care within the ministry.'* (Lines 209-217).

SULE (Catholic clergy): *'I may be in a parish you find medical professionals in the parish, 'oh no come let's start a clinic whereby one of us will come every day and come and give some assistance or attend to people', and then that has also helped a great deal in saving a lot of people.'* (Lines 162-165).

From the above quotes, future research can explore a model of referral through the interface between spirituality and psychology which can become an indirect context for collaboration between spirituality and medicine. In this way, a complete collaboration can be achieved that diminishes the areas of professional differences and emphasise the strengths of each profession.

5.5   **A summary of study**

Using the emerging master themes and constituent themes above, this study explored clergy and health professionals' perception of health seeking behaviours among Nigerian immigrants in the UK. Three main themes emerged from the corpus: 'Providers' Perceptions of Health Seeking Behaviours', 'Issues in Collaboration', and 'Contexts for Integration'. From the analysis, there was a full (100%) agreement among participants that religious coping style formed the major approach to cure among Nigerians in the UK. The importance attached to this factor was based on the degree of precedence it occupied among patients' order of health seeking preferences, given the availability of other methods.

Apart from confirming the importance of religion in response to illnesses/symptoms among immigrant Nigerians, participants expressed similar religious/cultural beliefs of their own, although with variations found among health professionals due to factors, such as the professional context in which they work, differences in their levels of religious commitment, religious affiliation, educational levels, and the level of socialisation and integration into the UK culture. Being part of the general African religious, cultural milieu, it is concluded that participants' religious and health beliefs could influence health workers in their provision of care, which in turn become an important factor in proffering care services to patients. Consequently, such mutual influences can develop into a cyclic system of religious and cultural influences on health decisions for both services users and providers alike. The implication is that similar beliefs held among care providers and patients provided enough evidence for the importance of clinician-client cultural matching; reflecting good rapport and success in therapy as reported by some medics (see 5.4.2, (i) – Moyi: Lines 89-92, 200-202; and Fifi: Lines 33-37; also, see 5.4.1, (ii) - Uju: Lines 53-

54). However, the experiences of applying such positive effects of cultural matching were reported as a challenge in therapy (see 5.4.2, (ii) - Moyi (Lines 273-273). This aspect informs the urgent need to encourage such needed rapport in therapy trough collaboration among care providers.

Therefore, the discussions further explored Nigerian immigrants' health seeking behaviours from the important position occupied by care providers as agents of motivation and support for health-related decisions. On this basis, this study emphasised various options for collaboration among health providers towards an integrative and culture-sensitive approach to care, while highlighting possible challenges/barriers and recommendations. The need for collaboration was commonly reported among care providers. However, the clergy showed a more practical approach to collaboration than the health workers who welcomed it in principle but felt constrained by the structures of the health system within which they work. By summing up these principles and practices, a more convenient context for collaboration was identified in the interface between spiritualty and psychology; which can be related to the historical connection between the 'spiritual' dimensions of mental illness distinction found across the world. Despite the optimism raised for possible collaboration, there were anticipated barriers expressed under two general categories – institutional and personal barriers/challenges. However, to arrive at a general understanding of the research question, it is necessary to discuss the findings of both aspects of this study together, using the pre-migration illness experiences and religio-cultural context in Nigeria for an in-depth exploration of health seeking behaviours of Nigerians in the context of immigration in the UK. This aspect forms the focus of the discussion section in the next chapter (Chapter 6)

CHAPTER SIX

6.0 Discussions and conclusions on the two phases of the cross-cultural study: A Synergy

6.1.   Discussions

The analytic processes in the two studies demonstrated a similarity of themes emerging from two different groups of Nigerian care providers, using different research methods in two distinct contexts of exploring their perceptions of health-seeking behaviours among Nigerians – those living in Nigeria and those living with immigration challenges in the UK. The main themes emerging from the thematic analysis on the Nigerian study group were, 'Providers' Perceptions of Health Seeking Behaviours in Nigeria', 'Contexts for Collaboration among Care Providers in Nigeria' and 'Challenges to collaboration in Nigeria'; while the three main themes from an IPA with the UK group were, 'Providers' Perceptions of Health Seeking Behaviours in the UK', 'Issues in Collaboration', and 'Contexts for Integration'. For the analytic synergy, clustering the main themes according to their similarities yielded two overarching themes which will guide the discussion: 'Providers' Perceptions of Health Seeking Behaviours' and 'Contexts for Collaboration' as indicated by the interview topics similar to both study groups. All thematic discussions were based on health providers' perceptions of Nigerian patients' response to illnesses and symptoms; based on the experiences within their particular contexts in Nigeria or the UK.

The brief subsections summarising findings in each phase of the study (studies 2 & 3) have specifically addressed the research objectives by identifying context-based determinants of health-seeking behaviours among Nigerians from the perspectives of Nigerian care providers (health workers, clergy, herbalists,

spiritualists, and other alternative medicine providers) (see 4.2.3), and Nigerian care providers in the UK (clergy and health workers only) (see 5.5); as well as exploring potentials for collaboration in their services. Therefore, attempts to embark upon a comparative analysis of findings were avoided as this will constitute a distraction from the research focus. Moreover, the study was not designed as a comparative study to analyse and compare participant experiences. Instead, this synergy focuses on the convergences and divergences of themes to identify the unique differences found within the two separate contexts as part of the socio-environmental determinants of health seeking behaviours being explored. Hence, without a strict comparative analysis, integrating the two study groups (Studies 2 & 3) provided an opportunity for a better understanding regarding the unique differences that characterise the different contexts of care provision in Nigeria and the UK, providers' attitudes and perceptions in particular; and how these can influence care provision in general through collaboration.

6.1.1. Providers' Perceptions of Health Seeking Behaviours – UK vs Nigerian Contexts

The results from both datasets show a general agreement among participants that religious coping style formed the major approach to cure among Nigerians both in the UK and in Nigeria. The role of religion and culture in coping with illness among minorities and immigrants of diverse cultures and contexts has been established in previous studies (Sanchez, Dillon, Ruffin & De La Rosa, 2012, as described in Chapter 2 (2.1.1.2). Also among non-immigrant patient populations, spirituality and religion have been identified as important resources in managing adverse health conditions (Karekla & Constantinou, 2010). Therefore, religion and culture hold much precedence among other health seeking options available for both immigrant and non-immigrant

Nigerians, although to varying degrees. For instance, influences from religious and cultural beliefs towards alternative cure methods were shown to be more pronounced in the Nigerian context, such that health workers felt the pressure to conform or compromise medical practises, which could also be related to the loose observance of regulations within the healthcare system. This is different from the UK context, where there were equally reports of a combination of all methods – medical and non-medical, with some health professionals also reported instances of compromising health regulations by directing patients towards spiritual/alternative cure means, but that would usually be in 'private'; because of the strict health professional regulation prevailing in the UK.

In all, the prominent role of religious leaders as care providers and potential influences towards care choices were reported in both studies. This is relevant to existing studies showing evidence for positive relationships between religion and health (Ivtzan, Chan, Gardner & Prasher, 2013; Saroglou, Buxant & Tilquin, 2008). Spiritual wellbeing is positively related to quality of life and negatively associated with hopelessness, anxiety, and cognitive avoidance (Buessing, Ostermann, & Matthiessen, 2005), it reduces vulnerability by increasing hope (Chao et al., 2002) which is vital for immigrants who could face hopelessness while away from home. Spirituality also fosters a feeling of connectedness with oneself and others (Faull & Hills, 2006), which can make up for the social support need among immigrants, especially when they become disconnected from their original social network (Mooren et al., 2001). Hence, it helps to foster new relationships, new meanings and purpose in life when all seems to be totally lost (Corry, Lewis, & Mallett, 2014) especially, in the context of immigration challenges.

The Nigerian group showed clearer evidence of cultural shifts towards Christian-based spiritual healing methods due to the overwhelming presence of the New Age religious movements in the country (see 2.1.3 and 2.1.4). In contrast, their influence is more regulated by the existing majority social culture in the UK as described in the literature section (see 2.1.2). The recent religio-spiritual movement in Nigeria followed by unprecedented popularity in Christian spiritual healing method was attributed to the current upsurge in the Pentecostal/Charismatic narrative for disease aetiology and cure orchestrated by publicly organised healing events ('Healing Crusades') as rooted in the history already discussed in chapter 2 (2.1.3.4). Therefore, by exploring the determinants of health seeking methods in Nigeria through the pull factors associated with religious and cultural beliefs, and their impact on patient illness perceptions and explanatory models (Okello, 2007), the prevalent health-seeking determinants among Nigerians as immigrants in the UK became more evident. For instance, beliefs in witchcraft or voodoo were reported as a strong influence on Nigerian native and immigrant patients, who believed their illnesses, were the result of spells from their enemies. Such beliefs compelled their recourse to spiritual healing through the witchdoctors, herbalists, or the clergymen. This finding is consistent with previous studies conducted among Africans (Iyalomhe & Iyalomhe, 2012). Consequently, these religious and cultural beliefs informed the construction of various health beliefs about illnesses/symptoms, which resulted in delayed and ineffective use of the healthcare services with the consequence of poor outcome (see 4.2.2.1 [i] & [ii]). Also, participants' experiences of health seeking in both Nigeria and the UK showed that patients embarked on self-medication through personal diagnosis and treatment. To do this, they were reported as using self-made local herbs or self-prescribed medications. However, in the Nigerian context these medications would be

easily procured over the counter including the use of fake and expired drugs from unqualified practitioners, resulting in poor health outcomes and mortality, consistent with a recent study in Nigeria (Yusuff & Wassi Sanni, 2011). The UK context, on the other hand, has prescription and dispensing standards which are highly regulated.

Such unregulated cure approaches and its consequences as prevalent in Nigeria have been associated with poor economies in the developing countries where the political systems influence health care provision and utilisation as discussed in chapter 2 (2.1.3). This has implications for access to health facilities and quality of care (Burnett & Peel, 2001; Fosu, 1994; Tipping & Segall, 1995). Health care seeking within the Nigerian context therefore, relates to the impact of poverty and poor social capital (Campbell, 2004; Gillies, 1998; Putman, 2000). Poor social capital, measured in terms of lack of funds and other values associated with poor access to healthcare facilities, is distinct from the UK context where the availability of basic free medical services was reported. It is not surprising therefore, that the cost/benefit factor reported in the Nigerian context has implications for Nigerians in the UK; where it was reported in terms of time, value, and benefits in study 1 (see 3.3.1[ii]) and reported as real cost in study 2 among Nigerians (see 4.2.2.1[vi]). Poor social capital also determined other factors associated with the provision of adequate and effective healthcare facilities, such as a lack of information/education necessary to understand the changing contexts of illness types and conditions, already discussed in pre-migration factors as barriers to healthcare utilisation among Nigerians in the UK (study 1: 3.3.2 [iii]. Poor health awareness has implications for the apparent confusion among patients regarding changes in disease types, as health information were based on cultural health beliefs and lay beliefs as reported in study 2 (see 4.2.2.1 [i] & [ii]) and discussed in study 3 as absolute reliance on God (see 5.4.1 [i]); all of which constituted

barriers to western health care utilization. For example, references to 'western diseases' as distinct from 'common infections' known to the local people were frequently made (study 2).

However, what constituted a 'western disease' and what should cure that, as opposed to 'common diseases' and what should cure them remained an unexplained mystery. These questions are related to health information, education and awareness which were equally reported as lacking mostly in the Nigerian context. The relationship between poverty and education was consequently discussed as the lack of access to vital health information and wrong use of treatment methods within the Nigerian context. The spiritual and miraculous procedures were the preferred treatment options which were regarded as effective, irrespective of the risk factors. Consistent with previous studies, the context of poor social capital and lack of education as well as inadequate provision of health care facilities has been shown to affect patients in most countries of Africa, including Nigeria (Abioye-Kuteyi et al., 2001). Finally, and critically, the health care beliefs from the Nigerian context continued to influence the health seeking behaviours among Nigerian immigrants in the UK, which has implications for integration (Berry, 1997; Berry, 2004) and access to the UK health system (NHS). This conclusion is also consistent with a similar and more recent study among immigrants in the US, where those who preferred their heritage culture over the cultural values of the host country adopted health seeking behaviours consistent with their heritage culture (Chang & Subramaniam, 2008).

6.1.2. Providers' Perceptions of Contexts for Collaboration – UK vs Nigerian Contexts

Considering that participants in both groups within this study were Nigerian care providers, it became necessary to explore the extent to which they could manage

these challenges and redirect patients to the healthcare services. This aspect was an opportunity to explore care providers' own beliefs and attitudes to care as they were part of the whole socio-cultural and environmental network of influences. In this regard, the impact of religious and cultural matching between care providers and patients were explored regarding patients' health seeking choices, as previous studies have shown that most African immigrants using the health system can become suspicious and evasive as already dicussed. Such barriers to health care consumption were attributed to cases where African patients were presented with new forms of therapy in an atmosphere lacking cordial relationships (Nwadiora, 1996), especially due to shared differences in beliefs and values between clients and patients. Burnett and Peel (2001) used the example of Counselling among African asylum seekers to confirm that some Western-oriented concepts and therapy conditions are not suitable for immigrants as their culture may not allow for personal issues to be discussed with unfamiliar persons.

Therefore, this aspect of integrating the two studies (studies 2 & 3) confirms the importance of religious and cultural beliefs in care within the Nigerian and UK care contexts. It also highlights the impact of religion and culture on Nigerians (both as patients and as care providers), suggesting the bases for the significant role of cultural-matching between patients and providers is obvious, and consistent with existing research (LaVeist & Carroll, 2002; McKinlay et al., 2002). Considering the extent to which this could be harnessed for an integrative healthcare system through collaboration, findings showed that both gate-keepers, non-health professionals, and acclaimed healthcare professionals within the Nigerian care context were not only willing to collaborate in care provision, but were already experiencing it in their practices (see summary in 4.2.3). In contrast, within the UK context health care providers were in principle willing to collaborate, whereas the clergy were already

practicing cross-referral to the medical professionals. The reason for the lack of referrals across to other providers outside the healthcare system in the UK context was based on its strict healthcare regulations/professional barriers in practice. Professional barriers in this regard did not affect the clergy in the UK context, but only their counterparts in the healthcare profession. However, for those in Nigeria professional barriers did not prevent the possibility of collaboration in a multi-dimensional pathway, because it was found to be inevitable in a context where it was nearly imposed by religious and cultural demands, coupled with a relaxed healthcare regulation. Yet, for health workers in both contexts, the crux of the matter centred on individual conviction and beliefs regarding the degree of spiritual intervention in human health conditions and hence, the level of its integration into care. Such personal convictions were also conditioned by levels of adherence to professional regulations, religious affiliations and degree of commitment to its principle/beliefs, degree of socialisation/westernisation (for those in Nigeria) and acculturation/integration factors (for those in the UK).

Such differences among providers regarding their religious affiliations, professional orientations, and levels of education and commitment to personal or professional beliefs can culminate into health professionals' beliefs and stereotypes known to influence the therapeutic process (Berry, 2004). In this case, a positive attitude to spirituality existed among healthcare professionals, but only pointed to the possible integration of spirituality into psychological therapies rather than medical cure practice. This limitation in integrating spirituality by some participants was indicative of acknowledged shortcomings in one another's treatment procedures hence, the process of collaboration that can maximise efficiency and outcome with minimal impact from the challenges already discussed (see 4.2.2.3 & 5.4.2) were explored.

Participants in the UK context were clear on the propriety of integrating spirituality in mental health, which confirms previous research (Edwards et al., 1999) regarding successful collaboration between the clergy and psychologists/mental health workers in different contexts. Integrating spirituality into counselling and the need for practitioner knowledge of spirituality has been confirmed by existing studies (Crossley & Salter, 2005; Shafranske, 2000; Wilding, May & Muir-Cochrane, 2005) showing that clients spirituality should be included in their care plan; and that practitioners should be trained to be aware of such needs. However, findings in the cross-cultural study (see study 3: 5.4.2 [ii] & [iii]) showed that one of the challenges for integrating spirituality among health practitioners was the lack of understanding of what spirituality entails and the exact nature of such needs and how to address them during consultations, consistent with previous studies (Corry et al., 2014) (see subsection 2.2). However, Correy et al., suggest that practitioners could use the working definition provided by Johnston and Mayers (2005) as a guide because it contains the components of most definitions that are empirical and universal (see 2.2 [iii]). Beyond the partial collaboration found among the UK group, findings from the Nigerian group confirmed an overall possibility for collaboration between medical/psychological and spiritual therapies, which was attributed to a seeming lack of professional barriers in cross-referrals and the context of dominant religious and cultural influences as already discussed.

In both contexts, the importance attached to spirituality in health care confirms the vital position occupied by religious leaders in achieving positive health outcomes. Therefore, harnessing the potentials for integrating spirituality within the healthcare system as found in the practice of collaboration in the Nigerian care context (between the spiritual and all aspects of healthcare – medical and psychological, and for both

emotional and physical health conditions) typifies a more beneficial approach for patients with strong religious orientation, such as Nigerians (see sub-section 2.1.3). This proposal is based on existing evidence from systemic thinkers, who postulate that the systems to which people are embedded, (such as the church), can play significant roles in their behaviours (Dallos & Stedmon, 2006). Consequently, an attachment to God fostered through religion/spirituality could result in a beneficial health outcome. A similar proposal for integration has been made for adopting counselling by refugees among refugees in Britain. Hence, refugees can train as counsellors to build trust, and make the therapeutic process embedded in the recipient's culture and religion for a more beneficial outcome (Burnett & Peel, 2001).

The value of spirituality in health outcomes in the Nigerian context provided an important dimension to the entire study. Previous research (Chibnall & Brooks, 2001), and the UK phase of the cross-cultural study (Study 3), identified difficulties among physicians and psychologists incorporating spirituality in their therapeutic protocols. According to a survey by Chibnall and Brooks (2001) on practices prevalent among physicians, little attention is given to spirituality. This is confirmed by Camara et al., (2000) in an independent study investigating test usage involving spirituality among psychologists. However, both studies contrast with the current evidence in study 2 (Nigerian care context) where healthcare providers (within medical and psychological settings) were willing to incorporate spirituality in their care procedures, both formally and informally; a situation not reported in the UK study. Although this outcome can be attributed to their religious beliefs and affiliations (as was expressed in high degree of commitment to the faith). Irrespective of differences in beliefs and values, it is recommended that therapists/providers should be prepared to meet their clients' spiritual demands. The most plausible way to do this is that spirituality should be

integrated into the therapeutic processes if it proves important to the clients (Koenig, 2010). Previous research confirms the value attached to spirituality by clients, such that among patients of chronic illness there has been apparent desire to have their spiritual needs incorporated within their treatment regimen (Dale & Hunt, 2008). Moadel et al., (1999) found that the lack among therapists to meet with their clients' spiritual demands in a culturally diverse cancer patient population ranged between 25% and 51%. Particularly, there continues to be sufficient evidence to show that patients' spiritual needs have not been met within the UK care context. For instance, a North-East London NHS Foundation Trust (NELFT) review found that low numbers of inpatients in the Trust had their spiritual needs considered in treatment, with many reporting that the context of care provision made it impossible for the expression of their spirituality (Igboaka, 2010). Also, a similar investigation confirmed that patients were afraid of talking about their spiritual beliefs to avoid being sectioned, or misdiagnosed with mental illness (Copsey, 1997). Such incidents show a lack of adequate integration of spirituality into medicine in UK, and provide some reasons for recommendations towards such integration. Considering the risk factors associated with poor health services delivery and utilisation vis-à-vis some noticeable improvements in complementary/alternative cure delivery, it becomes only reasonable that health workers should consider collaboration and cross referrals with other complementary therapists. Also as the popularity of spiritual healing methods continues to increase due to record growth in Christian evangelisation, and as Nigerian health workers equally expressed evidence of upholding similar religious beliefs (as was reported in studies 2 and 3), there is sufficient basis for recommending the collaboration process.

This call for an integrative health care model is necessary to avoid possible discrimination that culturally and religiously different patients might experience in their attempt to access the health services. Such discriminations do not only provide barriers and deprive immigrants the duty of care, but can also impede recovery where access was possible (Awara & Fasey, 2008). In the study by Awara and Fasey (2008), up to 50% of the sample expressed themselves as religious/spiritual and trusted that these aspects of their beliefs were helpful coping styles, yet such religious/spiritual needs were unmet during treatment. To address this situation, Pargamant (2007) proposed a new approach in psychotherapy called 'bio-psycho-socio-spiritual' therapy, which includes spirituality, so that it becomes more meaningful to users. Beyond psychological therapies, collaboration can also take place within the health care system between spirituality and bio-medical treatment approaches. This is based on previous research evidence (Awara & Fafey, 2008; Dale & Hunt, 2008; Rose et al., 2001; Koenig, 2010), and the studies presented in this thesis, confirming client's expectations for their spiritual needs to be satisfied within therapeutic process, irrespective of the illness condition. While acknowledging the challenges to collaboration as emerging from this thesis and confirmed by existing studies (Corry, Lewis & Mallett, 2014) regarding lack of consensus as to the remits covered by the concept of spirituality, and what it should mean for therapists and clients, there has been some recommended proviso (Corry et al., 2013, 2014) which can help to overcome such challenges (see general recommendations section 8.3). Clearly, therapists can operationalise the meaning of 'spirituality' based on already agreed elements shared by individual definitions (Johnston & Mayer, 2005). This template can become the basis for continued professional development (CPD) as well as fresh

training for practitioners within designated fields of medical and para-medical professions.

6.2. Limitations of the studies

Despite all the important findings from the studies discussed above (Studies 2 & 3), there are some limitations that need to be observed in adopting these results. They reflect the views of a sample made of mostly Nigerian Christians, as only few participants in the Nigerian group were non-Christians or their religious affiliation was undeclared, which could have biased the results. To include all Nigerians of different religions could better enrich such a study in the future. Moreover, the composition of the sample could also have biased the results, especially for the UK phase of the cross-cultural study where only the clergy and health care workers were recruited, leaving out other Nigerian practitioners of alternative medicine. Also, among the health workers, only medical and nursing professionals were represented excluding psychological therapists and mental health workers (health psychologists, clinical psychologists, counsellors, psychotherapists, etc.).

The study was conducted in the English language, which could be challenging for a second-speaker whose original language can affect expressions of ideas and meanings while speaking in a foreign language. However, using the English language was a better option considering that it is the *lingua franca* for all Nigerians; and the wide range of dialects spoken among Nigerians would have made it impossible to cater to each one in translation. To manage any difficulties however, the researcher used prompts to confirm meanings, and redirect the proceedings properly.

Although the research design for the UK study used interview methods for data collection due to its advantages (capturing participant's subjective experiences, as well

as deeper aspects of their experiences that could be sensitive and emotional; see Banister, Burman, Parker, Taylor, & Tindall, 1999), it has the limitations of non-validation from other participants. However, this limitation was managed by the adoption of focus group discussion (FGD) in the Nigerian study; as it has the potential for utilising the benefits of group dynamics to generate results and insights that could be missed in the interview method. The discursive benefit of a group discussion (FG) provides more opportunities to probe the research question further. Equally, the benefits of group discussion inherent in the FGD could be diminished where some sensitive aspects of the research question may not be proper to share in a group interactive discussion (Smith, 2004); but this was properly managed as the researcher ensured that participants could freely share their experiences based on their perception of patients' health seeking attitudes. This aspect was considered in advance, so the research protocol focused more on their perceptions of other people's (patients') health behaviours rather than directly speak about their own behaviours. This was further managed internally, by ensuring that the groups were homogenous (with similar experiences as care providers); and for external use of data, participants were guaranteed of their anonymity. However, although employing focus group discussions and interviews in each of studies (studies 2 & 3 respectively) provided the benefits of both approaches, this could have also posed some challenges in the choice of the analytic tool most appropriate for the focus groups. For instance, the discourse analysis (DA) has been suggested as most suitable for analysing focus group data (Smith, Flowers & Larkin, 2009), but for this study approach it presented the challenge of assessing phenomenology involved in the two settings, because of the possibility of comparing the two contexts of care provision - Nigeria and the UK – at the synergy section.

6.2.1 Reflexivity

By way of reflexivity necessary in qualitative studies, the results presented here do not constitute a definitive statement about help-seeking behaviours of Nigerians, as it was open to researcher bias during interpretation of participants' perceptions of various responses to illness/symptoms observed among Nigerians. Hence, the analysis represents some double hermeneutics of the interpretations of participants' representations of patients' behaviours, which could yield to researcher bias. Also, as the primary researcher belongs to the Nigerian immigrant group, it was possible that emotional attachment to the issues raised have influenced the results. Moreover, such bias effects could have influenced the interview process as well as participant responses, because participants may have provided what they perceived as expected responses. Similarly, the researcher's choice of themes and the strength of meanings attached to them could be biased because of association with similar experiences among the research groups. However, these effects were overcome by emphasising the altruistic and largely non-directional nature of the study which ensured an adequate mix of the diverse professions of clergy and medical/allied health professionals in the sample. Also, the researcher ensured that responses and themes reflected participants' opinions by double-checking with two independent supervisors. In addition, by using a qualitative research approach, this study is meant for in-depth exploration of personal experiences rather than generalisations of findings (Breakwell et al., 2006; Smith, 2004). Hence, it provides the necessary background depth for the development of a quantitative research study (Study 4) to further investigate the themes identified as important in the understanding of the health behaviours of Nigerians in the UK.

6.3. Implications for future studies

This cross-cultural study has provided an opportunity to investigate care providers' perceptions of health-seeking behaviours among Nigerians, both in their natural/heritage religious/cultural context before migration and as immigrants. It also helped to understand how these contexts influenced attitudes to care provision following cultural-matching between providers and patients; as well as the need to explore various means to collaborate with different alternative care providers, especially the clergy who were shown to be highly consulted by Nigerian patients. Moreover, undertaking a multi-purpose approach in a cross-cultural research design has helped to explore the health behaviours of Nigerians from both pre-migration and post-migration contexts to understand any changes in health behaviours of Nigerian immigrants due to acculturative factors. This aspect can help policy makers towards implementing a successful culture-sensitive and integrative method that can make the healthcare services in the UK (NHS) more effective in addressing the health needs of its diverse patient population. The inductive qualitative method also provided the advantage of identifying important and novel areas that have helped to inform and focus the next study in this thesis. The use of different research approaches, different sources of information in a multi-source approach that characterizes the mixed methods design in these studies have been shown to strengthen empirical studies in cross-cultural settings (Knipscheer & Kleber, 2001).

The next study therefore, presents a more generalisable investigation, drawing on pertinent concepts identified in the qualitative studies described in this thesis, to understand how the changing circumstances of Nigerian immigrants in a secular UK culture have impacted upon their pre-migration experiences of healthcare seeking and how persistent and influential is their traditional/religious values while away from their

heritage context in Nigeria. This aspect forms the basis for the quantitative questionnaire study (Study 4) on the role of acculturation, religion, and coping styles, on the attitudes towards seeking medical help as described in the next chapter (Chapter 7).

6.4. Conclusions

The discussions for integrating the two phases of the cross-cultural study were based on the two overarching themes emerging from the studies conducted within the Nigerian and UK contexts, after clustering their respective themes. This analytic synergy, through convergences and divergences of themes, confirmed that the determinants of the health-seeking methods adopted by Nigerians in both contexts were based upon their religious and cultural beliefs. The belief systems informed the perceptions of illness and explanatory models about diseases among both service users and providers alike. From the above insights regarding the roles of personal and environmental factors, especially the contexts in which individuals are embedded, it was possible to use this cross-cultural study to better understand healthcare seeking among Nigerians, from the perspectives of Nigerian care providers (clergy, alternative and complementary medicine, and health professionals) in two diverse contexts – relating to Nigerian immigrants and Nigerians in their country of birth. In addition to important health-seeking information provided on Nigerian service users, the two phases of the cross-cultural study approach also made it possible to corroborate previous studies on the need to raise awareness on providers' beliefs and values towards clinician-client cultural matching; without which healthcare provision, can become counterproductive. The issues of religious and cultural matching among care

providers and their patients necessitated the suggestion for integration and collaboration among providers; which is discussed in more details in chapter 8 (8.3).

CHAPTER SEVEN

STUDY 4

Title: A survey on the impact of acculturation, religion, and coping methods on seeking medical help among Nigerians in the UK.

7.1   **Introduction**

7.1.1 Summary

The first qualitative study of this PhD discussed the health-seeking behaviours of Nigerians in the UK. Thematic analyses identified important themes that influence healthcare seeking among this group, such as challenges encountered in the process of immigration (typified by acculturation issues, environmental and financial factors); coping methods (personal and social resources) adopted by individuals while adjusting to these challenges, influences from religious beliefs/practices, faith-based and cultural cure methods, illness perceptions or causal attribution and other barriers to healthcare utilisation. These findings showed that, although in some cases, participants accessed medical services, they relied mostly on religious and cultural treatment methods (such as prayers, and African traditional herbs). Hence, the study concluded that increased reliance on spiritual healing, and complementary/alternative methods, among other factors could negatively impact on healthcare utilisation (such as treatment options within the NHS) among immigrants. Such conclusion was buttressed by further evidence in the wake of proliferation of Nigerian-based churches (Black Majority Churches) who propose to administer healing cures for all kinds of illnesses and disease (as discussed in chapter 2). It was confirmed in study 1, that Nigerian immigrants use these centres for various needs.

Following the findings in study 1, two further qualitative studies (chapters 4, 5, & 6) were conducted as a cross-cultural exploration of health-seeking behaviours among Nigerians from the perspectives of Nigerian care providers (clergy, complementary therapists, and health professionals), in Nigeria and the UK. The two contexts of this study (the UK and Nigerian contexts) provided opportunities for understanding care providers' perceptions, roles, and potentials towards improved and integrative health services utilisation. Results suggested that religious and cultural beliefs were perceived by participants to have influenced health behaviours among Nigerian service users while at the same time reflected similar influences on providers' personal lives and professional practices. These studies further confirmed in particular, the important roles of Nigerian clergy and health professionals in health decisions among the community, and advocated for collaboration towards improved health care utilisation; though the UK sample thought it would not be possible as a result of the structure of the NHS.

With participants' affirmation of the need for a collaborative and integrative health care in both studies, despite its clinical and practical possibilities varying between the UK and Nigerian health structure, there were potential barriers such as differences in religious and cultural beliefs, health beliefs, underlying care principles, and education or lack of health awareness which was more profound among the Nigerian study. Therefore, the current quantitative survey was designed to investigate the interplay between important themes arising from the qualitative studies described above and listed systematically by variables in Table 7.1. This is with a view to providing further information about factors that impact on the health-seeking behaviours of a larger representative sample of Nigerian immigrants in the UK, and

how this understanding can help to predict and improve health services utilisation among immigrant populations.

Table 7.1

Summary of emerging variables from studies 1, 2, & 3

Constructs from qualitatively derived themes	Variables/types
Immigration challenges, (environmental stress, ill health, financial challenges, etc.) coping with these challenges/illnesses (social support: religious groups, families and friends, religious/complementary and professional help)	Acculturation/acculturative stress & Coping strategies (Independent variables).
Barriers to seeking professional help (Religious and cultural factors, Health beliefs and causal beliefs mediated by religious/cultural beliefs, previous experiences, and education rooted in religion)	Religious beliefs/Spirituality (Independent variables)
Health-seeking behaviours (professional and complementary/alternative care methods).	Healthcare utilisation (outcome variable)

7.1.2 Background to study

Following Berry's acculturation patterns discussed in details in chapter 2 (2.2 [v]), integration is considered as the most positive acculturation strategy, against assimilation or separation (Berry, 1997, 2006; Chen, Benet-Martinez & Bond, 2008). It is also known that policy makers in the UK favor integration (Phillimore, 2011). The British Government has recognised the need and benefits of integration, especially through the positive roles of migrant and refugee community organisations (MRCOs) (Home Office, 2005; Griffiths et al., 2006), through advocacy, support, and help for immigrants to celebrate their cultural identity (Phillimore, 2011). However, the type of acculturation strategy adopted can also be influenced by personal factors related to

pre-migration and post-migration experiences (as discussed in studies 1, 2, & 3). Other contributing factors include age, gender, and socio-economic status and cultural distance before migration, as well as prejudice, discrimination, coping strategies, available resources and social support (Berry, 1997; Phillimore, 2011). Ager and Strang (2004) have also recognised social capital as one of the positive factors that can impact on the process of integration among others, such as access to education, training, housing, and employment. They also identified some negative factors such as poor integration policy, negative attitudes from the host community, high rate of racism/discrimination, among others. Faced with adverse situations, individuals try to avoid stress and regain health and well-being by relying on their personal or social coping resources to change or accommodate the stressful environment. Research on stress and coping shows that stress conditions are predicted by antecedents such as environmental and personal variables, which are supported by themes in the first qualitative study of this PhD, in the form of 'acculturation issues' and 'coping methods' respectively; and are deemed relevant to the present study.

To better understand contextual differences regarding health-seeking behaviours among Nigerians in the UK, it is important to investigate those factors identified in previous studies within this thesis, (studies 1, 2, & 3) such as, acculturation, coping methods, and religious beliefs; in combination with socio-demographic factors (such as religious affiliation, length of stay in the UK, gender, and age) that could influence health behaviours. Therefore, among the expectations within this study (study 4), it was anticipated that the more religious Nigerian immigrants, will adopt the traditionalist acculturative patterns while adjusting to the new environment. Consequently, those who hold traditionalist religious beliefs will rely on their religion/culture for coping/cure. Therefore, more reliance on religious coping methods

will result in less healthcare services utilisation. Conversely, it was speculated that more acculturated immigrants will be motivated to cope through formal, professional help-seeking behaviours than the less acculturated who may rely more on their religious and cultural coping resources. Consequently, more reliance on religious/cultural coping methods (such as personal prayer and some religious institutions) will form a barrier to medical healthcare utilisation as those who score high on religious support are expected to score lower on medical help-seeking compared to those who score high on the use of formal institutional resources (such as social support with institutions that refer patients to professional health bodies). These propositions were informed by the existing literature on the impact of immigrants' values and beliefs on their health seeking behaviours. For instance, in the US, research shows that immigrants who keep to their heritage cultural values and beliefs in preference to the host cultural values are most likely to perceive/attribute illness causes, and adopt health seeking behaviours consistent with their original cultural heritage (Chang & Subramaniam, 2008). This aspect of the study will bear on some of the factors discussed within the biopsychosocial model (Chapter 2), especially, the health belief model, such as illness perception/causal attributions that can positively or negatively influence health seeking behaviours. According to Helman (2001) and Eisenbruch (1990), four conceptual categories reflect people's general attributions: 1) Western physiological causes (e.g. chemical imbalance in the brain), 2) non-Western physiological causes (e.g. movement of wind, drafts, gas, milk, flowing of air through the body, or crawling sensation), 3) stress (e.g. general life stress, trauma, or grief), 4) supernatural causes (God, destiny, dangerous/ negative spirits, witchcraft, evil eye, and voodoo). The religious/supernatural categories characterise illness attributions among Nigerians as shown in the qualitative studies within this thesis (studies 1, 2, &

3). Evidence from previous studies shows that contrasting influences from traditional/religious and secular values on people's opinion can cut across cultures and contexts (Bhui et al., 2002; Furnham & Pereira, 2008; Ikwuka et al., 2014; and see Chapter 2, and also sub-section 2.1.2).

Therefore, investigating acculturation, religious beliefs, coping mechanisms and health-seeking behaviours is particularly useful for research and policy among people of African descent (Nigerian immigrants) living in a culture dominated by secularism and individualism, which could impact on them differently towards health services utilisation. Bearing in mind the above factors, the major focus within this study therefore, was to investigate Nigerian immigrants' acculturative patterns (Traditionalists, Integrationists, or Assimilationists), religious beliefs (Traditionalists/African, Assimilationists/Western, or Integrationists/both), and their coping resources (personal, religious, or social) in relation to seeking medical help during acculturative stress/illnesses. The paucity of cross-cultural research with migrants from Nigeria makes it premature to make too specific predictions. However, some hypotheses based on the outcome expectations and speculations already mentioned, have been formulated to guide the study (7.3). Using these hypotheses, this study aimed to uncover any relationships between acculturation orientations, religious-cultural beliefs and coping methods; as well as gender, age, religious affiliation, and length of stay in the UK, when compared to attitudes towards seeking medical help among Nigerians in the UK. Findings from this study will help to uncover minority immigrant groups at risk, and potentially contribute to future focus of policy and health interventions on important risk factors that militate against adequate healthcare utilisation.

7.2 Research Aim

Rather than seek to confirm specific theories, this study aimed to investigate the roles of acculturation, religious beliefs, coping strategies, age, gender, religious affiliations, and length of residence in the UK, on attitudes towards medical help-seeking among Nigerians in the UK.

7.3 Hypotheses

H1. There will be a significant relationship between acculturation, religion, coping styles and attitudes towards seeking medical help.

H2. Participants will differ on acculturation, religious beliefs, coping styles, and attitudes to medical help-seeking based on gender, age, and religious affiliation.

H3. Acculturation, religious beliefs and coping styles will predict attitudes towards medical help-seeking among Nigerians over and above religious affiliation, age and length of residence in the UK.

7.4   Methods

7.4.1 Design

A quantitative cross-sectional study design was used employing questionnaires for data collection; and ethical approval was obtained before data collection (see sub-section 7.4.5 [Appendix 13]).

7.4.2. Materials

Participants received the information sheet to inform them about the purpose of the research, the issues of confidentiality, and freedom to participate or to withdraw at any time (Appendix 14). In addition, they also received the debrief form on the

expected outcome of the study for them to keep (Appendix 15). Both forms were provided as attachments to a questionnaire package of 58 items used to obtain the required data for analyses (Appendix 16). Socio-demographic information was obtained at the start of the questionnaire package, which included items on gender, age, length of residence in the UK, educational qualification, religious affiliation, and occupation (see Appendix 16:1). Then, measures of acculturation orientations and religious beliefs/behaviours (The MASPAD Scale, see Appendix 16:2) (Obasi, 2004), coping strategies (Brief COPE Scale, see Appendix 16:3) (Carver, 1997), and healthcare seeking behaviours - attitudes toward medical help-seeking (The action/intention medical help-seeking sub-scale, see Appendix 16:4) (DiLorenzo, Fischer & Dornelas, 2012) followed the socio-demographic questions. Detailed descriptions of the rationale behind the measures used in this study are contained in chapter 2 of this thesis (2.4.3). Among the three scales used, only the MASPAD can be used flexibly as a bi-dimensional or multi-dimensional measure (Obasi 2004); with good reliability on the orthogonality check as a bi-dimensional scale ($r = .071$ to $.246$) and as a multidimensional scale ($r = .032 - .264$) across three of its original studies. This aspect provided sufficient evidence for an independent assessment of each acculturation strategy, because the scores of the subscales were relatively independent from one another. Permission to adapt this scale to the purpose of the present study among immigrants of African descent in the UK was obtained as discussed in Chapter 2 (see Appendix 17:1, for personal communication, dated 7/20/2015). Hence, 15 items each were chosen from the 2 sub-scales of the original 45-item MASPAD (N = 30), and checked for validity and reliability (7.5.2.1). Also, with permission to adapt the Brief COPE Scale clearly expressed in the instruction section by the scale developers, the Brief COPE Scale for this study was adapted with 16

items selected from the 28 items of the 14 subscales of the original measure, and checked for validity and reliability (7.5.2.2). The measure for attitudes towards medical help-seeking was not adapted/changed from its original form; however, developers' permission was obtained to use it in its original form (see Appendix 17:2 for personal communication dated, 7/20/2015). The entire questionnaire package therefore consisted of 58 items and 6 socio-demographic questions. All questionnaires used in the study have been validated and widely used among different research populations (see sub-section 2.4.3).

A pilot study was conducted to ensure propriety of questionnaire items considering the multidimensional nature of the concept of interest and the particular religious and cultural differences, as well as migration experiences of the research population. The pilot study involved 10 participants recruited through personal contacts. The resulting feedback concerned dissatisfaction with disclosing participant's exact age. This change was effected in the new questionnaire by dropping the question on the age of arrival to the UK as this resulted in participants' exact age when summed up with their length of stay in the UK. Consequently, the sensitivity regarding disclosing exact age information was avoided by using the age-range format in the final questionnaire structure. No further issues were identified in the pilot study.

7.4.3 Participants

The sample size was calculated based on guidance of 10-15 participants per variable (Field, 2009). Calculating based on 15 participants per variable, it was estimated that 270 participants would be needed for the study. However, anticipating a non-completion rate of 20% the target sample size was set at 324 to be drawn from

Nigerian adult immigrants in the UK, irrespective of gender, religion, or tribe. A sample size of 324 is considered adequate from previous research (Tabachnick & Fidell, 2007).

Inclusion criteria were first generation Nigerian immigrants born and raised in Nigeria as adults before coming to live in the UK, to ensure they had experienced acculturative effects. These criteria were based on research findings showing that adult immigrants are more likely to retain the memories of their pre-migration cultural values and life experiences (Portes & Rumbaut, 2006), and may experience more challenges integrating with the new cultural environment (Schwartz, Pantin, Sullivan, Prado & Szapocznik, 2006). Exclusion criteria included all second-generation Nigerian immigrants; those under the age of 18; those born in Nigeria but migrated to the UK as minors; as well as institutionalised Nigerian immigrants.

7.4.4 Procedure

The total questionnaire package of 64 items (socio-demographic items n = 6, questionnaire items n = 58) was used for primary data collection, and took approximately 45-60 minutes. The process of identification and recruitment of participants took place between August and September 2015. Participants were recruited through the snowball process for a more extensive distribution and collection of questionnaires. Participants were given the information sheet containing adequate information about the purpose of the research, confidentiality, and freedom to participate or to withdraw at any time. They also received the questionnaires with debriefing section containing information about the expected outcome of the study for them to keep. Each questionnaire was marked with a unique reference number (01-560), to help identify individual data and participants were asked to take a note of their

reference number and cite this accordingly should they wish to withdraw their participation/data. Self-addressed and stamped envelopes in which to seal and return their questionnaires were provided to each participant. As there were no consent forms provided, informed consent was implied by participants' acceptance to complete the questionnaires; and this was explained within the information sheet provided to participants and clearly expressed as per instruction before completing the questionnaire.

A total of 560 questionnaires were distributed and 311 were returned (a 55.5% overall response rate); some by hand and some by post, out of which 14 were rejected for missing more than 4 items; thereby leaving a total of 297 completed questionnaires (53% accurately completed responses). The decision to drop participants conservatively, with only 4 missing items was based on the recommendation for the use of the 'Attitude Towards Medical Help-Seeking Scale' (Fischer et al., 2013). This same criterion was applied across all other scales so that any data with more than 4 missing items across all the scales was rejected.

7.4.5 Ethics

Ethical approval was granted by the Department of Psychology Ethics Committee (see Appendix 13). As already noted, informed consent was implied by participants' completion of the questionnaires as clearly indicated in the Information Sheet as well as the instruction section of the questionnaires. Adequate information about the purpose of the research, confidentiality, and freedom to participate or to withdraw at any time were also contained within the Information Sheet; and Debriefing Sheets also contained the expected outcome of the study. All these forms, including the chosen questionnaires formed parts of the ethical application.

7.4.6 Analysis

With the aid of the Statistical Package for the Social Sciences (SPSS 21) computer software, descriptive analysis was examined to summarise the characteristics of the sample population. Correlation analysis was used to examine the relationships between acculturation, religion, coping styles, and attitudes towards medical help-seeking; while the ANOVA, MANOVA, and t-tests were appropriately used to investigate group differences. Hierarchical multiple regression was used to determine whether acculturation, coping and religion predicted attitudes towards health seeking behaviour over and above the demographic variables measured. For the regression analysis, categorical variables were dummy coded as (0) and (1) for the analysis. To avoid covariant obscurity and to ensure accuracy in representation of specific socio-demographic variables involved in this study – gender, age, religious affiliations were analysed separately (7.5.4). As noted above, fourteen cases were removed from the analyses due to missing values, while final analyses were performed on 297 participants.

7.5   **Results**

7.5.1 Participant characteristics

As can be seen from Table 7.2, slightly more women than men participated in the survey. Participants were categorised into three age-groups: the young (18-40), the middle-aged (41-60) and the old (61 and over), with more middle aged persons (48%) shown to have been involved in the survey than other age groups. For years of residence in the UK, there were 288 respondents ranging from 1-53 years (M = 13.49, SD = 10.13) (see table 7.2).

Table 7.2
Participant socio-demographic characteristics (N= 6)

Variables	Totals (N=297)	Missing
Gender n (%) Female Male	 160 (53.9%) 137 (46.1%)	 -
Age-range, n (%) Young (18-40) Middle Age (41-60) Older Age (61-80)	 118 (39.8%) 142 (48%) 36 (12.2%).	 1 (.3%)
Residency n (%)	M = 13.49 SD = 10.13	9 (3.0%).
Religion n (%) Pentecostal Christians Mainline Christians Other Christians Muslims No-religion	 97 (34.3%) 136 (48%) 16 (5.7%). 9 (3.2%) 25 (8.8%)	 14 (4.7%)
Education n (%) Graduates Non-Graduates:	 236 (79.7%). 60 (20.3%)	 1 (.3%)
Profession n (%) Managers Professional occupations Administrative Skilled trades Students Unemployed and retired	 77 (25.9%); 154 (51.9%) 17 (5.7%) 17 (5.7%) 8 (2.8%) 14 (4.9%)	 10 (3.4%)

From the result shown in Table 7.2, more participants with Christian religious beliefs (Pentecostals, mainline Christians, and others) were recruited, accounting for 88%, compared to Muslims (3.2%) and those with no religion (8.8%). However, considering Christian denominational affiliations mainline Christians (Catholics, Anglicans, Baptists) accounted for more Christian participants (48%) than the Pentecostals (34.3%) and others (Jehovah Witness & Adventists (3.2%). There existed a significant disparity in educational qualification between graduates (79.7%) and non-graduates (20.3%), hence it was excluded from the analyses. Categorisation of participants' occupations was recoded into 6 groups: 1. Managers, directors and senior officials, Associate professional and technical occupations (for example, legal support, business and public service), 2. Professional occupations, Caring, leisure and other service occupations (for example, health profession – medical and dental professionals, nurses/midwives, therapists, social care workers, teachers), 3. Administrative and secretarial occupations, Sales and customer service occupations (for example, secretaries and sales/customer service officers), 4. Skilled trades occupations, Process, plant and machine operatives, and Elementary occupations (for example, drivers and mechanics), 5. Students, 6. Unemployed and retired. The aim was to simplify data presentation and to ensure that health-related professions which were of research interest were grouped together (Group 2). Hence, more participants from the health and caring professions were shown to be more involved in the study (51.9%) compared to non-health professionals, with the least being students (2.8%) (See Table 7.2). Subsequently, this variable was also excluded from the analyses as the groups were so mixed-up with no clear representation of the occupation of our research focus; it was not possible to use them without distorting the results.

7.5.2 Reliability and validity of the instruments used

7.5.2.1 The MASPAD

The initial approach to using the MASPAD involved an exploratory factor analysis to check for the validity and reliability of the items adapted from the original MASPAD subscales as already discussed in the materials section (7.4.2). The 30 items of the Measurement of Acculturation Strategies for People of African Descent (MASPAD) Scale were subjected to principal component analyses (PCA) using SPSS version 21. Prior to running the PCA, the suitability of data for factor analysis was considered, and the correlation matrix showed the presence of many coefficients of 0.3 and above. The Kaiser-Mayer-Olkin (KMO) value was 0.77, exceeding the recommended value of 0.6 (Kaiser, 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) reached statistical significance ($p = 0.00$), thereby supporting the factorability of the correlation matrix. Principal component analysis revealed the presence of 6 factors with eigenvalue exceeding 1, and explaining 19%, 11%, 10%, 7%, 5.4%, and 4.6% of the variance respectively. An inspection of the scree plots also showed a clear break after the sixth component (Figure7.1); and using Catell's (1966) scree test approach, it was decided to retain the 6 components for further investigation. The 6-factor solution therefore, explained a total of 56% of the variance, with Component 1 contributing 18.8%, Component 2 contributing 10.8%, Component 3 contributing 6.7%, Component 4 contributing 5.4, Component 5 contributing 4.6%, and Component 6 contributing 9.4%.

To help with the interpretation of these 6 components, oblimin rotation was performed. The rotated solution revealed the presence of simple structure (Thurstone, 1947), with all components showing a number of strong loadings and all variables loading substantially across all 6 components, which were considered more

appropriate in identifying responses from the sample , both for acculturation patterns and religious factors as shown in the pattern matrix (see Table 7.3): 'traditionalist behaviours', 'traditionalist beliefs', 'assimilationist behaviours', 'integrationist behaviours', 'religious beliefs', and 'religious behaviours' respectively. The factor analysis supported the use of the MASPAD Scale as a multi-dimensional scale following suggestions by the scale developer (Obasi, 2004). Possible overall total scores for this study ranged between 0 – 180; where individual item scores of 1-3 were regarded as low and 4 to 6 as medium to high scores.
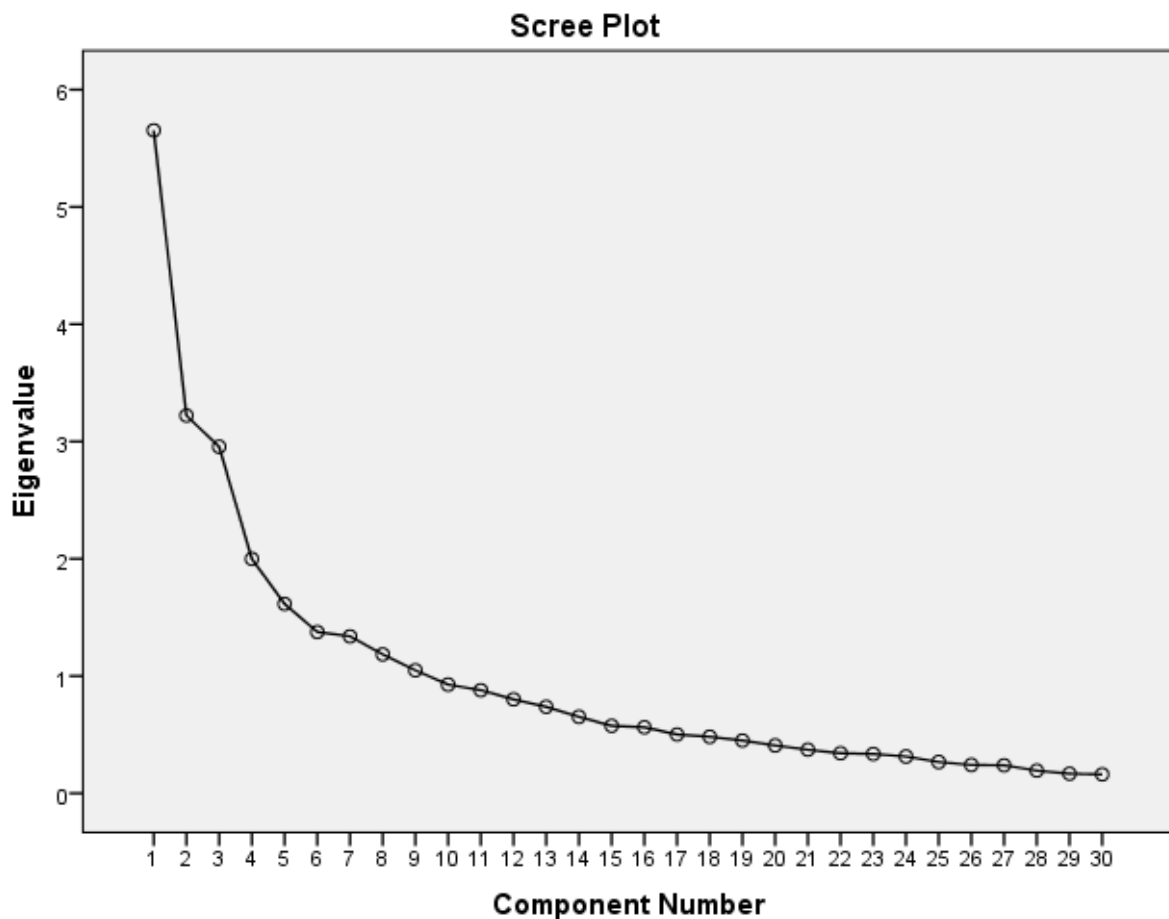
Figure 7.1. A scree plot showing 6 factors, for oblimin rotated component factor analysis.

MASPAD Items	Components					
	1 Traditionalist behaviours	2 Traditionalist beliefs	3 Assimilationist behaviours	4 Integrationist behaviours	5 Religious beliefs	6 Religious behaviours
2. African naming ceremony	**.698**					
11. African ancestry	**.549**					-.307
25. Black businesses	**-.510**	.310		.389		
5. African cultural practices	**.475**			.307		
3. African heritage	**-.455**		.381	-.345		
10. I maintain my cultural beliefs	**.376**			.358		-.345
26. marrying someone non-Black		**.753**				
29. injustices on Africans		**.727**				
30. different cultural values to fit in	.559	**.569**				
17. Modify values to fit in...		**.510**				
22. African rich history		**-.429**		.350		
4. British first…		**.417**				
9. putting on the *mask* to fit in			**.671**			
21. assimilating into other cultures			**.549**		.316	
7. People from different races…			**.542**			
15. people that are not black			**.518**	-.450		
16. Black owned businesses			**.465**		.301	
6. Ideas held by Blacks…			**.452**			.353
19. Festivals				**.742**		
13. spiritual person				**.699**		
18. My religious beliefs				**.698**		
14. religious person				**.599**	-.409	
23. African spiritual system					**.834**	
20. rituals and departed ancestors					**.781**	
24. I use African language					**.711**	
27. African art						**-.761**
8. Treating elders with respect						**-.579**
1. pride in being an African						**-.571**
28. events that impact my people						**-.570**
12. the way I behave at home	-.368		.418		.301	**-.467**

Note: Six major loadings for each item are bolded, and shown in different colours.

The 6-factor MASPAD subscales were further checked for acceptable reliability which yielded the following results: traditionalist behaviours (MASPADTRBEH) with Cronbach's alpha = 0.603, traditionalist beliefs (MASPADTRABEL) - Cronbach's alpha = 0.631, assimilationist behaviours (MASPADASSBEH) Cronbach's alpha = 0.673, integrationist behaviours (MASPADINTBEH) Cronbach's alpha = 0.584, religious beliefs (MASPADRELBEL) Cronbach's alpha = 0.778, and religious behaviours (MASPADRELBEH) Cronbach's alpha = 0.775; which were considered adequate. High scores on any of the items was indicative of expressing positive attitudes regarding traditionalist, assimilationist, integrationist, and religious behaviours or beliefs while low scores indicated the contrary. These 6 factors were subsequently used in the analysis described below (7.5.3).

7.5.2.2 The Brief COPE

The Brief COPE (Carver, 1997), a widely used and validated scale was used to obtain information on various coping strategies prevalent among Nigerian immigrants in the UK. This scale was adapted from the original measure to suit the present research population as suggested by the scale author (Carver, 1997), details of the adaptation procedure was discussed in previous section (7.4.2). The 16 items (8 Subscales) were not subjected to further factor analysis as the Brief COPE is a long standing, validated and reliable scale widely used in research. However, a reliability check was conducted for the purposes of this study, and the chosen subscales loaded on the factors as follows: active coping = 0.52; denial = 0.34; emotional support = 0.67; instrumental support = 0.80; behavioural disengagement = 0.67; venting = 0.45; religion = 0.71; and self-blame = 0.56. Although, the lower loading for 'denial' and

'venting' did not meet the 0.50 recommended threshold (Comrey & Lee, 1992), they were given consideration based on recommendations for loading values by Tabachnick and Fidell (2013). Such consideration (to retain and reflect on them in the discussion section) also followed from their value in previous qualitative studies in this thesis (see Table 7.1 above) regarding immigration challenges. Moreover, there was no sufficient reason to drop the two subscales as both also, had the lowest loadings of all the subscales in the original scale validation (Carver, 1997) (see 2.4.3 [ii]). The 16 items selected were all straight questions (no reverse item), scored 1-4 following the Likert response format, with possible total score range of 0 to 64.

7.5.2.3 The Attitudes Toward Seeking Medical Care Scale

The 12-item action/intention measure of attitudes toward seeking medical care scale (DiLorenzo, Dornelas & Fischer, 2015) was used in its original form as one of 4 subscales in a 35-items scale "Attitudes Toward Seeking Medical Care Scale" developed by Fischer et al., (2013) (see subsection 2.4.3 [iii]). This subscale on its own yielded an acceptable Cronbach's alpha (0.671) and was used to obtain information on the attitude towards medical healthcare utilisation among Nigerians in the UK. Items on this scale contained willingness to seek professional medical help or not; with scores ranging between 0 to 36, from responses (agree, partly agree, partly disagree, and disagree) scored as 3-0 for straight items and 0-3 for reversed items. Low scores were rated as 0 - 1 and high scores from 2 - 3. Low scores indicated negative attitudes towards medical help-seeking and high scores showed positive attitudes to seeking professional medical help.

7.5.3 Correlations between scales

Hypothesis 1: There will be a significant relationship between acculturation into the British culture, religion, coping styles and attitudes towards seeking medical help.

In order to test the first hypothesis (H1), on the association between attitudes towards medical help-seeking (as measured by the Attitudes Towards Seeking Medical Care Scale) and the independent variables: traditionalist behaviours, traditionalist beliefs, assimilationist behaviours, integrationist behaviours, religious beliefs, and religious behaviours (as measured by the MASPAD Scale and verified by the factor analysis solution presented in section 7.5.2.1 above); and coping methods: active coping, denial, emotional support, instrumental support, behavioural disengagement, venting, religious cope, and self-blame (as measured by the Brief COPE Scale) a Pearson product-moment correlation coefficient was conducted. The result showed a negative correlation between attitudes to medical help-seeking and religious behaviours ($r = -0.16$, $n = 297$, $p < .05$) (Table 6.5), behavioural disengagement ($r = -0.24$, $n = 297$, $p < .05$) and self-blame ($r = -0.24$, 297, $p < .05$) (Table 6.5), with high levels of religiosity (exhibiting religious behaviours) associated with lower levels of medical help-seeking; and increased use of behavioural disengagement and self-blame coping styles were also associated with lower levels of medical help-seeking.

There were positive correlations between attitudes towards medical help-seeking and several coping methods, such as instrumental support ($r = 0.15$, $n = 297$, $p < 0.05$), emotional support ($r = 0.12$, $n = 297$, $p < 0.05$) and active coping ($r = 0.12$, $n = 297$, $p < 0.05$) (Table 7.5) with increases in the use of instrumental support, emotional support, and active coping associated with increase in medical help seeking. There were no relationships between acculturative orientations

(assimilationist, traditionalist, integration) and medical help-seeking. However, all relationships were small (r = .10 to .29) (Cohen, 1988), with no more than 6% shared variance in any of the correlations following the coefficients of determination result.

The correlations across the independent variables (MASPAD and Brief Cope Scales) also provided important information regarding different acculturation strategies, religion, and coping styles adopted by Nigerian immigrants in the UK. For instance, there were negative correlations between assimilative behaviours and religious behaviours (r = - 0.12, n = 297, p < 0.05) and between religious behaviours and two coping styles: denial (r = - 0.13, n = 297, p < 0.05) and religious coping (r = - 0.18, n = 297, p < 0.01). The implication is that the more Nigerian immigrants become assimilated into the British culture, the less they exhibited religious behaviours and the more they engaged in religious behaviours the less they employed denial and religious coping styles, such that being religious does not necessarily compel one to use religious coping. As expected, 'integrationist' acculturation pattern significantly correlated positively with religious behaviours, because integration encourages the retention of both heritage and host cultures (see details in Table 7.4).

Table 7.4

Pearson Product-moment Correlation Between Measures (MASPAD, BCOPE & ATMHS)

Scales	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1.Traditionalist Beliefs		0.45**	0.15*	0.19**	0.57**	0.22**	0.20**	0.07	0.11	0.08	0.11	0.08	0.06	0.05	0.01
2. Traditionalist Behaviours			0.20**	0.19**	0.54**	0.33**	0.08	0.25**	0.21**	0.28**	0.18**	0.22**	0.15**	0.13*	0.08
3. Assimilationist Behaviours				0.32**	0.07	0.10	0.09	-0.12*	0.03	-0.06	0.21**	0.09	-0.05	0.07	0.09
4. Integrationist Behaviours					0.09	-0.10	0.07	0.16**	-0.09	-0.04	-0.01	-0.10	-0.11	-0.01	-0.06
5. Religious beliefs						0.44**	0.17**	0.02	0.19**	0.33**	0.14*	0.20**	0.21**	0.24**	0.06
6. Religious coping							0.21**	-0.18**	0.44**	0.40**	0.05	0.35**	0.41**	0.32**	0.01
7. Self-blame coping								0.03	0.22**	0.05	0.43**	0.30**	0.14*	0.45**	-0.24**
8. Religious behaviours									0.04	-0.02	0.09	-0.13*	-0.02	-0.00	-0.06**
9. Emotional support										0.51**	0.07	0.25**	0.63**	0.30**	0.12*
10. Active coping											-0.05	0.17**	0.76**	0.26**	0.12*
11. Behavioural Disengagement												0.35**	0.02	0.19**	-0.24**
12. Denial													0.17**	0.29**	-0.01
13. Instrumental support														0.34**	0.15**
14. Venting															-0.01
15. Medical help seeking															

Note: significant correlations = ** $p < 0.01$ (2-tailed), * $p < 0.05$ (2-tailed).

7.5.4. Examining group differences in acculturation, religion, coping styles, and attitudes to medical help seeking outcomes (H2 - Participants will differ on acculturation, religious beliefs/behaviours, coping styles, and attitudes to medical help-seeking based on gender, age, and religious affiliation).

7.5.4.1 Gender differences on the outcomes of the MASPAD, Brief COPE, and Medical help-seeking Scales

To investigate gender differences in acculturation and religious beliefs a one-way between-groups multivariate analysis of variance (MANOVA) was carried out. Six dependent variables were used: traditionalist beliefs, traditionalist behaviours, assimilationist behaviours, integrationist behaviours, religious beliefs, and religious behaviors, as measured by the Measurement of Acculturation Scale for People of African Descent (MASPAD, see also section 7.5.3 above). The independent variable was gender (males and females). Preliminary assumption testing was carried out to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance and covariance matrices, and multicolliniarity, with no violation. The result showed there was a statistically significant difference between males and females on the combined (total scale scores) dependent variables, $F (6, 290) = 7.47$, $p = 0.01$; Wilks' $\lambda = 0.87$. Following the significant result obtained, it was necessary to investigate further if males and females differed on all the dependent variables using the between-subjects effects. The results showed that the only differences to reach statistical significance were traditional beliefs $F (1, 295) = 5.95$, $p = 0.02$, traditional behaviours $F (1, 295) = 5.25$, $p = 0.02$, and religious beliefs, $F (1, 295) = 30.05$, $p < 0.01$. Further inspection of the mean scores showed that females scored higher than males on all the significant differences reported above, as shown in Figure 7.4.
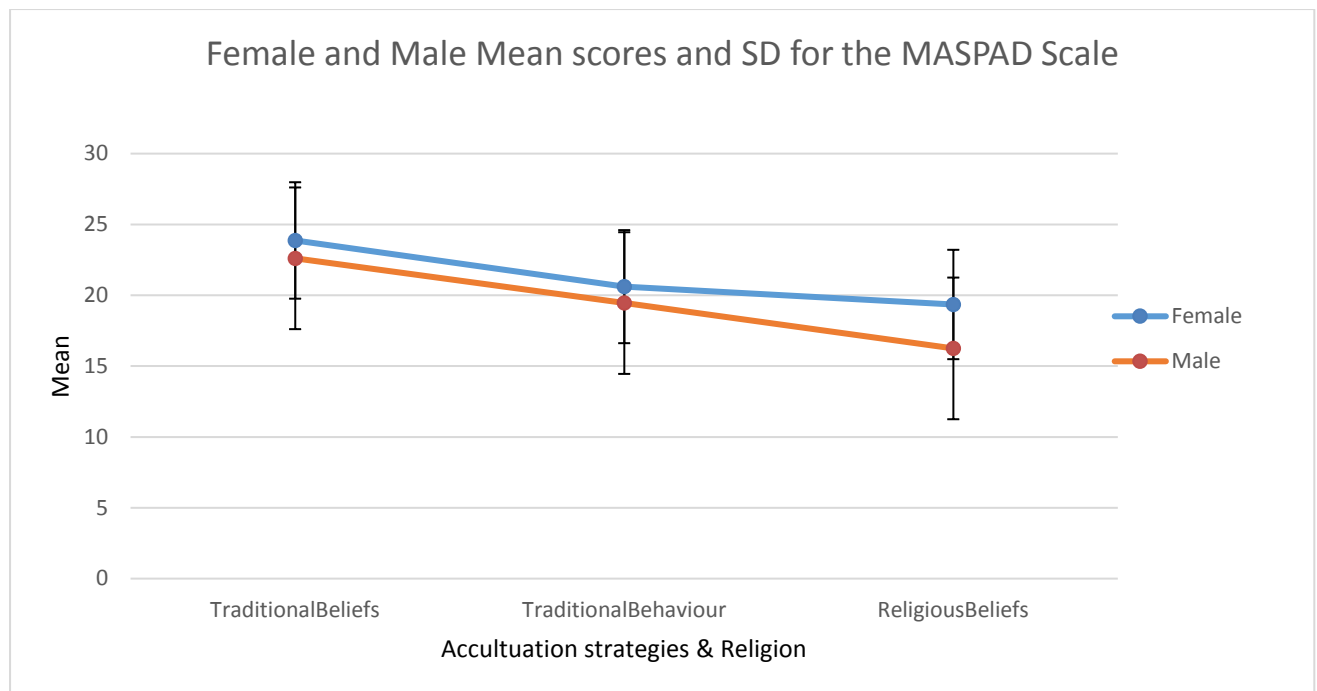
Error bars: +/- 1 SD

Figure 7.4. Significant means scores on the MASPAD Scale by gender.

Analyses were also carried out on gender differences and the coping methods used by Nigerian immigrants, using a one-way between-groups multivariate analysis of variance (MANOVA). The variables involved were, active cope, denial, emotional support, instrumental support, behavioural disengagement, venting, religious coping, and self-blame as measured by the Brief Cope Scale. The result showed a statistically significant difference between males and females on the coping styles, $F(8, 287) = 2.27$, $p = 0.02$; Wilks' λ = 0.94. The test of between-subjects effects showed that only 3 coping methods were statistically significant: religious coping $F(1, 294) = 8.51$, $p< 0.01$, behavioural disengagement $F(1, 294) = 4.13$, $p< = 0.05$, and venting $F(1, 294) = 4.98$, $p< = 0.05$. By inspecting the means scores it was revealed that females also scored higher than males on all the differences: religious coping (Females: M = 6.68, SD = 1.70; Males: M = 6.05, SD = 2.01), behavioural disengagement (Females: M =

3.30, SD = 1.52; Males: M = 2.93, SD = 1.59) and venting (Females: M = 4.38, SD = 1.72, Males: M = 3.94, SD = 1.63).

Moreover, to investigate if any significant difference existed in the mean attitudes towards medical help-seeking scores due to gender, an independent-sample t-test was carried out, thereby comparing the attitudes towards medical help-seeking scores for male and female participants. There was no significant difference in scores for males (M = 28.71, SD = 4.68) and females (M = 29.53, SD = 4.95; $t_{(295)}$ = -1.46, p< 0.05, two-tailed). Therefore, no gender differences were found relating to attitudes towards medical help-seeking.

7.5.4.2 Age differences on the outcomes of the MASPAD, Brief COPE, and Medical Help-Seeking Scales

A one-way between-groups multivariate analysis of variance (MANOVA) was carried out to investigate age differences in acculturation and religious beliefs using the following variables: traditionalist beliefs, traditionalist behaviours, assimilationist behaviours, integrationist behaviours, religious beliefs, and religious behaviors, as measured by the MASPAD Scale. Age comprised three groups: the young, middle-aged, and older people. There was a statistically significant difference between groups on the combined dependent variables (total MASPAD scores), $F_{(12, 576)}$ = 1.8, p< = 0.05; Wilks' λ = 0.93; partial eta squared = 0.04. The between-subjects analysis on the subscales showed only the religious behaviours subscale was found to reach statistical significance: $F_{(2, 293)}$ = 3.73, p< 0.05, with the young age-group scoring higher compared to the middle-aged participants; and followed by the older group of participants. Younger people therefore exhibited more religious behaviours than the older generation (see Figure 7.5).
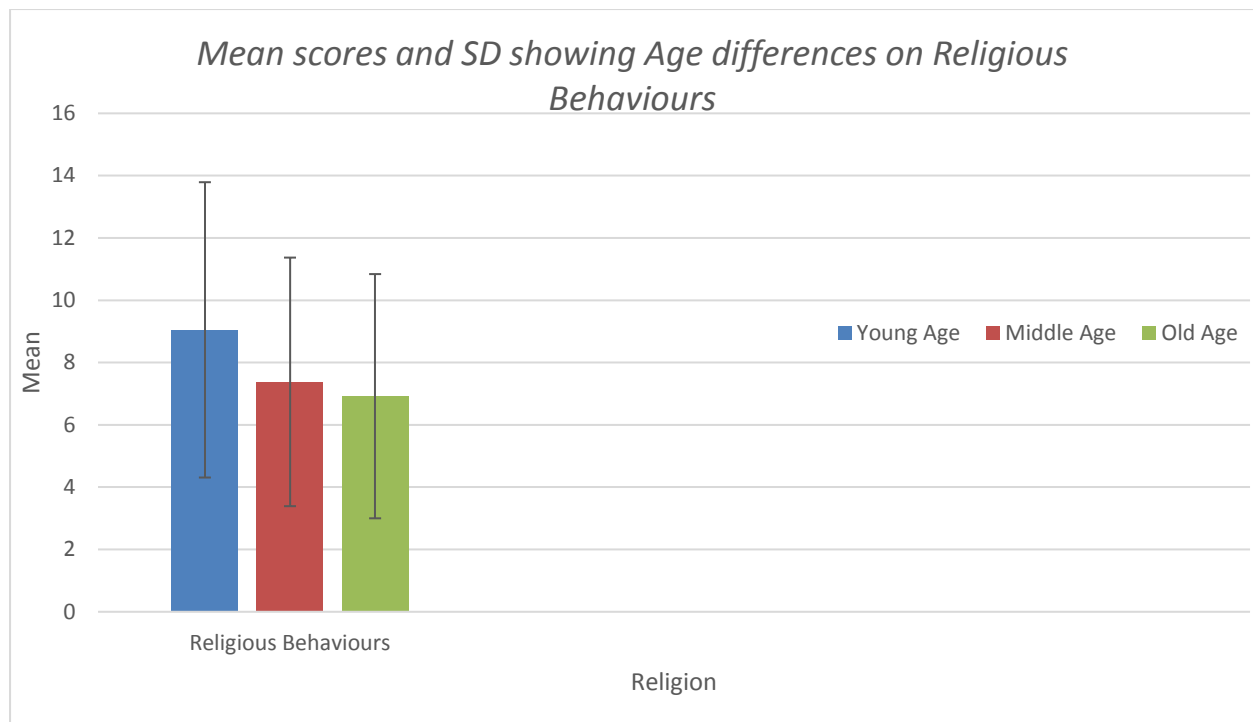
Error bars: +/- 1 SD

Figure 7.5. Mean differences for religious behaviours (MASPAD Scale) by Age group.

Furthermore, a similar multivariate analysis (MANOVA) was also carried out to investigate the impact of age differences on the coping styles employed by Nigerian immigrants, based on the following variables: active cope, denial, emotional support, instrumental support, behavioural disengagement, venting, religious coping, and self-blame of the Brief COPE Scale. Age was retained in three groups (Group1: Young Age-group, Group 2: Middle-age group, Group 3: Old Age-group); and the outcome revealed a statistically significant difference between different age groups on the combined dependent variables, $F(16, 570) = 1.88$, $p < 0.05$; Wilks' $\lambda = 0.90$; partial eta squared = 0.05. However, to understand whether the age groups differed on all the coping styles the between-subjects output showed that only active coping and denial reached a significant level at $F(2, 292) = 3.23$, $p < 0.05$ partial eta squared = 0.02 and $F(2, 292) = 5.54$, $p< = 0.01$, partial eta squared = 0.04, respectively. Again, younger

people (young and middle age groups) scored higher (M = 5.79, SD = 1.68; M = 5.58, SD = 1.92 respectively) than the elderly (M = 5.03, SD = 1.88) on using active coping methods. Conversely, the elderly scored higher (M = 4.11, SD = 1.73) than the younger age-groups (young: M = 3.05, SD = 1.39, and middle ages: M = 3.89, SD = 1.67) on adopting denial as a means of coping.

Regarding the above age differences in response to the MASPAD and Brief COPE Scales, it was necessary to further explore age differences and attitudes towards medical help-seeking as measured by the Attitudes Towards Medical Care Scale. This investigation was based on a one-way between-groups analysis of variance (ANOVA); using the same age groups (Group 1: Young-Age, Group 2: Middle-Age, Group 3: Old-Age). There was a statistically significant difference at the $p < 0.05$ level in attitudes towards medical help-seeking scores for the three groups: $F (2, 293) = 5.4$, $p < 0.01$. Post-hoc comparison using the Turkey HSD test indicated that the mean score for Group1: Young people ($M = 28.2$, $SD = 4.73$) was significantly different from Group 3: Old people ($M = 30.5$, $SD = 4.61$). The mean score for Group 2: Middle-Age ($M = 28.6$, $SD = 4.9$) was significantly different from Group 3 (Old people), but the young (Group 1) did not differ significantly from the middle-aged (Group 2), showing that older people scored higher in using medical help seeking than the young/middle aged.

7.5.4.3 Religious Affiliation on the outcomes of the MASPAD, Brief COPE, and Medical Help-Seeking Scales

A similar one-way MANOVA was conducted to explore the impact of religious affiliation on the differences in traditionalist beliefs, traditionalist behaviours, assimilationist behaviours, integrationist behaviours, religious beliefs, and religious

behaviors. Religious affiliation comprised 3 groups: Group 1: Christian Religion (Pentecostals, Catholics, Baptists, and Anglicans), Group 2: Other Religions (Jehovah's Witnesses, Muslims, and Adventists), and Group 3: No-Religion. The result showed there were significant differences between affiliation to the Christian religion, to other religions, and to no religion at all, on the combined dependent variables, F $(18, 815) = 25.3$, $p < 0.01$; Wilks' $\lambda = 0.28$, partial eta squared = 0.34. Between-subjects effects revealed that all the subscale scores between groups were significant: traditionalist beliefs $F(3, 293) = 5.11$, $p < 0.01$, partial eta squared = 0.05; traditionalist behaviours , $F(3, 293) = 16.72$, $p < 0.01$, partial eta squared = 0.15; assimilationist behaviours $F(3, 293) = 50.56$, $p < 0.01$, partial eta squared = 0.34; integrationist behaviours $F(3, 293) = 6.05$, $p < 0.01$, partial eta squared = 0.06; religious beliefs F $(3, 293) = 27.26$, $p < 0.01$, partial eta squared = 0.22; and religious behaviours $F(3, 293) = 21.9$, $p < 0.01$, partial eta squared = 0.18. These results were also confirmed by comparison in the mean scores showing that those with religious affiliation (Christians and other religions) scored higher than those with no religion, on all the acculturative and religious factors except religious behaviours (see Figure 7.6). Therefore, those with religious affiliations held more acculturative strategies and religious beliefs than those with no affiliation to a religious group, but contrary to expectations, those with no religious affiliations exhibited more religious behaviours than those affiliated to a particular religious group, showing that affiliation to a religious group does not necessarily imply being more religious/spiritual in deeds/commitment.
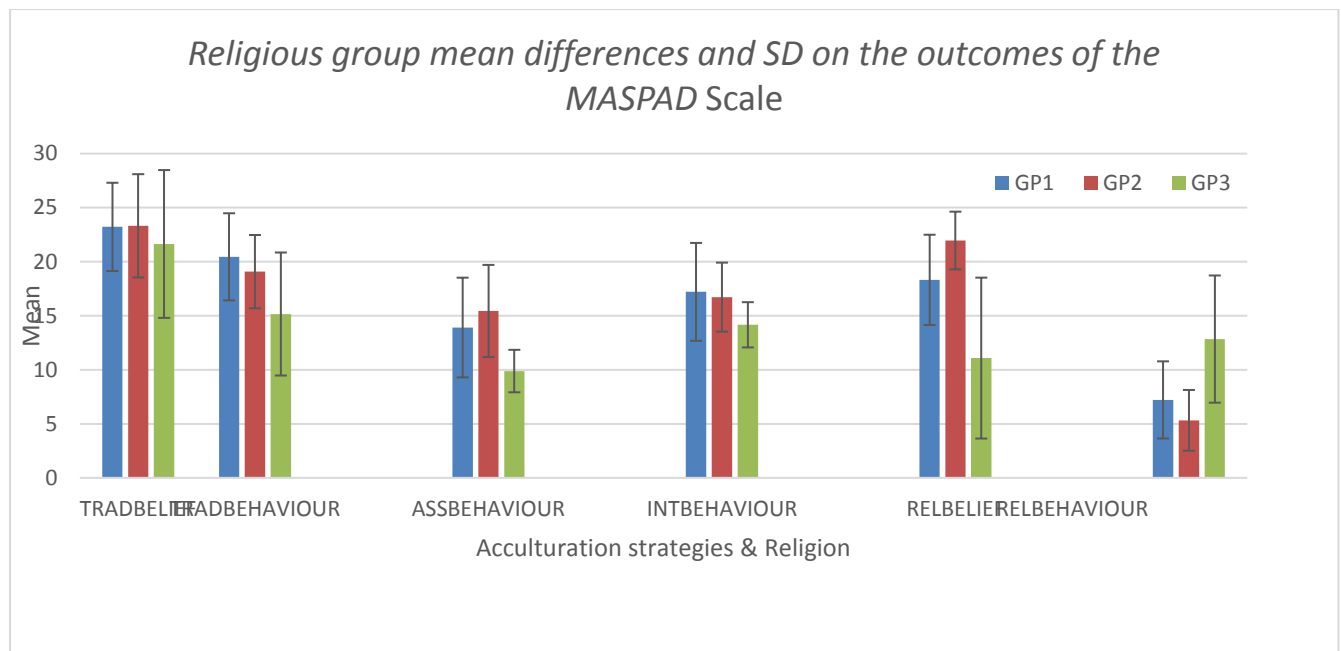
Error bars: +/- 1 SD

Figure 7.6. Mean scores for the significant differences on acculturative strategies (MASPAD Scale) by religious groups

Finally, a post hoc test was conducted using the Tukey HSD, and the results revealed a significant difference in mean values for traditionalist behaviours between Christians and those without religion ($MD = 5.35$, $p < 0.01$) and between those of other religions and non-religious ($MD = 3.95$, $p < 0.05$). Also, for assimilative behaviours, there was a significant difference in values between Christians and non-religious ($MD = 4.03$, $p < 0.01$) and between those of other religion and non-religious ($MD = 5.56$, $p < 0.01$). Further findings from this test showed that the difference in mean scores between the Christian groups and those with no religious affiliations on integrationist behaviours were also statistically significant at $MD = 3.05$, $p < 0.02$. The religious aspects equally yielded significant results regarding differences in mean values, such as religious beliefs being significantly different between the Christians and other religions ($MD = 3.64$, $p < 0.01$), between the Christians and non-religious ($MD = 7.24$,

p< 0.01), and between those of other religion and the no-religious affiliation group (*MD* = 10.88, *p*< 0.01); for religious behaviours, the mean differences were expectedly significant only between Christians and the non-religious (*MD* = 5.63, *p*< 0.01) and between those of other religion and the non-religious (*MD* = 7.52, *p*< 0.01).

Another one-way between-groups (religious affiliations) multivariate analysis of variance (MANOVA), was carried out on the eight different coping styles (dependent variables): active cope, denial, emotional support, instrumental support, behavioural disengagement, venting, religious coping, and self-blame, as measured by the Brief COPE Scale. The independent variable was the 3 groups of religious affiliation (Group 1: Christian Religion; Group 2: Other Religions; Group 3: No Religion). There was a statistically significant difference between religious affiliation and types of coping used by Nigerian immigrants, $F_{(24, 827)} = 9.76$, $p < 0.001$; Wilks' λ = 0.48; partial eta squared = 0.21; and the between-subjects effects indicated that all coping styles except 'self-blame', attained statistical significance: active coping $F_{(3, 292)} = 28.13$, p< 0.01, partial eta squared = 0.22; coping by denial $F_{(3, 292)} = 12.68$, *p*< 0.01, partial eta squared = 0.11; emotional support $F_{(3, 292)} = 12.41$, $p = 0.01$, partial eta squared = 0.11; instrumental support $F_{(3, 292)} = 17.24$, *p*< 0.01, partial eta squared = 0.15, behavioural disengagement, $F_{(3, 292)} = 2.96$, *p*< 0.05, partial eta squared = 0.03; venting, $F_{(3, 292)} = 2.84$, *p*< 0.05, partial eta squared = 0.03, and religious coping $F_{(3, 292)} = 41.30$, *p*< 0.01, partial eta squared = 0.29. The mean scores indicated that those with religious affiliation: Christians (Gp1) and other religions (Gp 2) scored higher than those without any religious affiliation (Gp 3) on all the statistically significant coping subscales. By implication, being affiliated to a particular religious group resulted in increased use of such coping styles as active coping, denial, emotional and instrumental support, as well as behavioural disengagement than not

being affiliated to a religious organisation. Post hoc analysis (Tukey HSD) showed the difference in mean values for active cope to be significant between Christians and those of other religious affiliations (MD = 1.24, p< 0.05), and between Christian and non-religious (MD = 2.76, p< 0.01); between those of other religion and no-religion (MD = 1.52, p< 0.05). Also, coping by denial showed a statistical difference in value between the Christian and no-religion groups (MD = 2.00, p< 0.01) as well as those of other religion and no-religion (MD = 2.32, p< 0.01). For emotional support, the significant difference occurred only between Christian and other religious groups (1 & 2) (MD = 1.73, p< 0.01) and between Christians and non-religious (1 & 3) (MD = 1.77, p< 0.01), which is like instrumental support where the difference occurred between the Christian and other religions (1 & 2) (MD = 1.70, p< 0.01) and between the Christian and no-religious groups (1 & 3) (MD = 2.34, p< 0.01). The difference in mean value for religious cope was significant between the same groups as coping with denial: Groups 1 & 3 (MD = 3.63, p< 0.01) and Groups 2 & 3 (MD = 3.84, p< 0.01). For coping by behavioural disengagement and venting, only two groups were found to have significant differences in mean values between them – Groups.1 & 2 (MD = 0.93, p< 0.5) and Groups. 2 & 3 (MD = 1.36, p< 0.05) respectively. This test showed that only active coping was significantly difference in mean scores between all the three groups.

Finally, a one-way between-groups ANOVA was conducted to investigate Religious affiliation and medical help seeking, using the same groups as in the analysis above. There was also a statistically significant difference at the $p < .05$ level in attitudes towards medical help-seeking between the three groups: F (3, 293) = 8.3, p< 0.01. Post-hoc comparison based on the Turkey HSD test indicated that the mean score for Group1 (Christian religious group) (M = 29.7, SD = 4.44,) was significantly different from Group 3 (No Religion) (M = 25, SD = 3.77). Group 2 (Other Religions)

(M = 27.9, SD = 7.52) did not differ significantly from either Group 1 or 3. Therefore, it was concluded that those with religious affiliation (Christians) had more positive attitudes towards using the medical health services than those without any religious affiliations.

7.5.5 Predicting attitudes toward medical help-seeking – Hypothesis 3

Based on the correlational results found in section 7.5.3 which indicated significant associations between scales, it was important to investigate the third hypothesis in this study, on whether acculturation, religion and coping styles will predict attitudes towards medical help-seeking among Nigerians over and above religious affiliation, age and length of residence in the UK. Also, because of the significant impact noted on sociodemographic group differences (section 7.5.4), this investigation was used to determine if additional information on group influences (age, gender, religious affiliation) and length of stay in the UK improved attitudes towards medical help-seeking among Nigerians, over and above that provided by differences in acculturation strategies, religious beliefs/behaviours, and coping styles employed in dealing with potential challenges during migration (such as ill health associated with acculturative stress).

A hierarchical multiple regression analyses (HMRA) was conducted to assess the ability of Acculturative orientations (measured by the MASPAD Scale), and Coping styles (measured by the Brief COPE Scale) to predict attitudes towards medical help-seeking after controlling for the influence of age, gender, religious affiliation, and length of residence. The variables selected for entry into the regression were age, gender, religious affiliation, length of residence; traditionalist behaviours, assimilationist behaviours, religious behaviors, active cope, emotional support, instrumental support,

behavioural disengagement, and self-blame. The selection was based on Hosmer and Lemeshow's criteria of including p values < 0.25 (Alan, 2012; Hosmer & Lemeshow, 2013). Religious affiliation and age were dummy-coded as (0) and (1).

A total of 273 cases were analysed. Age, gender, religious affiliation, and length of residence were entered at Step 1, explaining 35.2%, (F (5, 266) = 7.11, p <0.01) of the variance in attitudes towards medical help-seeking; and after entry of traditionalist behaviours, assimilationist behaviours, religious behaviors, active cope, emotional support, instrumental support, behavioural disengagement, and self-blame at Step 2, the total variance explained by the model as a whole, was 48.9%, F (14, 258) = 5.81, p < 0.01. Therefore, the variables of interest (traditionalist behaviours, assimilationist behaviours, religious behaviors, active cope, emotional support, instrumental support, behavioural disengagement, and self-blame) explained an additional 12% of the variance in attitude towards medical help-seeking, after controlling for age, gender, religious affiliation, and length of stay in the UK, R square change = 0.12, F change (6, 258) = 4.91, p = < 0.01. In the final model (step 2), only four variables made a significant contribution to the model (age, Christian religious affiliation, behavioural disengagement, and self-blame), with affiliation to the Christian religion recording the highest value (β= 0.271, p < 0.01) than age (β = -0.182, p < 0.01), self-blame (β = -0.208, p < 0.01), and behavioural disengagement (β= -0.212, p < 0.01). However, instrumental support as a coping style has been considered as an important contributor in the model as it tended towards attaining significance (see Table 6.8). The β values therefore, showed that belonging to the Christian religious group predicted increased (positive) attitude towards medical help seeking, while age, self-blame and behavioural disengagement predicted a decrease (negative) in attitude towards medical help-seeking among Nigerian immigrants in the UK. Also, the use of

instrumental support has the potential for contributing towards the model's prediction of an increase in attitudes towards medical help seeking. This showed that the model was a good fit in predicting medical help seeking from age, religious affiliation, and coping styles.

Table 7.5

HMRA predicting attitudes towards medical help-seeking

predictor	R-square (Adjusted)	R	F	P	Beta value	P	Part correlation
Step 1:	0.1	0.35	6.26	0.001			
Gender					0.08	0.16	0.08
young Age group					-0.08	0.24	-0.07
middle Age group					-0.16	**0.02**	-0.14
Length of residence in the UK					0.16	**0.01**	0.14
Christian religious group					0.3	**0.01**	0.21
Other Religions					0.07	0.46	0.04
Step 2.	0.19	0.49	5.81	0.001			
Gender					0.1	0.09	0.09
young Age Group					-0.08	0.24	-0.06
middle Age Group					-0.18	**0.01***	-0.15
Length of residence in the UK					0.11	0.1	0.09
Christian Rel. Group					0.27	**0.01***	0.14
Other Religions					0.13	0.2	0.07
Assimilative Behaviours					0.08	0.19	0.07
Religious Behaviours					-0.02	0.74	-0.02
Traditionalist Behaviours					0.04	0.59	0.03
Active Coping styles					-0.16	0.07	-0.1
Emotional Support					0.08	0.3	0.06
Instrumental Support					0.19	0.05	0.11
Behavioural Disengagement					-0.21	**0.00****	-0.18
Self-Blame					-0.21	**0.00****	-0.18

Note: *p < 0.05, **p < 0.01 at 95% confidence limit

7.6.   **Discussions**

Before delving into the results derived from this study sample, it is important to note that participant characteristics indicated that more women participated in the survey compared to men. Also, the composition of the sample by length of stay in the UK was important in relation to acculturation and medical help-seeking, as more of those who have stayed for over 5 years in the country took part in the study. The investigation regarding religion necessitated the involvement of religious groups cutting across Christianity, Islam, and those without any religion, but most participants were Christians. Therefore, religious affiliation was recoded into a combination of three different groups to meet the requirements of the regression analysis, although these groups may differ in their basic principles and beliefs (such as Christians (Gp1): comprising the Pentecostals, Catholics, Baptists, and Anglicans; Other Religions (GP2): constituted by Jehovah's Witnesses, Muslims, and Adventists; and those without any religious affiliation (Gp3). The three major analyses conducted within this study (correlations, group differences, and hierarchical multiple regression to predict medical help-seeking) showed some important results regarding healthcare seeking in relation to acculturative strategies, religious beliefs /behaviours, coping skills, age, gender, religious affiliations and length of stay in the UK.

7.6.1. Correlations between and within the variables (MASPAD, BCOPE, ATMHS)

7.6.1.1 Acculturation, Religion and Coping styles

About the first hypothesis, findings from the present study are consistent with previous   studies showing that immigrants' values and behaviours undergo changes due to influences exerted from the host culture (Berry, 1980, 2006; Schwartz et al., 2006). Exploring relationships between acculturation, religion, and coping styles (measured by the MASPAD and the Brief COPE Scales), the results revealed some negative correlations

between assimilative behaviours and religious behaviours; and between religious behaviours, denial, and religious coping. Therefore, Nigerian immigrants who became assimilated into the British culture were less likely to exhibit religious behaviours and the more they engaged in religious behaviours the less they could engage in denial and religious coping styles. This result has important implications for integration policy. In particular, the negative association between religious behaviours and religious coping is of interest here, as the religious items of the MASPAD were based on African religious/cultural values (meant for people of African descent) while some participants were shown to be influenced by assimilationist acculturation pattern that impacted on their African religious behaviours; as already shown above, in the negative relationship between assimilationist behaviours and religious behaviours (the first result in this subsection). This could explain the unexpected negative association between religious behaviours and religious coping. Moreover, such result could imply that being a religious person is not mutually linked to the use of religious coping methods, nor the appropriation of religious values and principles; because religion can serve different purposes for different people (Hill, 2010; Thompson, Thomas & Head, 2012).

The investigation of heritage cultural preference (traditionalist acculturation pattern) in relation to coping styles preferred by Nigerian immigrants in the UK, showed that 'traditionalist beliefs' and 'traditionalist behaviours' consistently had significant relationships with active coping, emotional support and religious coping styles, as well as instrumental support, coping by disengagement, and use of self-blame, which has implications for medical help-seeking. The aspect of religious coping (a reflection of religious behaviour), being positively associated with traditionalist beliefs (retaining of one's heritage cultural/religious values) is an inverse outcome corresponding to the negative correlation between assimilation and religious behaviours noted above. Hence, despite the

negative effects of assimilation or religious behaviour, some participants still retained their heritage religious/cultural values towards increased reliance on religious coping/treatment methods. This result confirms the conclusions drawn from the three qualitative studies already discussed (Studies 1, 2, 3), regarding the prevalence of religious cure/coping methods as the preferred means of treatment/coping with illnesses/acculturative stress among Nigerians at home and in the UK (see 3.3.2, 4.2.3, & 5.5). These results are consistent with existing studies confirming the importance of African traditional/cultural values in relation to the choice of coping/cure methods (Orjiakor & So, 2013; McCabe & Priebe, 2004; Idemudia, 2003); which are also relevant regarding the established role of the family among Africans, as important means of emotional support in the face of life challenges (Organista et al., 2010; Damafing, 2008).

As expected, there were significant correlations between assimilation and traditionalist beliefs and behaviours since more participants have integrated into the new culture after many years of residing in the country (still retaining aspects of their heritage culture), but no such relationship was found between assimilation and medical help-seeking as shown in previous studies (Fassaert et al., 2009). Hence, the more Nigerians become assimilated into the British culture, the more they also continue to adhere to their heritage culture and religion. Relating this result to the preceding negative association found between assimilation and religious behaviours, it is concluded that, though assimilationist acculturation patterns could hamper traditional religious behaviours, it did not increase medical help-seeking among Nigerian immigrants. This is because traditionalist acculturation patterns (upholding their heritage religious/cultural values) countered such effects by correlating positively with religious coping methods. Therefore, pre-migration cultural and religious experiences are important influences on immigrants' health behaviours as an enduring factor (see study 2), which strengthens the proposal for

integration (maintenance of both heritage and host culture) contained within this thesis. This proposal is consistent with previous studies among immigrants showing that cultural change through integration can enhance health and well-being. For instance, participating in the new/host society while maintaining the culture of origin, has been shown to enhance quality of life among immigrants (Koneru et al., 2007).

7.6.1.2 Religion, Coping styles, and Medical help-seeking

The correlational results also showed some relationships between religion, coping styles (measured on the MASPAD & Brief COPE Scale) and attitudes towards medical help-seeking. There was a negative correlation between attitudes to medical help-seeking and religious behaviours, behavioural disengagement, and self-blame; implying that high levels of exhibiting religious behaviours were related to lower levels of medical help-seeking while increased use of behavioural disengagement and self-blame as coping styles indicated lower levels of medical help-seeking. Understandably, both 'self-blame' (turning blame on self, criticising self) and 'behavioural disengagement' (giving up efforts to cope) are regarded as avoidance approaches (as shown to be associated with traditionalist acculturation patter, see 7.6.1.1), and can become barriers to healthcare utilisation (Cooper, Katona & Livingston, 2008). This new information on the negative impact of avoidance coping methods on health care utilisation among Nigerian immigrants confirms findings from existing studies among other immigrants of non-Western origin (Nap et al., 2015; Yoon, Langrehr & Ong, 2011). Also, the positive association between traditionalist acculturation pattern and religious coping (7.6.1.1) can impact on attitudes towards medical help-seeking.

Arriving from a socio-cultural background based on communalism, with great dependence on families and religious groups for support, into a culture based on

individualism such as the UK, African immigrants can face frustration and resort to 'denial' when family support becomes unavailable, with the 'dreams' of a better life in the host country becoming elusive which compounds the feelings of loss regarding the country of origin (Mooren et al., 2001). Hence, Nigerian immigrants could have adopted personal adjustment mechanisms in dealing with the new challenges by reappraising the situation in 'denial' or by 'blaming self' for wrong decisions and misfortunes of leaving/missing home (such themes relevant to these issues were discussed in study 1). Such relationships between coping acculturation hs been shown in existing studies among immigrants both in clinical and population settings (Yoon et al., 2011; Koneru et al., 2007) as reflected in the association between higher cultural adaptation and less psychological distress. However, some findings regarding cultural adaptation and quality of life have been inconsistent. The clinical study with Hispanic Americans conducted by Thomas and Suris (2004), reported a positive link while another clinical study with Vietnamese women in Taiwan showed a negative association (Yang & Wang, 2011), but a population study among Chinese Americans found no association at all (Lieber, Chan, Nihira & Mink, 2001). Such inconsistencies could be explained by differences in the process of acculturation across migrant groups and across host countries, in relation to such factors as reasons for migration, migration history, host-countries' migration policy, variations in length of stay, perceived discrimination, employment issues and health conditions among migrants (Nap et al., 2015).

Furthermore, the use of other coping styles, such as instrumental support, emotional support, and active coping were associated with increases in medical help-seeking. These results support some existing research on the interrelationships between the processes of acculturation and factors related to immigration and coping with its challenges, such as migration history, regulations within the host-country, length of stay,

religion, employment, and health issues (Nap et al., 2015). For instance, a study by Kamperman et al., (2007) among Turkish, Moroccan, and Surinamese immigrants in the Netherlands found that higher levels of involvement with the Dutch culture (assimilationists) and lower levels of involvement with heritage culture (traditionalists) led to increased use of professional mental health care. Also, the results showed that various coping styles employed by Nigerian immigrants were associated with positive attitudes towards seeking medical help, as the more they engaged in avoidance coping approaches (such as 'Behavioural disengagement' and 'Denial') the less they utilised professional medical care. This outcome is contrary to an existing study (Kamperman, Komproe & de Jong, 2007), among immigrants of non-Western (African and Asian) background showing no association between such avoidance coping methods and utilisation of mental health care facilities. Such variation in research outcomes could be related to differences in predisposition and enabling factors facing participants in different research situations (Anderson, 1995). For instance, Turkish, Moroccan, and Surinamese immigrants are culturally different from Nigerian immigrants, even though they all come from a non-Western background. Also, the current study involved a healthy sample rather than those with suspected psychiatric morbidity as in Kamperman et al's study. Moreover, important factors that influence acculturation, such as migration history, host-country migration regulations and perceived discrimination differ across countries (in this case, the Netherlands and the UK) (Nap et al., 2015), which could have influenced the results being compared.

The above results have adequately addressed the first hypothetical question (H1): Is there any relationship between attitudes to medical help seeking and acculturation orientations, religion and coping styles? Hence, this subsection (7.6.1) shows various associations among the variables, both within and between the independent and

dependent variables. About medical help-seeking, the results show that, religion rather than assimilation into the British culture, is a more important determinant (7.6.1.1 & 7.6.1.2); which confirms the role of religion and culture in health services utilisation among Nigerians as already discussed in studies 1, 2, and 3 (see 3.3.2, 4.2.3, & 5.5). Moreover, these findings are consistent with previous studies where religion has been shown to be relevant among minorities and immigrants' health behaviours (Pargament et al., 2000; Sanchez et al., 2012). Therefore, it can be concluded that religion posed a stronger influence on the health-seeking attitudes among Nigerians in the UK, over and above other factors. However, it is important to validate this conclusion particularly with findings on attitudes to medical help-seeking and religious group influences (religious affiliation) as discussed in the next subsection (7.6.2); linking the two hypotheses (H1 & H2) to the main thesis within this PhD.

7.6.2. Group/Socio-demographic Differences vs. MASPAD, BCOPE and ATMHS Responses

To address the second hypothesis regarding any variations in the responses obtained from the MASPAD and Brief COPE Scales due to differences in group and socio-demographic characteristics, the analysis provided some interesting results. About to gender, females were shown to score higher than males on traditionalist beliefs, traditionalist behaviours, and religious beliefs. Also, females were shown to use more of religious coping, behavioural disengagement and venting than males. Moreover, to investigate if any significant differences resulted in the measure of attitudes towards medical help-seeking when compared between males and females, the findings showed no significant differences in scores due to gender. Therefore, any observable differences in the attitudes towards medical help-seeking among Nigerian immigrants in the UK were

not attributable to gender differences. However, it was not surprising that females were found to be more religious (exhibited more religious beliefs) than males, a result consistent with existing research both among immigrant and non-immigrant populations (Lewis, Varvatsoulias & Williams, 2012). Consequently, females were also found to engage in more religious coping than males; but no gender difference existed regarding attitudes towards medical help-seeking, which is contrary to existing studies (Kamperman et al., 2001) showing that females seek more medical help than men (although this study was in relation to mental health issues). Such findings on gender difference in medical help-seeking has been found to cut across, both African and non-african population (Rickwood & Braithwaite, 1994; Verhaak, 1995); although it was also associated with other social variables that positively influenced help-seeking attitudes, such as marital status (divorced or widowed women) (Verhaak, 1995; Kamperman et al., 2001). In the current thesis, the results also showed that women used more traditionalist acculturation strategies and upheld African oriented religious beliefs (MASPAD) than men, which is contrary to existing studies where elderly men were regarded as the custodians of African tradition and religion (Ikuenobe, 2006). However, it is important to note that these studies differed in contexts; for where Ikuenobe's findings were among non-immigrant Africans, the present study involved immigrant Nigerians/Africans assimilated/integrated into a western culture; which further confirms that African/Nigerian immigrants retain their traditional beliefs irrespective of gender differences, and in spite of the effects of the host culture. This is buttressed by the previous results on the negative associations between assimilation and religious behaviours countered by the positive correlation between assimilationist and traditionalist beliefs and behaviours (see subsection 7.6.1.1). This is an important new finding which can be the focus of future studies particularly designed on the role of gender in upholding African traditional values among Nigerians in diaspora.

Meanwhile, investigating the effects of age on any differences in the responses obtained on the MASPAD acculturative strategies and religion, the results showed that younger persons exhibited more religious behaviours than the elderly; again, this is contrary to existing research regarding the position of the elderly in upholding heritage cultural values (Ikuenobe, 2006) as already discussed above. The investigation on the coping methods preferred by Nigerian immigrants revealed that younger people (young and middle age groups) adopted more of active coping approaches than the elderly; but the elderly were shown to use more of denial than the younger age-groups. However, when compared on attitudes towards medical help-seeking, it was found that older people sought medical help more than the young/middle aged persons; a result that can be attributed to greater health needs among ageing individuals compared to young people as consistent with existing studies (Nguyen, 2011; Giacco, Matanov & Priebe, 2014). Hence, both results are consistent with previous studies among immigrants, as lack of relationship between avoidance coping approaches (such as denial) and health care consumption has also been confirmed in previous studies (Kamperman et al., 2007). In general, previous studies have established the effects of the need factors on health care consumption, both among immigrant and non-immigrant populations (Verhaak, 1995; Kamperman et al., 2001). Furthermore, findings on the role of age on acculturation and religion, revealed no relationship with acculturative strategies (either by assimilationist, integrationist, or traditionalist patterns); which is consistent with previous studies among immigrants of non-Western background - African/Asian (Kamperman et al., 2007).

The result obtained in relation to the effects of religious affiliations on acculturative strategies and religious beliefs/behaviours (MASPAD) showed that those with religious affiliations held more acculturative strategies and religious beliefs than those with no affiliation to any religious group at all. This result has important implications for a broader

understanding of the roles of religion, such as its social functions that can enhance integration as consistent with existing studies showing a close link between religion/spirituality and social support (Hill, 2010). Contrary to expectations those with no affiliation to any religious organisation turned out to exhibit more religious behaviours than those affiliated to religious groups; which can be attributed to the potential bias from the way 'religious affiliations' was recoded and grouped to meet the assumptions of the statistical analyses (Muslims were grouped together with the Jehovah Witnesses, Baptists, and Adventists) irrespective of their fundamental differences. This result could also be understood from the context of the distinction between depth of religiousness/spirituality and merely belonging to a religious organisation without any intentions to put the principles into practice. Hence, affiliation to a religion may not explain the depth of religious beliefs or practices, nor commitment to its spiritual motives. For instance, in a study on the benefits of religious faith among diverse races, Thompson et al., (2012) found a link between faith and higher self-esteem among both Whites and Blacks (African Americans); and Myers (2000) also reported that churchgoers from different racial backgrounds expressed more optimism about life than non-churchgoers. Consequently, the present study explored the impact of religious affiliation on coping strategies adopted by Nigerian immigrants in the UK; and the result showed that those affiliated to religious groups used more of active coping, emotional support, instrumental support, as well as behavioural disengagement than those with no religious affiliations at all. Furthermore, the investigations regarding the effects of religious affiliation on seeking medical help showed that those with particular affiliation to the Christian religion had more positive attitudes towards using the medical health services compared to those without any religious affiliations. This result confirms the conclusions from the first hypothesis (and has implications for the findings in the three qualitative studies, see chapters 3, 4, 5

& 6); and can be linked the predictions of the third hypothesis (H3) in the next subsection (7.6.3), on whether religion can predict health seeking-behaviours among Nigerian immigrants in the UK, while controlling for other variables.

7.6.3. Predicting attitudes towards medical help-seeking

The results from the model used to attempt a prediction of attitudes towards medical help- seeking showed that Christian religious group predicted increased or positive attitudes towards medical help-seeking. Overall, those with religious affiliations showed more use of medical help seeking than those with no religious affiliations, which implies that religion was not a barrier to medical help-seeking. Although religious beliefs can become a barrier to medical help-seeking among some migrant communities, this result confirms that it can also provide some important advantages consistent with previous studies; such as coping with the consequences of distress (Pargament & Cummings, 2010), dealing with addictions (Magrini, 2015), adverse effects of unemployment (Shams & Jackson, 1993) and acculturative stress during immigration (Mazumdar & Mazumdar, 2009).

About Age, old age predicted increased/positive medical help-seeking while young age predicted less/negative attitudes to medical help-seeking (as age increases, the attitudes towards medical help-seeking also increases and vice versa). Self-blame and Behavioural disengagement predicted a decrease or negative attitudes towards medical help seeking among Nigerian immigrants in the UK. This is consistent with previous studies that have identified 'self-blame' and 'behavioural disengagement' as maladaptive coping styles (Cooper et al., 2008; Meyer, 2001). Also, the use of instrumental support was shown to have made vital contributions towards the model's fit in predicting attitudes towards medical help seeking, by showing that increase in the use of instrumental support

can equally increase the use of medical help. By implication, an increase in religious affiliation can increase attitudes towards medical help-seeking (as may be contrary to the expectation that religion would be a barrier to medical help-seeking); and an increase in age, use of self-blame and behavioural disengagement would lead to a decrease in attitudes towards seeking medical help. Therefore, from the analyses it was concluded that the model was a good fit in predicting medical help-seeking from age, religious affiliation, and coping styles.

Using the models in this study to predict attitudes towards medical help-seeking among Nigerian immigrants in the UK showed that some socio-demographic variables (Age and Christian religious affiliation) and coping styles (behavioural disengagement and self-blame) significantly contributed to the model, with the Christian religion being the highest predictor of attitudes to medical help-seeking. This result implies that, although the variables of interest (acculturation strategies, religion, and coping styles) within the MSAPAD and Brief COPE Scales explained 12% of the variance in attitudes towards medical help-seeking after controlling for age, gender, religious affiliation, and length of stay in the UK; religious affiliation and age provided important influences in determining attitudes towards seeking medical help among Nigerian immigrants in the UK. This finding has a positive link with the conclusions drawn from the two preceding hypotheses (H1 & H2) on the important role of religion among Nigerian immigrants' health-seeking behaviours in the UK. It also underscores the veracity of findings in the previous qualitative studies (Studies 1, 2, & 3), as well as the conclusions of the first and second hypothesis in the current study (Study 4), regarding the significant role of religious and cultural factors as valuable determinants of health-related decisions and ultimately, healthcare utilisation among Nigerians; not minding that more Christians participated in the study.

Finally, the conclusions drawn from all the studies within this thesis (Studies 1, 2, 3, & 4) underscore the emphasis placed on integrative and culture-sensitive health systems that can incorporate care providers from different cultural and professional backgrounds especially from immigrant communities (such as Nigerian clergy and alternative care providers) within the formal care system through collaboration. This proposal follows from existing evidence, that as a buffer for the effects of general distress that can impact more on immigrants, there is potential for improved quality of life among religious people as they take advantage of the social support inherent in religious affiliation (Hill, 2010). Moreover, with particular reference to Nigerian immigrants coming from a highly religious country, existing studies on national differences in spirituality and its benefits show that happiness and life satisfaction are more in countries where high values are placed on religion (Stavrova, Fetchenhauer & Schlosser, 2013). Yet, these results do not negate the need to enhance service consumption among immigrants, because when compared with members of the host society (Whites), minority immigrant groups are found to show poorer attitudes towards health services utilisation (Postnote, 2007). A similar result exists in a Dutch study which reported that young immigrants, even though they seemed to experience more psychological conditions, under-utilised outpatient mental health services compared to their native counterparts (Verhulp, Stevens, van de Schoot & Vollebergh, 2013).

7.6.4 Limitations

This study acknowledges some limitations that may have impacted its findings, such as the issue of representativeness of the sample. The apparent under-representation of some religious groups within the sample was partly due to the emotional and sensitive nature of the study, with more Christians (88%) involved compared to

Muslims (3.2%). Also, those without any religious affiliation had a low representation (8.8%), although this would be expected from a population known to be very religious - African or Christian (see 2.1.3, 2.1.4). More specifically, the distribution of Christians as the dominant religious group in this study does not show equal representation among various denominations. For instance, Catholics (n = 95) and Pentecostals (n = 97) constituted the highest numbers of the Christian groups while the Baptists, Anglicans, Adventists, and Jehovah Witness together constituted only 22.9% of the entire Christian population. Then for the analyses, Jehovah's Witnesses, Islamists, and Adventists were grouped as one (Others religions), which could have biased the results on the impact of religious affiliations. Therefore, the findings of the present study cannot be used to make generalisations regarding all religions or all Christian groups. This factor could be better understood with further research focused on individual religious groups and their unique structure and characteristics. Also, there was a considerable disparity between graduates (79.7%) and non-graduates (20.3%) which did not show a fair representation in terms of educational attainment of Nigerians immigrating to the UK. Hence, this factor was excluded from analyses; which could have altered the results and provided further information as an important determinant of health-seeking behaviours among Nigerian immigrants as consistent with previous studies showing that education predicted mental help-seeking consumption among migrants (Knipscheer & Kleber, 2001). Moreover, with respect to the Nigerian population in the UK, the data did not represent all religious groups nor show adequate reflection of intra-cultural differences among the Nigerian people, which are important factors unaccounted for. Therefore, future studies in this area could account for these factors by focusing on specific religious or ethnic groups from Nigeria. Also, years of residence in the UK was predominantly between 7-20 years, with highest frequency for 10 and 12 years of stay (8.3%) while length of stay from 31 and above were

the least at .3%. This trend can be explained by possible though unconfirmed reasons that, those within 10 years' residence and above were more likely to have obtained an unrestricted residence permit, while those below 5 years' residence could be suspicious of unnecessary probing and thereby avoided participation. However, researchers contend that the problem of 'representativeness' or 'nonresponse' in studies may not have important consequences for the adequateness of associating measures between variables (von Loon et al., 2003); and in any case the conclusions drawn in this study firmly relate only to the particular population studied here.

Furthermore, it could be argued that a contrasting group was necessary for comparative purposes; but this was not part of the study design (to match White Caucasian/British against the Nigerian immigrants). However, in this regard, the involvement of participants who have assimilated into the British culture, with different length of time of residence in the UK could have provided the opportunity for indirect comparison (comparators) for the research questions. Also, the integrationists (those who have both heritage and host culture) found within the research sample could have effected similar purpose for comparison if necessary. Future studies could use first and second generation immigrants from Nigeria to investigate any such effects following from findings presented in the current study. Also, data for this study were obtained through self-reporting questionnaires following a snowballing method of recruitment; hence, the participants were self-selected. This aspect could have introduced both sampling and response biases. Also, researchers have advocated that a longitudinal design is more ideal for studies on help-seeking behaviours (Kamperman et al., 2007), as cross-sectional designs could be prone to retrospective bias. However, the limitation does not apply here as the present study was not related to issues of recall, but intention/attitudes towards

performing positive health behaviours, hence no risk of underreporting of health actions was involved.

Finally, the questionnaires used in this study were designed to measure intentions rather than actual behaviours. Therefore, it is important to acknowledge that this study only measured intentions to act and not actual behaviours; as real threats (such as actual threatening health conditions) are known to elicit different responses compared to perceived or virtual threats. This aspect provides the scope for improvements in future research. In view of these limitations, this study ensured that robust statistical computations were employed for valid and reliable results, such as the hierarchical multiple regression analysis (HMRA) and component factor analyses to ensure that all questionnaires were specifically suitable for the present study, with acceptable Cronbach's alphas (see 7.5.2).

7.6.5 Implications for future studies

Following the limitations noted above, and the measures employed to manage their effects, this study has provided useful information on acculturation, religion, and coping styles as important determinants for health services utilisation among this highly educated and largely Christian and Pentecostal Nigerian immigrant population in the UK. The findings have implications for the present health services structure in the UK. To overcome the disparity in health care utilisation, with consequences for health inequalities in the UK population, investments should be made towards the institution's outreaching programme to incorporate immigrants' diverse religious and cultural values in health and well-being. Moreover, special efforts should be directed towards increased awareness on the adverse effects of certain acculturation strategies such as 'separation' that can result from cultural and religious colonies, and to encourage integration programmes for

immigrants through more relaxed policies. However, the results suggest no evidence to lay too much emphasis on cultural differences (overly culturalised differences) in health services utilisation to the detriment of similarities in practical skills, because some immigrants from non-western backgrounds may have acquired western skills like that of the host culture before migration. Those with sufficient skills akin to the host culture have been shown to exhibit higher rates of adjustment and integration compared to those inclined to their minority heritage culture. Also, the results suggest that care should be taken not to demonise religious differences within the population, as religion did not prevent immigrants' attitudes towards medical help-seeking. It is important for policy makers to recognise cultural and religious difference, without ignoring common grounds for cultural integration and health intervention as research shows that cultural matching among patients and therapists improves health outcome (Blignault et al., 2008; McKinney, 2007). To ignore this aspect would create unnecessary distance between both migrant groups (intra-group division) and between migrants and the larger British population.

Moreover, the present study has provided new information regarding 'self-blame' and 'behavioural disengagement' as salient coping styles that can become barriers to medical help-seeking among immigrants over and above family support or religion. However, immigrants' reliance on such coping methods against seeking medical help could be viewed as a consequence of adjusting to the new challenges experienced by immigrants, especially when they encounter a socio-cultural background different from theirs, with practical loss of family networks and feelings of unfulfilled hopes. Therefore, the health system can be designed to reach out to immigrants at the grass-root through their cultural and religious networks, with trained health workers from their own communities as health guides to enhance integration/collaboration. The results of the

socio-demographic analysis also suggest future policy and practice must consider individual differences (for example in age and gender) in aspects of health care of immigrants.

7.7 Conclusions

Overall, the findings derived from this study have relevance to previous studies on the effects of migration on cultural and religious values, especially when immigrants move from a region that is dominated by collectivism such as Nigeria, to regions where individualism is emphasised such as the UK. Based on this, Nigerians, as other immigrants from Africa are perceived as a family-oriented group, with a strong attachment to their religion and culture. Hence, religion and culture have been identified as relevant determinants to how immigrants cope with the changing circumstances of immigration and the bases for the help-seeking approaches adopted in response to acculturative stress. Previous studies on acculturation orientations also identified relevant factors that explain how immigrants become influenced by the host culture towards seeking medical help, which has been confirmed in the current study; showing that integration with the British society can consequently improve medical help-seeking. Such outstanding effects of integrationist acculturation pattern underscores the fact that heritage cultural and religious values influenced intentions to seeking medical help among Nigerians, both in the UK and Nigeria; which is consistent with previous qualitative findings within this thesis on a broader exploration of how Nigerians perceived and responded to illness conditions (Studies 1, 2, 3). Therefore, the next chapter is dedicated to the process of integrating all the findings from the four studies already concluded and reported within this PhD, so that they can be situated within a broader research literature.

CHAPTER EIGHT

8.0.   **General Discussions and Conclusions**

This thesis explored how Nigerians in the UK responded to illnesses in relation to their religious and cultural beliefs, and how these factors impacted on their access to and use of professional help within the British health system. The processes of enhanced collaboration among the clergy and health workers were central to developing an understanding towards an integrative and culture-sensitive care system that can encourage healthcare utilisation among immigrants. This research adopted a methodological approach that incorporated both idiographic and nomothetic research principles in a mixed-methods design, with a dominant qualitative strand (Qual-quant Strand). Four studies were carried out; to explore the socio-psychological determinants of health-seeking behaviours among Nigerian Christians in the UK (Study 1); to explore Nigerian and UK care utilisation and provision from the perspectives of Nigerian clergy, herbalists, complementary medicine healers, and healthcare professionals in Nigeria and the UK (Studies 2 & 3). Studies 2 and 3 were designed as a cross-cultural study to explore religious and cultural influences on health seeking behaviours before and after migration to understand how immigrant health behaviours could have been influenced by pre-migration factors/experiences in relation to acculturative factors in the context of migration in the UK; and these diverse care approaches can be integrated. Finally, a survey was conducted on the roles of acculturative strategies, religious beliefs/behaviours, and coping styles on attitudes towards medical help-seeking among Nigerians of all religions in the UK, irrespective of religious persuasion (Chapter 4). The studies were designed to address the objectives of this thesis, which was not theory-driven - a priori; rather all studies were approached with an open, unbiased inductive principle. The qualitative and

quantitative methodological traditions were used to integrate all the findings; while the bio-psychosocial model was used as a suitable theoretical framework during the triangulation of findings (8.1.2.3).

In this chapter, findings from each study are first summarized (8.1.1) and later situated within broader research perspectives, using the bio-psychosocial model as its guiding principle following the discussions in chapter 2 (2.1.5.1). Next, the triangulation process was based on clustering the findings from all four studies within this thesis, using a model developed from the NVivo software as a guide (Figure 8.6) (8.1.2). Some research limitations related to the four studies were acknowledged, with suggestions for future research (8.2). This chapter also contains some useful recommendations for health professionals and for policy and integration workers (8.3); with a recommendation for a future study on an integrative model borrowing from the theory of transformative coping (TTC) (see 1.2 & 2.2 [viii]). Finally, the chapter ends with the general conclusion (8.4).

8.1   **Discussions**

8.1.1 Summaries of findings

Study 1: Exploring health-seeking behaviours among Nigerian Christians in the UK: towards enhanced health services utilisation (Chapter 3)

Study 1 was a qualitative study exploring the socio-psychological determinants of health seeking behaviours among Nigerian Christians living in the UK, with participants comprising adults from different socio-economic backgrounds and representing diverse ethnic groups from Nigeria. Hence, participants were born and raised within different religious and cultural influences in Nigeria before migrating to live in the UK. The results of the Thematic Analysis (TA) yielded four main themes derived from their respective basic themes: 'Immigration challenges' (difficulties from the environment, financial

difficulties, and the use of different coping styles), 'Barriers to health care utilisation' (past experiences of illnesses and treatment approaches, held religious, cultural, and health beliefs, use of other treatment alternatives), 'Facilitators to health care utilisation' (some positive experiences of medical help-seeking, illness conditions) and 'Acculturation issues' (collaborative efforts, attitudinal change), as shown diagrammatically in Figure 8.1 below.
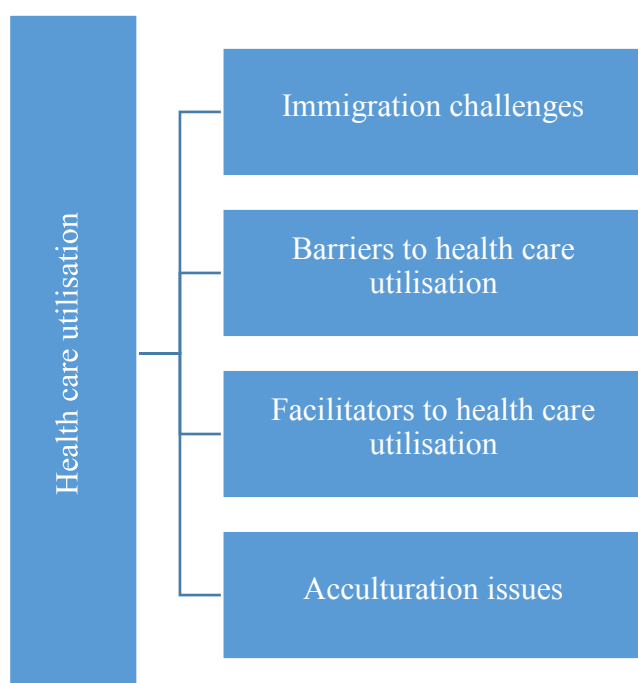
Figure 8.1. A summary of themes discussed in study 1

The in-depth interviews and focus group discussion (FGD) exploring these themes showed that challenges faced during immigration, poor doctor-patient relationships, ignorance, language differences, religious and cultural beliefs, as well as past experiences relative to illness type, influenced health-seeking behaviours of Nigerian Christians in the UK. Religious and cultural beliefs, in addition to many personal, cultural, and environmental challenges due to the circumstances of immigration were evidently

reported as important barriers to medical help-seeking among Nigerian Christians in the UK. These factors have relevance to findings in subsequent studies, such as the ability for the Christian religion to predict positive help-seeking in study 4. However, two similar, but distinct results were reported in that study (study 4); where the test of relationships among variables (Hypothesis 1) showed a negative correlation between 'religious behaviour' and medical help-seeking; confirming findings in study 1. However, the regression analysis (Hypothesis 3) showed that 'religious affiliation' (belonging to the Christian religion) on its own predicted positive attitudes to medical help-seeking, rather than being a barrier. These results are not contradictory because 'religious affiliation' as a socio-demographic variable is quite different from 'religious behaviour' as a response to immigration challenges/acculturative stress (items measured in the MASPAD Scale responses) (see 7.5.3 & 7.5.4). Therefore, a clear distinction among different religious groups, and between 'religious behaviours' and 'religious affiliations' are useful in future studies; for a better understanding of the role of religion in healthcare seeking among Nigerian immigrants. Also, vital is to clarify the characteristics of African oriented religion (Christian or Traditional) as distinct from Western-oriented religion (usually Christianity), traditional cultures as distinct from secularised cultures in order to appreciate the uniqueness of different 'religious groups' and their respective 'religious behaviours' (see 7.6.2).

Study 2: Nigerian care providers' perceptions of health-seeking within the Nigerian care context: A cross-cultural study (Part 1) (Chapters 4 & 6)

This second study undertaken in the Nigerian care context, qualitatively explored the determinants of health seeking behaviours among Nigerians from the perspectives of Nigerian care providers (clergy, herbalists/alternative medicine providers, and health

professionals), using a cross-cultural approach. It explored the processes of collaboration among different care providers and the challenges that should be expected. Three global themes and their respective basic themes in this phase were: 'Providers' perceptions of health-seeking behaviours in Nigeria' (Influences of cultural/health beliefs, health beliefs based on lay beliefs, influences of providers' beliefs, illness condition, the role of cost in healthcare, stigma and accessibility of healthcare); 'Contexts for collaboration among care providers in Nigeria' (Willingness for collaboration, Multidimensional referral pathway); and 'Challenges to collaboration in Nigeria' (such as patients' trust in herbal or faith healers, conflict of care principles among providers, poor care legislation/regulations, Trust between professionals), as shown in Figure 8.2. These themes were used to describe the experiences of providing care within the Nigerian socio-religious and cultural context by health workers and gatekeepers. It also provided evidence of consensus regarding the use of unorthodox help-seeking methods, especially the spiritual/faith-based approach due to the dominance and easy access to spiritual healing alternative.

In addition to religious and cultural determinants, poverty and ignorance were identified as enhancing the apathy for biomedical cure among the Nigerian people. In this instance, the Nigerian care context differed from the UK context, as Nigerian patients paid for medical services, which is free in the UK. Care providers expressed a willingness to collaborate as they regarded it necessary towards curbing inherent abuses and harm to which patients were exposed, but not without addressing some of the challenges noted earlier.
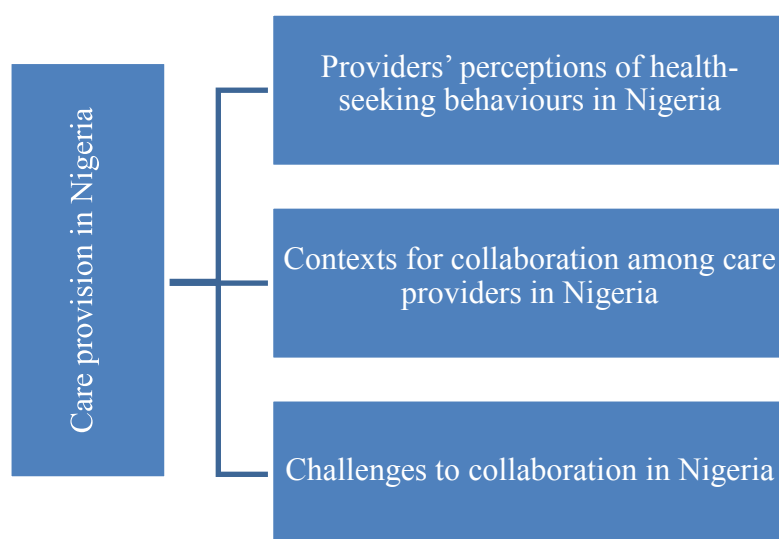
Figure 8.2. A summary of the thematic analysis guiding the findings in study 2

Study 3: Nigerian care providers' perceptions of health-seeking among Nigerian immigrants within the UK care context: A cross-cultural study (Part 2) (Chapters 5 & 6)

This investigation formed the second part of the cross-cultural qualitative study aimed at understanding health-seeking behaviours from the perspectives of Nigerian care providers working among Nigerians within the UK care context. This aspect provided an important source of information as these Nigerian care providers were more at the frontline of providing care for Nigerian immigrants. Also, the potentials for collaboration among care providers to enhance health services utilisation was explored, especially by incorporating the spiritual methods into care through collaboration with the clergy. The Interpretative Phenomenological Analysis (IPA) gave rise to three main themes with their respective constituent themes as follows: 'Providers' Perceptions of Health Seeking Behaviours' (Support from the Church/God first, Providers' perceptions on determinants for healthcare utilisation; 'Issues in Collaboration' (Openness to collaboration, Personal

and professional Challenges, Institutional and Personal barriers); 'Contexts for Integration' (Interface for spirituality and health), see Figure 8.3.
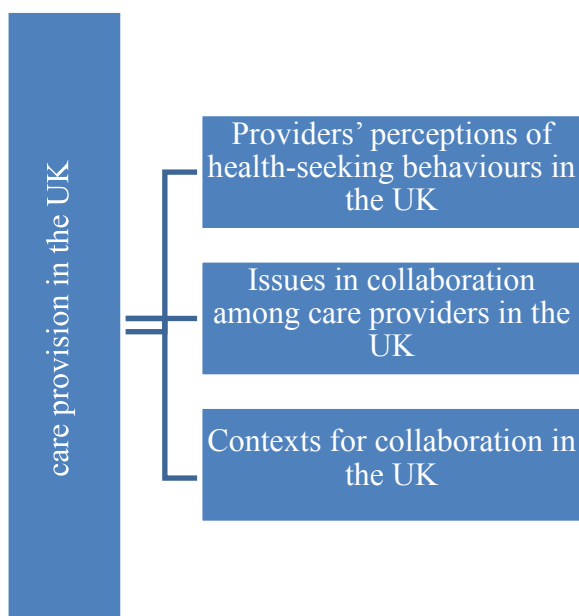
Figure 8.3. Summary of the IPA themes used in the discursive analysis of study 3

Discussions following the emerging themes concluded a full agreement among participants that religion constituted the major coping style for Nigerians in the UK. Similarly, some care providers alluded to the influence of religious/cultural beliefs on their approach to care, especially when dealing with Nigerian patients. These influences manifested as implicit referrals to alternative methods in an informal or personal care forum. However, such influences varied among health professionals depending on their levels of religious commitment/affiliation, adherence to professional guidelines, and integration into the host culture - acculturation. Following the confirmation of religious and cultural influences among Nigerians, both as service users and service providers, it was necessary to explore the possibilities of integrating the faith-based methods within the UK

care context. The result showed that although all care providers accepted the usefulness to collaborate, health professionals regarded it only as a possibility in principle, but not practicable compared to the clergy who were already practicing cross-referral to the health professionals. The position taken by the health professionals was attributed to strict professional regulations guiding their practices in the UK; as opposed to a loose regulation operative in Nigeria. Consequently, healthcare professionals expressed a lack of similar strict guidelines for the spiritual cure approach, hence a seeming lack of trust for other care methods. However, health workers here in the UK context, accepted that the possibility for collaboration and integration would be better achieved between the spiritual and psychological therapies.

Study 4: A survey on the impact of acculturation, religion, and coping methods on attitudes towards seeking medical help among Nigerians in the UK (Chapter 7).

Following the findings from the three in-depth qualitative studies described above, three important factors resonate from the themes, as more influential in the health behaviours of Nigerians, both in the UK and Nigerian contexts. First, **religion/culture** can inform health beliefs that influence pre-migration health-seeking behaviours; secondly, these religious/cultural factors (pre-migration) can translate into **coping methods** for dealing with post-migration/immigration challenges or acculturative stress; and finally, the encounter between the old and new cultures can result in different **acculturation strategies** adopted by immigrants, depending on socio-demographic factors. All of which can have health consequences for Nigerians. Hence, this quantitative survey investigated these factors further using three main hypotheses. The aim was to understand the interplay between important themes related to religion and culture, health beliefs, coping

methods, acculturation, and socio-demographic factors as identified in studies 1-3, and via the literature identified in the introduction to this thesis (Chapter 2). Results helped to predict important determinants to health services utilisation as barriers or facilitators among a larger representation of Nigerian immigrants in the UK; as summarised in the respective hypothesis below:

Hypothesis 1: The association of acculturation, religion, and coping styles with medical help-seeking

The results addressing the first hypothesis showed that religious and cultural factors were relevant determinants for how Nigerian immigrants coped with the challenges of immigration. More religious behaviours correlated with lower levels of medical help-seeking; although a different result was derived from the multiple regression analysis (H3) showing that belonging to the Christian religion predicted increased use of medical help; both distinct and non-contradictory results as already mentioned (see study 1 above, 8.1.1). Meanwhile, increased use of behavioural disengagement and self-blame in coping led to lower levels of medical help-seeking. Also, the use of other coping styles, such as instrumental support, emotional support, and active coping were associated with increased medical help seeking (as depicted in Figure 8.4). Besides, there was a negative association between religious behaviours and religious coping which is of particular interest here and need mentioning; as it could imply that being a religious person is not mutually linked to the use of religious coping methods, as would be speculated.

Hypothesis 2: The effects of Group/Socio-demographic Differences

<u>Gender:</u>

Results showed that females expressed more traditionalist beliefs, traditionalist behaviours, and religious beliefs than males, and used more religious coping, behavioural disengagement and venting than males. However, males and females did not differ in their attitudes towards medical help-seeking, hence gender did not play any role in observed attitudes towards medical help seeking among Nigerians in the UK.
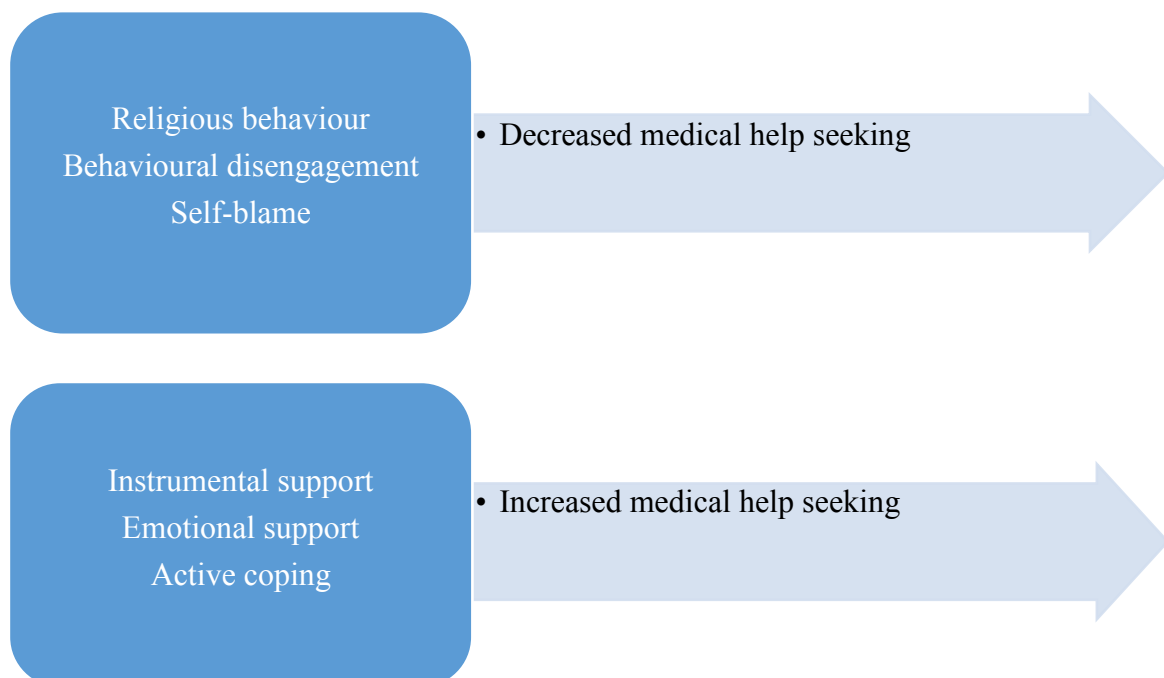
Figure 8.4. A flow of association between the independent variables and the dependent variables.

Age:

With regards to age, the result showed that younger persons exhibited more religious behaviours than the elderly participants; and younger people also adopted more active coping than the elderly while the elderly used more of denial than younger persons.

However, older people were found to express more positive attitudes towards using medical help than the young/middle aged persons.

Religious Affiliation:

Participants were shown to differ in traditionalist beliefs, traditionalist behaviours, assimilationist behaviours, integrationist behaviours, and religious beliefs due to their religious affiliation. Hence, those who belonged to a religious group were shown to score higher on acculturative strategies and religious beliefs than those with no affiliation to any religious group at all. However, contrary to expectation, those with no religious affiliation showed more religious behaviours than those with religious affiliations. This outcome can imply that belonging to a religious group does not confer religiousness or religiosity; and it is important to note that the depth of religiosity/religiousness was not part of the items measured by the MASPAD Scale (see 2.4.3 [i]), hence it is beyond the scope of this thesis. The MASPAD contained items on African religious/cultural beliefs requiring responses on how participants perceived them, or how they would behave (religious behaviours) under certain conditions, in view of such beliefs relating to them as Africans. The aspect of religiosity or depth of spirituality is an opportunity for future research, so it could be compared with merely belonging to a religious group (religious affiliation) for any differences or relationships. Results also showed that being affiliated to a particular religion resulted in increased use of active coping, denial, emotional support, instrumental support, as well as behavioural disengagement than not being affiliated to a religious group. Hence, there is a need to engage immigrant communities through their religious leaders towards more integration into the host community, to enhance access to its care system (NHS) as well. Consequently, as the important aspect of this thesis concerns the factors that impact on health-seeking behaviours, results from this hypothesis showed that belonging to the Christian religion had more positive effects on attitudes towards

using medical help than not belonging to a religious group. The next interest then, was to understand the extent to which religion can predict medical help-seeking following such positive relationships and effects reported in hypothesis 1 and 2 above.

Hypothesis 3: Predicting attitudes towards medical help seeking

The regression model was found to predict attitudes towards medical help seeking, with the Christian religion and age predicting increased medical help-seeking (the younger the individual, the less medical help-seeking; and the older the more medical help-seeking); while self-blame and behavioural disengagement yielded a negative prediction on attitudes towards medical help-seeking. Therefore, the Christian religion and old age predicted increased medical help-seeking (facilitators) while young age, self-blame, and behavioural disengagement were viewed as contributing to less medical help seeking (barriers). Additionally, instrumental support was highlighted as a potentially important contributor (facilitator) towards positive attitudes to medical help (this is shown in Figure 8.5 below).
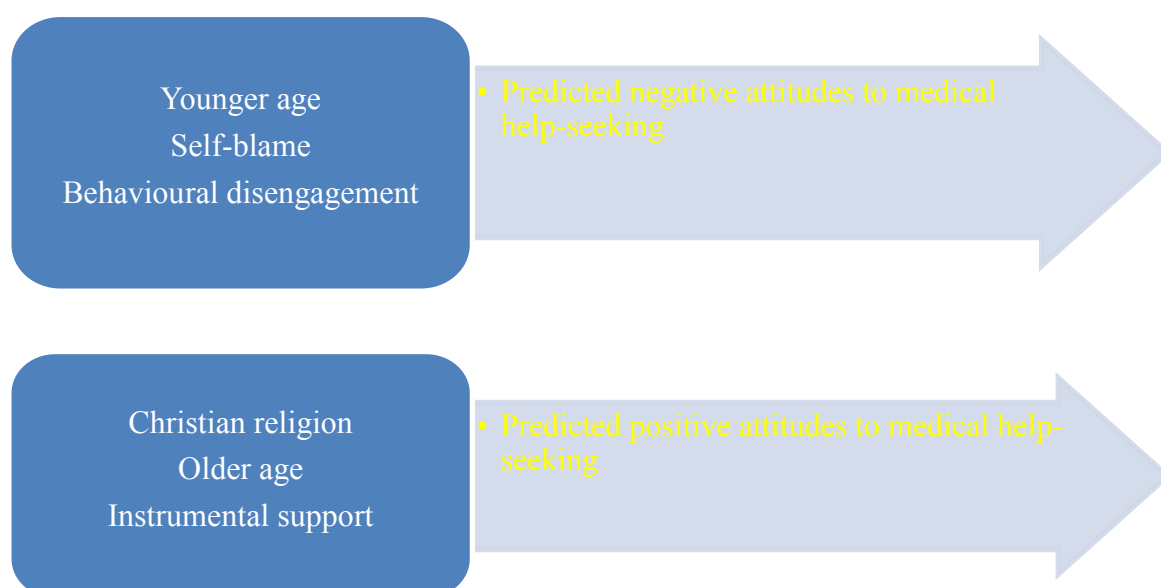
Figure 8.5. The impact of socio-demographic variables and coping styles in predicting attitudes towards medical help-seeking

Surprisingly, none of the acculturative patterns (traditionalist behaviours, traditionalist beliefs, assimilationist behaviours, integrationist behaviours) nor length of stay in the UK predicted attitudes towards medical help; not even assimilation into the mainstream British culture (assimilationist behaviours) shown to have correlated negatively with religious behaviours. Hence, on the premises (H1) that 'religious behaviours' was associated with reduced 'religious coping', and with increased use of 'religious coping' expected to reduce 'medical help-seeking' (see Figure 8.4), where 'assimilationist behaviours' were associated with reduced 'religious behaviours' (see 7.6.1.1), it was expected therefore, that 'assimilationist behaviours' could equally be associated with reduced 'religious coping' and increased 'medical help-seeking'; but not in this case. Although the MASPAD Scale was not designed specifically to investigate acculturative strategies in relation to medical help-seeking among people of African descent resident in Europe (as it is more American), its dimensions as adapted for this study yielded important information on the negative impact of assimilation strategy, and the positive role of religious affiliation; not only for medical help-seeking, but also towards traditionalist, assimilationist, and integrationist patterns of acculturation (see H2). This outcome underscores the proposition within this thesis to extend the benefits of integration and collaboration within the health system as well (see 1.2). Moreover, findings from this study has provided the impetus for future studies that can develop a more appropriate scale for use among African immigrants in Europe, for the specific purpose of investigating acculturation strategies in relation to medical help-seeking. Also, the results of acculturation strategies may vary among people of African descent, when compared between those who have had long-standing contact with the West through colonisation and evangelisation before migration (such as Nigerians, colonised by Britain and living in Britain) and those who were not (such as Afro-Americans). Besides, the lack

of acculturative effects on medical help-seeking can also be understood from the fact that this study did not account for present and past illness conditions, as well as immigration history of participating immigrants; both of which can affect acculturation strategies and help-seeking behaviours.

8.1.2 Integrating the thesis: A triangulation approach

The qualitative and quantitative studies have been useful in providing insights into the different factors useful in investigating health-seeking behaviours of Nigerian immigrants before, and during migration to the UK. Several important barriers and facilitators to health services utilisation have been identified in both the Nigerian and the UK care contexts. Bearing in mind that a biopsychosocial approach to the study of health behaviours was useful in framing the research questions to better explore the interplay between personal, social, and environmental factors (religious/cultural, spiritual, and socio-demographic), relevant to participants' responses to symptoms and illnesses; the results from the four studies were clustered to best represent the major themes across the studies (Figure 8.6). This process was achieved using the NVivo 10 software to guide the triangulated discussions in this subsection (8.1.2.). All aspects of the discussions were used to contextualise the findings from all studies within this thesis.

The integration model (Figure 8.6) shows that important findings on health-seeking behaviours (with particular reference to important facilitators and barriers) (8.1.2.1), and issues on collaboration among providers towards integrative cure approaches (with regard to potential barriers and facilitators) (8.1.2.2), were the main themes feeding into the point of integration. The central point of integration consequently, forms the final and conclusive part of this general discussion, using some theoretical references as the basis for triangulation (8.1.2.3). Other aspects of this triangulated discussion formed a cycle of

interplay with the main themes. Hence, the barriers and facilitators to medical help-seeking interact with challenges and facilitators to collaboration to reflect on the triangulation point, (through health seeking behaviours and the processes of collaboration identified in the qualitative studies) while sociodemographic factors (Religious affiliation and Age) are shown as important predictors of medical help-seeking (Study 4).
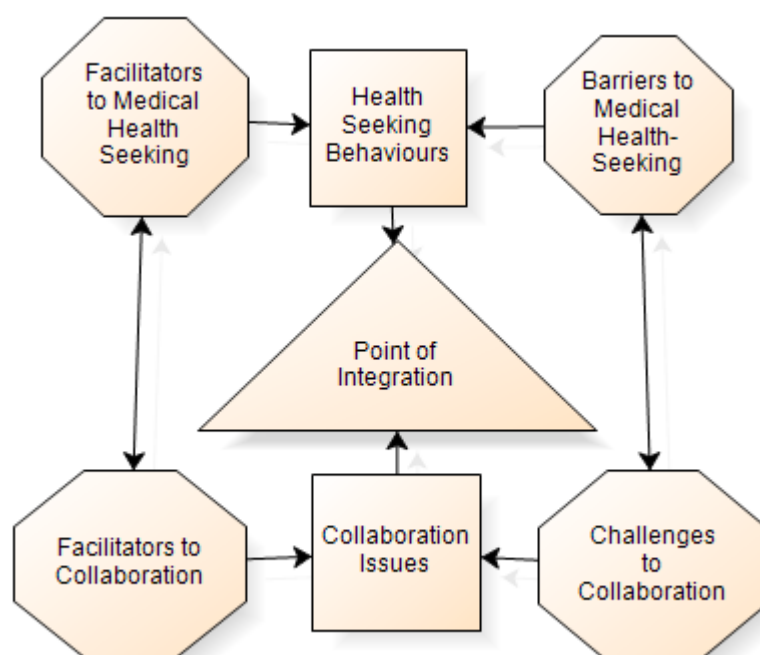
Figure 8.6. A triangulation model to guide the contextualised discussions

Note: This model forms a guiding network for the contextualised and integrative discussions incorporating the 4 studies within this PhD. The symmetrical flow between 'Barriers to Medical Health-Seeking' and 'Challenges to Collaboration' through to 'Facilitators to Collaboration' and 'Facilitators to Medical Health Seeking' helped to form a complete interaction between all aspects of the model.

8.1.2.1 Contextualising Nigerian health-seeking behaviours

The studies have provided important opportunities to explore the behavioural responses to illnesses – both physical and psychological – among Nigerians in their heritage and host cultures as immigrants. Findings showed that religious/cultural factors and coping strategies underlie their basic responses to illnesses. Furthermore, there were differences in religious and culture-related behaviours which characterised the treatments sought before migration (Nigerian context) and after migration (UK context). Such approaches included participants' recourse to social support found mostly in the UK context. The emotional and practical support sought by participants in the UK could be either informal support from friends, relatives, and peers or formal support from society (such as church and governmental or non-governmental organisations) as was found by Dilorio et al., (2006). In this thesis (see study 1) the need for support among Nigerians was reported to be associated with the loss of family support during migration, a need consistent with findings from previous studies among immigrants (Kamperman, Komproe & De Jong, 2007). In their study among immigrants in the Netherlands, Kamperman et al., found an association between feelings of loss for one's country of origin and increased psychiatric problems. Although none of the studies within this thesis investigated the relationship between immigration and psychiatric problems, since no cases of psychiatric problems were reported in the UK studies (studies 1, 3 & 4), it is possible that family support networks commonly associated with Africans as a communal-oriented people was drawn upon by the participants studied here. This is an opportunity for future studies to explore such relationships, with specific reference to Nigerians in the UK.

Social support is relevant in coping with adversity among non-immigrants of different ethnic backgrounds (Meyer-Weitz et al., 2000b; Vervoort et al., 2010). Existing studies among ethnic minorities showed that failed attempts to solve health problems

personally or among intimate circles of friends and family resulted in consultations with community leaders such as pastors/spiritual healers (Knipscheer & Kleber, 2001), and only when this approach fails, will the regular health care system be used. For instance, in the study by Knipscheer and Kleber (2001) among Surinamese populations in the Netherlands, over half of the research sample (58%) (Proportionately more Hindustani of African sub-cultural origin) initially tried to solve their problems by self-effort, consulting with friends, relatives and families, and used home-made treatment/medication. Also, consultations with alternative providers in the form of spiritual healers ('bonuman' or lukuman') were also reported, though on a lesser scale. However, available evidence on consultations with alternative healers among the Dutch (Knipscheer & Kleber, 2001), shows that such practice was not confined to immigrants or Africans alone. Knipscheer and Kleber (2001) reported that similar consultations with alternative healers among the native Dutch (such as *paragnosts* who see into the future), was shown to be as frequent as their Surinamese counterparts.

The reports of alternative practices within this thesis can be linked to the religious and cultural worldviews that influence help-seeking methods, as people's cultural beliefs and identity are known to be related to their perception of the world as well as such issues as health beliefs and behaviours (Gardner, 2005). For instance, the use of religious coping strategies or treatment options during illnesses (and other unfavourable circumstances) were reported in all the qualitative studies within this thesis, and confirmed in the quantitative study as 'religious behaviours' which was associated with decreased medical help-seeking. However, a more specific analysis within the quantitative study showed that the Christian religion predicted access to medical help-seeking. Therefore, religion as such could not be identified as a barrier to medical help-seeking among Nigerian immigrants. Previous studies have confirmed the usefulness of

religious coping in illnesses, both among immigrant and non-immigrant groups irrespective of countries of origin (Jacobson et al., 2006; Karekla & Constantinou, 2010; Sanchez et al., 2012). Future research needs to investigate the importance of religion, with a clear distinction between 'religious behaviours' and 'religious affiliations' to determine if any particular religious groups are more at risk and which aspects of religious behaviours impact on medical help-seeking.

Notwithstanding the prevalence of traditional and spiritual methods of cure found in both the Nigerian and the UK care contexts (studies 1, 2, & 3), there were no reports among Nigerians in the UK about explicit consultations with traditional healers or 'witch-doctors'. Rather they prepared African traditional herbs themselves (self-care or self-medication) and relied on Christian spiritual healing. The use of self-medication is consistent with existing studies as a common phenomenon among native patients in developing countries (Anwar et al., 2015). The WHO expressed the understanding of 'self-care' to imply the individuals' (families or communities) ability to promote health and prevent diseases, as well as their ability to maintain health by coping with illness and disability with or without the support of official health-care providers (WHO, 2009); while 'self-medication' is perceived as people's selection and use of medication, both orthodox and herbal/traditional remedies in order to treat self-recognised and diagnosed illnesses or symptoms (WHO, 1998). However, self-medication as an integral aspect of self-care is not restricted to developing countries alone. Such practices have also been reported in studies among industrialised populations, but there seems to be a variation that characterizes its nature in either developing or developed economies (Anwar et al., 2015). The practice of self-medication in developed countries occurs in a more regulated way when necessary, and mostly guided by available information from the internet, books, magazines, package inserts and other media operative in Western countries; which is

contrary to its practice in developing countries. Moreover, developed countries have effective legislation to control access to many medicines through prescription (Anwar et al., 2015); as also found in this thesis (see study 3). Consequently, the unrestricted responses to illness/symptoms in developing countries, such as Nigeria presents a situation where patients rely heavily on the advice from family and friends, spiritual leaders, family heads, overprescribing physicians and those inclined towards complementary methods, unqualified drug dealers, and the pressure from marketing adverts (Yusuff & Wassi Sanni, 2011; Anwar et al., 2015), as reported in study 2. These factors contribute to differences between the Nigerian and the UK care contexts represented in this thesis.

Although, religious and cultural treatment options were prevalent as already described in chapters 3, 4 and 5, participants were also shown to be engaging with the healthcare system. In this case, health-seeking attitudes were influenced by a combination of all possible alternatives such as the use of self-prescribed alternative medicines/herbs prepared at home or procured over-the-counter, as well as consultations with both conventional and non-conventional therapists. However, as religion and culture were found to hold much importance among health-seeking options for both immigrant and non-immigrant Nigerians, the vantage position of religious leaders in influencing health behaviours was clearly shown (see chapters 3, 4, 5 and 6). A typical example was the Nigerian context where care providers reported that patients expressed a comfortable shift towards a more Christian-based spiritual healing method (study 2). This situation was attributed to the current upsurge of 'New Age' religious movements (Pentecostal/Charismatic), which can be relevant to the health-seeking behaviours observed in the UK context, and is consistent with findings of previous studies regarding the impact of patient illness perceptions and explanatory models (Okello, 2007; Kendall-

Taylor et al., 2009). For instance, beliefs such as 'spells from witchcraft or voodoo' were found among Nigerian native and immigrant patients (in studies 1, 2 and 3), which could have influenced their health-seeking behaviours as consistent with previous research among Africans (Iyalomhe & Iyalomhe, 2012). In most cases, these beliefs were reported as barriers to medical help-seeking consistent with previous studies (Taffa & Chepngeno, 2005), and this is the focus of the next part of this discussion.

(i) Barriers to healthcare seeking

As personal attitudes and beliefs are known to influence health behaviours (Bandura, 2004), some personal behaviours and beliefs identified within this thesis were shown to be related to different coping styles adopted in response to illness/symptoms. These coping styles interplayed with medical help-seeking. In particular, within the UK context, study 4 showed that the use of 'behavioural disengagement' and 'self-blame' were associated with poor attitudes towards seeking medical help, while 'instrumental support', 'emotional support', and 'active coping' styles were associated with increased medical help-seeking. Moreover, the theme on acculturation identified in the first qualitative study (study 1) was further explored using the quantitative approach (study 4), and the result showed that holding onto heritage cultural beliefs and behaviours ('traditionalist beliefs' and 'traditionalist behaviours') were associated with active coping, emotional support and religious coping styles, as well as instrumental support, coping by disengagement, and use of self-blame, which can have important implications for medical help-seeking. Although none of the major acculturation strategies investigated ('assimilationist', 'integrationists' and 'traditionalists') were shown to be directly associated with attitudes towards medical help-seeking, they were associated with other factors that could be indirectly related to positive or negative attitudes towards medical

help-seeking. For instance, assimilation into the British culture was found to be associated with reduced religious behaviours, and could indirectly impact on medical help-seeking as subsequently revealed in the result for the first hypothesis, showing that more religious behaviours led to reduced medical help-seeking (see summary in 8.1.1). Conversely, if 'religious behaviours' was associated with reduced medical help seeking, it invariably implies that immigrants were adopting other alternative options related to their religion/culture. Hence, increased religious behaviours would logically mean that immigrants retained their heritage culture/religion through the traditionalist acculturation pattern which led to increased religious coping as mentioned above and confirmed by the association between integrationist behaviours (retention of both heritage and host cultures) and religious behaviours (see 7.5.3.1). This aspect is consistent with a previous study conducted among immigrants in the US, where those who preferred their heritage culture over the host culture (traditionalists) were found to adopt healthcare seeking behaviours consistent with their heritage culture (Chang & Subramaniam, 2008); and provides a case for an integrative health scheme.

As cultural and religious beliefs were themes already shown within this thesis to influence health-seeking behaviours among Nigerians (studies 1, 2, & 3), it was necessary to explore such themes against socio-demographic factors such as gender, which plays an important role in most traditional cultures, especially in Africa (Sperstad & Werner, 2005). The maternal role of child-bearing within traditional, religious cultures is a typical example, which influences women's experiences and responses to illnesses consistent with findings among women from traditional Islamic cultures (Abassi et al., 2011), and among people from traditional African and Christian cultures, such as Nigeria (Iyalomhe & Iyalomhe, 2012, Abioye-Kuteyi et al., 2001). This study (study 4) therefore compared gender differences on several important outcomes, and women were found to

use more 'religious coping', 'behavioural disengagement' and 'venting' than men, although they did not differ in their attitudes towards seeking medical help. This is contrary to expectations, as existing studies have shown that women in both traditional Muslim and Christian religions may delay health care utilisation (Abassi et al., 2011, Abubakar et al., 2013) compared to men, because they relied more on the teachings of their religious tradition/leaders. When explored further among different age groups in study 4, younger participants were shown to have adopted more active coping styles than the elderly who used more of 'denial' to cope, but they in turn sought more medical help than younger persons. About religious affiliation, the results showed that belonging to a religious group led to more 'active coping', 'denial', 'emotional support' and 'instrumental support'. In particular, the use of 'denial', 'emotional support' and 'instrumental support' could translate into barriers to medical help-seeking if not well managed, as it could redirect help-seeking away from the medical system when used as an end in itself. Consequently, coping by 'self-blame' and 'behavioural disengagement' predicted less use of medical help. While formulating new strategies to help immigrants' use of health care seeking, individual differences need to be considered.

The qualitative studies (studies 1, 2 and 3) had provided additional subjective inferences on certain barriers to medical help-seeking among Nigerians such as beliefs in a strict dichotomy between physical and spiritual illness aetiology. Hence, where illnesses were perceived to be 'spiritually motivated', it led to the use of spiritual healing/prayer in preference to any advice towards uptake of the bio-medical option. This theme confirms findings in recent studies among Africans on the prevalence of supernatural disease aetiology being the basis for seeking traditional healing and consequently, a barrier to medical help-seeking (Nsereko et al., 2011). However, the study within the UK context (studies 1 & 3) showed a divergence of opinion regarding illness

aetiology due to differences in religious beliefs between two main Christian groups. Those affiliated to the Pentecostal/charismatic groups expressed the strictest sense of physical and spiritual dichotomy, with more emphasis on the spiritual than those affiliated to the mainline group. This was reflected in the discrepancies from the results on 'religious behaviours' and 'religious affiliation' in relation to medical help-seeking in study 4 (see 8.1.1), with implications for findings in other reports on religious beliefs and practices, especially in relation to health care utilisation (see 7.6.2).

Other socio-psychological and environmental determinants of health-seeking found within the research presented here includes the availability and accessibility of alternative methods, which were reported more in the Nigerian context due to the prevailing religio-cultural belief systems; past experiences of illness management before and during migration, and the negative experiences of accessing the NHS, as reported especially in the UK context. The impact of the family as support system among Africans was equally reported as a potential barrier to medical help-seeking, especially the elders and significant others such as family heads and spiritual leaders (religious ministers), which is consistent with existing research (Abubakar et al., 2013). Hence, in a critical analysis of the role of social support from families, is was found that family members could serve as facilitators as well as barriers to medical health-seeking as they may provide directions towards or against medical help. Other factors reported in both the Nigerian and the UK qualitative study contexts (study 1, 2, & 3) included physical and structural barriers, past experiences, costs/poverty, as well easy access to other treatment options (self-treatment, spiritual healing, and herbal medicines). These factors were more prevalent within the Nigerian context in view of poor social capital and lack of education towards the provision and use of adequate and efficient health facilities, which is consistent with findings from previous studies regarding patients in most developing

countries, especially Africa (Abioye-Kuteyi et al., 2001).

(ii) Facilitators to healthcare seeking

This part of the discussion relates to factors identified as potential facilitators to medical help-seeking. They were mainly themes found within the UK care context (study 1) and the factors derived from the survey study (Study 4), such as the positive aspects of the NHS and experiences that could encourage its continued use (Study 1); as well as some coping methods and socio-demographic factors found among Nigerian immigrants (Study 4). Such advantages reported in the first inductive qualitative study included, free medical services, and prompt response in emergency situations. The condition of the illness being experienced provided another facilitating factor towards seeking medical help found within this thesis (studies 1, 2, & 3), as severe illnesses prompted immediate recourse to medical help; which is consistent with previous findings about illness conditions perceived by patients (Tuckett, 1976). Such illness perceptions would usually involve lay assessments of the illnesses as to the risk or perceived seriousness and threat they posed to the individual; as postulated by the biopsychosocial approach to illness (see 2.1.5), especially the health belief model (see section 8.1.2.3). However, the element of 'perceived risk' from this model was cast into a shadow of controversy in view of observed health behaviors among Nigerians who were reported as sourcing spiritual healing for all kinds of health conditions including HIV/AIDS (see 2.1.1.3). This aspect needs further investigation for a proper understanding of risk taking attitudes in a cultural context relating to Nigerians.

Regarding the cross-cultural qualitative studies (studies 2 & 3) conducted from the perspective of Nigerian care providers, some vital information regarding the impact of care providers' health perceptions were reported. Care providers' beliefs and attitudes

were shown to reflect on the over-all health-seeking behaviours among Nigerians; as consistent with existing studies that health professionals' beliefs and stereotypes are important factors in therapy processes and outcomes (Berry, 2004). The role of Nigerian care providers' own religio-cultural and health beliefs as reported in study 2, was found to have impacted differently on the healthcare seeking behaviours of Nigerians. As facilitators to medical help-seeking, care providers (clergy, herbalists, spiritualists, and health workers) within the Nigerian context reported their experiences of directing patients towards formal healthcare systems despite patients' lay beliefs and insistence on other alternatives (CAM). However, the medical professionals in Nigeria expressed overwhelming pressures in certain cases to compromise their medical practice to refer patients towards other non-medical/unorthodox alternatives. Some of the gatekeepers (especially the complementary therapists and spiritual healers) expressed confidence in the efficacy and popularity of their methods above the bio-medical option, while reporting that some health professionals equally helped to promote their methods. By implication, these gatekeepers are more likely to insist on their treatment methods than refer patients to the hospitals, which therefore serves as a barrier to medical help-seeking in Nigeria. In the same vein, within the UK care context (study 3), there were similar reports of cross-referrals between the health care professionals and clergy, although the health care professionals in this instance, did so only in private or informally. They explained that such cautious approach to cross-referral was due to the strict observance of professional regulations guiding medical practice. Such variation in the level of observance or implementation of professional care regulations distinguished the two care contexts – Nigeria and the UK. Hence, based upon participants' acknowledgement of some shortcomings in their treatment procedure and the need to provide patients with comprehensive care, the studies (2 & 3) explored the process of collaboration that can

maximise care efficiency and outcome, which is the focus of the next aspect of this synthesis (8.1.2.2).

Overall, the reported differences in care providers' preparedness to cross-refer patients in both contexts depended on many influential factors. These included, the strength of personal opinions about illness aetiology, personal health beliefs and care principles, personal beliefs regarding the efficacy of their respective methods, degree of adherence to professional guidelines, commitment to religious/cultural beliefs, educational attainment, levels of socialisation and adaptation to the western culture, and personal experiences of care provision in context. These factors, as well as other personal/subjective factors could translate care providers' influences as either facilitators or barriers to medical help-seeking among Nigerians, which needed further investigation (Study 4). Further data from the quantitative study (study 4) identified some relationships between medical health-seeking and some important determinants such as useful coping strategies (including active coping, instrumental and emotional supports) as already discussed in the study summary for hypothesis 1 (8.1.1). Also, two demographic factors (Christian religious affiliation and age) predicted medical help-seeking as important facilitators to general healthcare seeking among Nigerian immigrants (see Figures 8.4 & 8.5).

8.1.2.2. Contextualising collaboration among care providers

Studies 2 and 3 showed there were important differences regarding collaboration among various care providers towards an integrative and culture-sensitive care approach, as well as possible challenges. As patients' health decisions were found to be influenced by family members and religious leaders, who could also be working as care providers as already discussed, the cross-cultural studies (studies 2 & 3) explored potentials for

collaboration among care providers in both formal, professional and informal or non-professional care contexts. These aims were based on established evidence that Blacks are less satisfied with the health services, which can be addressed through patient-therapist cultural matching (Knipscheer & Kleber, 2001). For instance, in their study Knipscheer and Kleber found that 71% of the Surinamese clients in the Netherlands valued ethnic matching between clients and therapists towards their help seeking behaviours. This has important implications for a more culture-sensitive approach to health intervention, and is consistent with previous research showing that health interventions and research involving lay members of immgrant communities can help tailore health intervention to the specific needs of Sub-Sahara African immigrants, which are particularly acceptable (Nostlinger & Loos, 2016).

Studies 2 and 3 provided evidence of collaboration among different care providers through cross-referral of patients, although the clergy within the UK context showed a more practical approach to collaboration than their health care counterparts. Invariably, the health care professionals felt that collaboration with the clergy can only be in principle and not feasible as professional guidelines would make in impracticable (even though they can do so informally). However, the health care providers in the Nigerian context showed practical evidence of collaboration with other care providers, with some positive appraisal of the complementary/spiritual methods as well as caution regarding some possible abuses. These variations in the two care contexts were attributed to apparent socio-cultural differences in the two societies. For instance, where the Nigerian context (Study 2) was characterised by the popularity of spiritual healing due to proliferations in the New Age Christian-based spiritual movements when compared to the UK (Study 3), the UK context would boast of a more stringent care system with regards to professional regulation compared to the Nigerian context. To address the difficulties incorporating the

spiritual approach within the formal healthcare settings, health care professionals within the UK context proffered a solution in psychology-spirituality collaboration. This suggestion is attributable to the age-long connection between the 'spiritual' dimensions of mental illnesses and their therapies as known across the globe (Sheldrake, 1998; Downey, 1997). However, although care providers in the Nigerian context were prepared for an all-inclusive collaboration as distinct from the UK context, both health care professionals, the clergy, and alternative care providers did agree on a balanced and more regulated alternative method that can match the demands of professionalism in care.

The optimism for a successful collaboration notwithstanding, care should be taken to avoid too much emphasis on cultural differentiation, as it could suggest the presence of an unnecessary gap between the host society and immigrants. Such negative perception can become counter-productive, without encouraging integration nor facilitating help-seeking within the mainstream formal care setting (Knipscheer & Kleber, 2001). This thesis identified some potential barriers to collaboration and possible solutions, which are discussed next.

(i) Barriers to collaboration

Notwithstanding the reported willingness for collaboration, both in principle and practice, there were challenges that can slow its progress. Basic issues found within the UK and Nigerian care contexts (studies 2 and 3) included differences in beliefs and interests among providers, such as religious and health beliefs, as well as professional interests. A typical example of the interplay between differing opinions and beliefs among providers on care beliefs was shown where health care professionals may differ from the clergy on illness aetiology and principles of care/cure if they do not share the same

religious beliefs, but may agree on the same matter (supernatural aetiology and intervention in health) if they have the same religious affiliation. Therefore, where these differences become institutionalised, they present vital obstacles to successful collaboration. Consequently, successful collaboration could be affected as different care methodologies engaged in some form of competition and professional rivalry consistent with previous studies (Sperry & Shafranske, 2005). Furthermore, some studies viewed such barriers as related to basic differences between the secular and spiritual approaches to illness aetiology, with philosophical and ideological differences across secular and Christian movements (such as traditional and liberal Christians) (McMinn, Vogel & Heyne, 2010). In all, findings from the cross-cultural studies (especially study 3) showed that the most effective barrier was based upon codified interests represented as institutional regulations and professional codes of conduct within and between various care groups, which can stifle any attempt towards collaboration. To address these barriers, health care professionals within the UK care context tried to exclude the medical profession from any integration with the spiritual care method, but suggested that some other areas of the formal healthcare system could be more amenable to collaboration which is the focus of the next part of this subsection.

(ii) Facilitators to collaboration

From the findings derived from the UK context of the cross-cultural qualitative studies, a more convenient integration process was identified in the interface between spirtualty and psychology (clergy and psychologists/psychotherapists), which is consistent with an existing study conducted by McMinn et al., (1998), among US clergy and psychologists in which both care providers showed shared collaborative experiences. In their study, both the clergy and psychologists were shown to be jointly involved in

mental health consultations and cross-referrals, parish workshops, and community work in the prisons chaplaincy. In another study (Benes et al., 2000), the collaboration between spirituality and psychology was also shown to be successful for mental health services, with both groups sharing experiences in social services under the auspices of the catholic church. Other studies have also indicated outstanding successes in this area, showing that using cross-referrals and joint trainings between psychologists and the clergy can foster successful care plans, especially for the emotionally disturbed (Chappelle, 2006).

Collaboration can therefore enhance effective client-clinician cultural matching by incorporating gate-keepers and other care providers from minority immigrant communities. In this way, spiritual leaders could be involved at the initial stages of consultation in the form of parish care centres or community-based care projects; which is already shown to be successful among Africans (Summerton, 2006; Wreford, 2005). This process could serve as a first-stage counselling and motivation unit, applying motivational interviewing to encourage some hard-to-reach clients to access medical help - NHS. Recommendations for a feasible integration process suitable for care context within the UK and other care contexts is provided later in this chapter (see 8.3).

8.1.2.3. The integration point: a theoretical appraisal

The point of integrating the thesis within the PhD has been developed from the summaries (8.1.1) and basic discussions (8.1.2) on the four studies conducted within this project. The entire discussion culminated to two broad aspects: the contextualised understandings of health-seeking behaviours among Nigerians (8.1.2.1) and the contextualised experiences of collaborative efforts among Nigerian care providers (8.1.2.2). Since one of the major objectives of health research is to predict health behaviour (Study 4) to inform policy towards the design of appropriate interventions that

can change negative health attitudes, the studies within this project have been used to identify how Nigerians in different contexts – cultural, social and professional - understand health and interpret the causes of poor health outcome. Such perceptions were based upon their particular circumstances, religio-cultural beliefs and practices, both as immigrants and non-immigrants. However, to initiate, promote, and maintain desired health actions or change maladaptive behaviours, theories and models become useful guides. As a guiding principle, the theories and models loosely reflected in this thesis are useful tools that can inform future policy in sustaining positive attitudes towards medical help-seeking or change negative attitudes and other barriers to healthcare utilisation identified among Nigerians. This aspect is the focus of the current subsection: explore some theories and models engaged in this thesis as reference points to situate the thesis within a broader research context; explore the potential for theoretical development in future research that can apply some or all the theories/models deductively within the contexts already provided in this PhD.

Although the studies within this thesis were not theory-driven – *a priori*, some theories/models were used as guiding principles to focus the research aims and objectives. The two main models highlighted in this thesis are the bio-medical model, specifically relevant to research objectives on attitudes towards medical help-seeking (study 4), and the bio-psychosocial models relevant to the studies aimed at identifying biological, psychological, social, and environmental determinants to health-seeking behaviours among Nigerians (studies 1, 2, 3, & 4). A review of some of these theories and models, already briefly described in Chapter 2, (2.1.5) can properly position the research approach in this thesis as a multi-causal approach to health research, which will necessitate cultural considerations in the design of future health interventions within the UK healthcare system – the NHS.

(i) The bio-medical model

The biomedical model sees diseases as resulting from biological malfunctions and treatment is sought by putting aright the ailing part of the biological system; an approach that has dominated the understanding of illnesses, aetiology and treatment through Western medicine since the eighteenth century (Crossley, 2000). However, the implication of this model for health behaviours, which is the focus of the research presented in this thesis is that the preventive aspect of healthcare was neglected, with an approach to cure based on treatment only. Also, under this model of cure, patients were considered as passive objects and doctor-patient relationship was only in one direction (paternalistic) in favour of the doctor (Marks et al., 2005). As a multi-disciplinary research programme, with interest in different aspects that could influence health behaviours (immigration, acculturation, culture, religion/spirituality, coping strategies, and health), this thesis could not be driven by the biomedical model. Also, based upon current understandings of behaviours, including the aetiology, diagnosis, treatment methods, and relationships in consulting, this thesis had to engage other models for its initial studies (studies 1, 2, & 3), while retaining the aim of exploring attitudes to medical help-seeking due to the benefits inherent in the medical and biological principles of cure. The implication was that, for patients to avail of the benefits of the bio-medical cure approach, they needed to access and use it. For instance, as existing studies confirm the effects of poor clinician-patient matching with its negative impact on doctor-patient communication (Ademuwagun, 1998), data presented in this thesis also showed that the bio-medical approach (NHS) was less attractive to African/Nigerian immigrants with less satisfaction towards its services compared to their Caucasian counterparts confirming previous research (Borowsky et al., 2000; Fiscella, Franks, Doescher & Saver, 2002; Dunlop et al., 2003). Therefore, the biopsychosocial-related models were considered more useful in

providing the necessary information to achieve the set objectives, because patients' circumstances have become important in medical decision (Mechanic, 1978).

(ii) The bio-psychosocial models

The Health Belief Model (HBM) is one of the foremost models of health behaviors used in public health to identify factors related to why people behave in a particular manner so as to promote health and prevent diseases (Rosenstock, 1966; Becker, 1974; Janz & Becker, 1984). The model proposes that human action is guided by their beliefs about the effects of the illness and its consequences on them, that is, perceived threats that are related to their evaluation of their own vulnerability/susceptibility, as well as the perceived severity of the illness and its consequences. This model includes an evaluation of the consequences of the health-related action and their abilities to undertake them, evaluation of perceived benefits from taking the health action, and any potential barriers (material and psychological) towards achieving the set goal. These aspects of the model underlie the research aims of the three qualitative studies on how beliefs (health beliefs and religio-cultural beliefs) determined health-seeking behaviors among Nigerians, both as service users and service providers. It also considered potential barriers to healthcare utilization for service users and collaboration among care providers. The themes emerging from the three qualitative studies on some sections of the Nigerian population (Christians in the UK) were further investigated among the general population, with important findings confirming the role of beliefs on medical help-seeking (Study 4).

Of special relevance to this study is the aspect of the model termed 'cues to action', which is related to both internal and external factors that can influence health actions, such as the degree and nature of the illness/symptom (illness condition), the role of information dissemination such as the media, and the role of relevant persons known as

'powerful others' who are regarded as knowledgeable, influential, and custodians of useful tips to health success. The results from this thesis have identified such cues to health behaviours among Nigerians to be mostly from families, religious leaders, and elders, both in Nigeria and the UK. Therefore, this element of the HBM is quite relevant to this thesis, and consistent with previous research among Africans who hold onto their traditional family and religious values for vital health decisions (Kamya, 1997; Damafing, 2008). The element of susceptibility also contributed in the studies' attempt to identify Nigerian immigrants as most at risk, vulnerable minority, with potential challenges from the new environment (such as discrimination and potentially new kinds of illness conditions unknown to them before migration) that if misinterpreted in their severity, could become barriers to medical help-seeking. Hausmann Muela et al., (2002) uncovered such wrong perceptions of disease threat among a rural Kenyan community resulting in poor health outcomes. Moreover, investigating these factors in different contexts (UK & Nigeria) underscores the importance of the principles of the HBM for this thesis; as the factors that influence health behaviours (such as individual's held beliefs/values about illnesses) vary between times and places (from community to community, culture to culture, gerenration to generation) (MacKian, 2003). However, in spite of these useful contributions from the HBM in understanding and predicting health behaviors among Nigerians, it failed to recognize aspects of behavioural intention, previous experiences, perceived control and other components like self-efficacy, as well as social environmental components which are augmented by the Theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB); but which are not within the scope of this chapter.

Other aspects of the bio-psychosocial model useful to this thesis are derived from the healthcare utilization model, rooted in the Andersen Model (Andersen & Newman, 1973). According to this model, three categories – *predisposing, enabling*, and *need*

factors – follow a logical sequence in determining health decisions. The first category of predisposing factors involves some demographic variables like age, gender, religion, global health assessment, past experiences of illness, formal education, general attitudes towards the health services, and knowledge already gained about the illness in question. The second cluster – 'enabling factors' – involves financial resources at the person's disposal, availability of service, access to social security like health insurance scheme, and social network support; while the third step – 'need factors' - represents such issues as perceived severity, length of sickness, and its cost or consequences (like out of work or school effects). These factors are considered against their end – treatment actions – which could be one or a combination of many methods (self-treatment at home through choice remedies of herbal or pharmaceutical type, procuring over the counter medications, consulting the pharmacist or the hospital - private or public), especially, consulting with religious/spiritual healers (who equally act as health advisors), which is among the interests of this thesis. Hence, the dynamic process of arriving at a therapy choice based on personal dispositions (socio-demographic information/SES), the role of 'significant others' (religious leaders and the elders) and the social support network were considered in understanding the determinants of health-seeking behaviours among the Nigerians (studies 1, 2, 3, & 4). For instance, study 4 confirmed older 'age' as a predictive factor for increased medical help-seeking (older people sought more medical help than the young), while all the qualitative studies identified the use of religious cure methods as pivotal in the health-seeking behaviours of Nigerians thereby highlighting the important role of 'significant others' (such as elders and religious leaders) in the care pathway. The prediction of health behaviours through collaboration with the community (community and religious leaders) was therefore, the element adopted from the ethnographic model, and advocated within this thesis. Hence, the next subsection contains the details of the

proposed model for integration/collaboration – the TTC – already mentioned in previous chapters (2.2 [viii]).

(iii) The Theory of Transformative Coping (TTC)

This theory proposes that transformative coping styles can be achieved through a combination of creativity and spirituality that, 'builds resilience which buffers against stressful experiences and can help improve and maintain mental health and wellbeing. It constitutes active cultivation of personal resources while simultaneously reducing deficiencies.' (Corry et al., 2014, p.103). As this is a means of empowering patients to develop inner resources for their future benefit in place of maladaptive coping responses, there is no potential harm that should result in any unhealthy rivalry or suspicion among medical practitioners and other care providers. Moreover, some findings within this thesis provided a convenient opportunity for integrating spirituality into medicine, possibly by using a model such as the TTC. For instance, the health care professionals, (especially medics within the UK care context) conceded to the collaborative notion only in principle; and while proposing that psychological therapies provided a better context for practical integration of spirituality, some accepted that they used 'coaching' in addition to medical treatment. Based on this premise, the principles of transformative coping can be applied in a similar way as 'coaching' to suit the bio-medical care context, while Pargament's (2007) biopsychosocial-spiritual model can be adapted to the psychological care context. This way, a further collaboration between transformative coping and a biopsychosocial-spiritual approach becomes less challenging to creating a soft landing for the holistic healthcare - physical, mental, social, and spiritual proposed by the WHO (2001). The success of this proposal rests on the premise that the basic concepts involved in the TCC - creativity and spirituality – are unlikely to pose any dangers to patients. For instance, creativity is shown to imply such skills as writing, drawing, painting, singing/music, crafts,

gardening etc., through which personal emotions can be expressed, while spirituality involves those aspects as reflection, contemplation, mindfulness, transcendence, meaning finding, connecting etc. (Correy et al., 2014, p. 95). These dimensions of the individual that can be engaged within the confines of creativity and spirituality are not new to individuals, but simply need to be harnessed by health professionals. The confidence that spirituality can be integrated within the healthcare system (especially with medicine) through TTC follows from research evidence from medical studies itself, showing that faith, prayer, and spirituality can improve and sustain health and wellbeing as well as recovery from illness by serving as a trigger for necessary emotions that subsequently influence physiological systems (Koenig, McCullough & Larson, 2001).

About to creativity, existing studies (Puig, Lee, Goodwin & Sherrard, 2006) confirm that creative arts therapy has been effective on the emotions, spirituality, and psychological wellbeing of cancer patients. Their study concluded that creativity transformed negative emotions to positive ones to enhance psychological wellbeing. Therefore, consistent with the findings from previous studies (Aina, 2006; Sabuni, 2007), where the psychological and physiological, spiritual and physical conditions are shown to be related in a holistic way, especially for Africans, it follows that an improvement in psychological wellbeing can consequently improve physical wellbeing and vice versa. By tapping into the opportunity created by the recent NHS reorganisation to integrate spirituality through the TTC, immigrant patients who have poor attitudes towards medical help can be motivated towards the bio-medical care system through their creative and spiritual gifts. The details of how this programme can become feasible at the grass-root care level are part of the general recommendations provided towards the end of this thesis (see 8.3).

In summary, from the theoretical perspectives discussed in this section it is evident that some elements of the models have provided important guides towards explaining healthcare seeking behaviours among Nigerians. The cultural element which is intrinsically linked with religion/spirituality - beliefs, values, and practices that are sustained through the interplay of various elements within migration, such as acculturation were untangled within this thesis. The pre-and post migration aspects were explored and linked up, as the models acknowledged the importance of past-experience/knowledge and illness perceptions in health-related decisions. Although the references drawn from the models within this thesis followed an inductive principle, they have provided useful opportunities for further studies that can apply the principles of the models from a deductive perspective while studying health-related issues among the Nigerian people. Therefore, despite the shortcomings of applying the theories in non-experimental and non-clinical perspectives, this thesis provides the impetus for future studies that can account for the research limitations detailed in the next section.

8.2. Limitations

There are noticeable shortcomings to this thesis, which implies that the inferences and generalisability of findings obtained from this research may be restricted. First, the research aims were to arrive at results that could be generalised on the Nigerian population in the UK, but this cannot be the case as the qualitative studies provided findings from the subjective experiences of few participants and were not designed to be generalisable, beyond that of the participants. The three qualitative studies may have been prone to researcher bias, especially where the researcher could have been under the impression of dealing with a vulnerable group (Nigerian immigrants) during collection of data. This process of 'identification with participants' could result from the researcher's

own background as an immigrant from Nigeria. Sequel to this, 'power relations' between the researcher and participants could have influenced the qualitative research results (Banister et al., 1999). In this case, the researcher could have gained a vantage position over participants due to researcher's social status as a cleric. Also, the issue of social desirability bias affects the results of qualitative studies as participants try to give expected responses, or avoid responses that have implications of stigma or shame.

Regarding the qualitative research protocol, the English language was used at the interviews and focus group discussions, which has the potential for affecting intended meanings, especially as the English language was not their first language. Also, the quantitative study relied on self-reports of participants' intentions to perform certain acculturative, religious, coping and health behaviours, rather than a measure of actual behaviours (Armitage & Connor, 2001). Previous studies have shown that real threats are known to elicit different responses compared to perceived threats, and the relationships between intentions and behaviours are usually weak (Bresnahan et al., 2007; Sheeran, 2002). However, this limitation did not affect the results and conclusions within this thesis because for some variables, such as religion (which is an important aspect of this thesis) real and perceived threats are shown to provide similar effects irrespective of the condition under investigation as consistent with existing studies; where religious and spiritual resources were found to be important means of support for many patients when investigated under actual and perceived conditions (life-threatening and life-changing conditions (Park, 2005). In addition, the 'Attitudes Towards Seeking Medical Help Scale' used in this thesis was an intention-based subscale validated with an actual help-seeking subscale. Future investigations can take this aspect further with particular reference to the Nigerian population.

Adding to the constraint imposed on the generalisability of the research findings in this thesis is the potential unrepresentativeness of the self-selected nature of the sample, both for the qualitative and quantitative studies. The participants recruited for the quantitative study, although based on self-reporting questionnaires, were not randomly assigned, but were recruited through a snowballing method which could introduce sampling and biases. There were unequal representations of some religious groups, with the Christians being over- represented (88%) compared to Muslims (3.2%). Therefore, as some religious groups failed to meet the required number of data sets necessary for the regression analysis, the variable (religious affiliation) was recoded; with those decalring no religious affiliation forming a distinct group without verification (taking for granted the information provided on the self-reported questionnaire). This approach could therefore, be lacking in sensitivity and could somewhat bias the results. Future research should target individual religious groups and their unique characteristics, with recruitment based on specific members only or a study designed for non-religious persons. Moreover, any such studies among religious groups should measure and distinguish between belonging to a religious group (religious affiliation) and commitment to religious beliefs/principles or religiosity expressed in religious behaviours. This approach could be more beneficial because those who hold strong religious beliefs while belonging to a religious group could present similar responses as those who hold strong religious beliefs, but not belonging to any religious group. Again, the sample reported in study 4 did not show adequate representation of the intra-cultural differences among the Nigerian people, an important factor that should be considered in future research by focusing on specific ethnic/tribal region of the country, such as the Igbo, Yoruba, Hausa, Ibibio etc. Furthermore, on the representativeness of the studies, the qualitative studies (Studies 1 & 3) aimed at understanding the health-seeking behaviours of Nigerian Christians also

failed to represent all Christian groups equally, as Catholics, Anglicans and Pentecostals were the main participating religions. Also, in study 3 conducted among care providers in the UK, only medics and nurses represented healthcare workers, inadvertently excluding psychological therapists; while only the Catholic and Pentecostal clerics represented the clergy. The data are therefore representative of these participating populations only. However, previous studies conclude that the problem of representativeness or nonresponses do not have serious consequences for the adequateness of associations between variables (von Loon et al., 2003), and in this thesis, the large sample was considered adequate to counter some of the limitations imposed by research assumptions.

Furthermore, some aspects of the research designs used for the qualitative studies, such as interviews and focus groups for data collection were known to have their respective limitations. For instance, since the qualitative designs were aimed at in-depth exploration of health-seeking behaviours among Nigerians, using personal interviews alone (study 3) did not provide enough opportunity for cross-verification of ideas through possible interventions that could have come from other participants with different opinions/experiences. This interactive process provides the opportunity to probe further on different aspects of the discussions, which could have enriched the study further. However, such limitations from the interview methods were well managed by adopting the focus group discussions for the first phase of the study (study 2), although that approach has its own limitations too. For instance, participants may not be well disposed to discuss some sensitive aspects of their health in the presence of other unfamiliar persons; but in this thesis (studies 2 & 3) participants often made references to their patients' health behaviours rather than theirs, which made it easier to speak about in group discussions. To balance the respective limitations possible from the different

approaches so that they did not affect results from the overall cross-cultural study, a synergy of designs and analysis was used to integrate both studies and to avail of the advantages of interviews and focus groups (see chapter 6). Moreover, the first qualitative study (study 1) employed both interviews and focus group discussions, and the analyses for all the qualitative studies were conducted using different analytic tools (TA and IPA) that ensured the thesis remained true to qualitative research principles and drew from their benefits. Future research could use other analytic tools such as grounded theory (GT), with a design aimed at theory building (Glaser & Strauss, 2006) beyond initial exploration of health experiences used in the present thesis. Also, the cross-sectional design adopted in the survey (study 4) has been associated with retrospective bias (Kamperman et al., 2007), so that future studies could use a longitudinal design.

There were concerns regarding the inclusion of some variables with low factor loadings (Cronbach, 1951) in the quantitative analyses (Study 4), such as 'venting' and 'denial' of the Brief COPE Scale (venting = 0.34, denial = 0.45), both of which also scored the least in the original scale validation (50 and 54 respectively). Such loadings may be because the subscales of the measure used only two items, and internal consistency for measures are known to increase as scales are lengthened (Cronbach, 1951). Furthermore, there is a dearth of research on venting as a coping strategy among Africans (Kimemia, Asner-Self & Daire, 2011). By implication, Western-oriented constructs for coping may not represent similar ideas for people of African descent. Therefore, the Brief COPE may not have provided adequate assessment tool for the vital means of coping prevalent among the research population. Future research could first adopt an in-depth qualitative approach for a better understanding of coping factors among Nigerians with the aim of developing a better scale for people of African descent. Also, some statistical assumptions could have been violated in study 4, such as the dependent variable (DV)

not normally distributed (sig = .000, with actual mean and 5% trimmed mean not equal); and although the Q-Q Plot shows a somewhat straight line, the histogram shows it is negatively skewed. However, this was ignored because the large sample size and statistical power were adjudged adequate to overlook these assumptions; as previous studies show that such inconsistencies and seeming violations usually occur when studies involve large sample sizes and therefore, can be ignored (Tabachnick & Fidell, 2007). Other methodological shortcomings in this thesis also need to be addressed in future research, such as using control groups to compare/contrast findings. This approach could enrich future research, where groups are matched by randomisation, involving such groups as first and second generation Nigerian immigrants, Nigerian and non-Nigerian immigrants, White British and Nigerians, participants with health conditions, or specific sects/denominations of a religious or cultural group from Nigeria (such as Catholics vs Pentecostals), or between Nigerian and non-Nigerian Muslims, etc.

Two vital socio-demographic variables – occupation and educational attainment – were excluded from the final analyses within this thesis for lack of clarity of information needed for statistical computation, and future research should investigate these and other aspects that are potentially equally important for health decisions, such as self-efficacy and locus of control; where 'external locus of control', for instance, has been found to impede the disclosure of personal feelings of illness leading to lower healthcare consumption (Tijhuis, Peters & Foets, 1990; Kamperman et al., 2001). Above all, it should be acknowledged that none of the studies conducted within this thesis accounted for present and past illness conditions, as well as immigration story associated with participants as both factors could have affected the results presented in this thesis. Despite these shortcomings, the data obtained in these studies have provided sufficient results and scope for recommendations for improvements in future research, theory,

policy development, and clinical practice.

8.3 General Recommendations

The results from this thesis could have theoretical, practical, and policy implications. First, there has been a dearth of cross-cultural research verifying psychosocial theories and models from the perspectives of Nigerians, both in their heritage culture and as immigrants. The findings in this thesis have provided a reference point from an inductive perspective, which can be extended through a deductive application of health theories and models to better understand health behaviours among Africans. Importantly, some findings within this thesis did not differ from most health experiences with other non-African or non-migrant populations, but what is particularly informative was the revelation that African traditional religion, cast in a Christian (Pentecostal) mould has formed a unique religo-cultural mix, with the Bible as the basis for interpreting world events. The overall perception of these events among Nigerians can consequently influence health-seeking behaviours in a particular way; which needs to be addressed by policymakers. Hence, following the results presented within this thesis, it is suggested that health policy could consider collaboration among care providers for an integrative care model; as integrating spirituality within formal healthcare systems does not aim to replace the bio-medical approach to care but to enhance it, as already noted (1.2).

This proposed integration process (collaboration between faith-based cure and the bio-medical approach) could be tested using the application of the theory of transformative coping (TTC) already discussed (see 2.2 [viii] & 8.1.2.3 [iii]). This can take place at the community/parish level; so, the Clinical Commissioning Groups (CCGs)

already mentioned (see section 1.2), can work with immigrant communities/healthcare workers as health guides already advocated (see 7.6.5). This is an instance of pooling together, resources within various religious/cultural groups and the NHS using remote support system approach. Hence, religious ministers can assist as health guides in their churches or cultural centres to help isolated, but potential service-users in considering the medical/therapeutic option during illnesses/symptoms. This proposal is consistent with research findings showing that health and social services interventions are more effective in a culturally sensitive environment (Atkinson, 1985; Sue, Zane & Young, 1994). This proposal aims to incorporate already existing informal treatment options that can be identified among Nigerian immigrants into the formal healthcare system; which can then be extended to immigrants from other countries. If these proposals are implemented, there is a high expectation for a successful collaboration towards a better health outcome. To achieve this, there is a need for future research, especially in a cross-cultural context; so, that a working definition for the concepts of 'spirituality' and 'creativity' can be developed that will be applicable to both Westerners and non-Westerners alike. It will also require appropriate funding in practice to start off at the grass-root level, such as the church parish community as already suggested (2.1.1.3).

This need is urgent because, although Africans have imbibed both traditional African ways of knowing and the scientific method of knowing (through colonisation and evangelisation); they usually engage with both the medical and the religious/spiritual cure methods depending on the more appealing context (Ogunniyi, 1987). Incidentally, existing evidence shows that, among the medical, complementary (CAM), and spiritual cure approaches, the more appealing choice is the spiritual/faith-based healing experiences. Although the CAM has been recognised by WHO as a way of addressing the cultural needs of the world's diverse patient population (1978), it did not include spiritual healing,

yet existing studies in the USA show that when the definition of CAM included the spiritual methods it recorded increased access by patients, with healing prayer being the most frequently utilised aspect (Barnes, Powell-Griner, McFann & Nahin, 2004). Also, within this thesis, there was no explicit reference to consultations with practitioners of African traditional medicine nor the 'witch-doctors' (only the use of homemade herbs and nuts such as 'bitter-kola' were reported), while most participants (either as service users or providers) were inclined to use the faith-based Christian approach in one form or another. Although, this could be due to the composition of the sample in the present thesis, where most participants were Christians (studies 1 & 3). However, a previous study with a sample consisting of a mixture of Muslims and Christians in Kenya, confirmed the findings in the present thesis; emphasising that, '…the traditional healing was found to be out-dated…it was backward and irrelevant for people in the modern world to still go for traditional healing' (Abubakar et al., 2013, p. 5). Therefore, there is a need to understand the changing face of cultural beliefs in view of the emerging popularity around spiritual healing, especially among Christian Pentecostalism and its challenges to modern life; with special reference to health issues in the context of immigration and globalisation (Adogame, 2007). Moreover, African culture is deemed to be far from homogeneous; and unlike the Western model of illness conception, which is mainly bio-medical (Sabuni, 2007), the African concept of illness aetiology is more holistic (the natural and the supernatural), with implications for the wellbeing of mind, body, and spirit (Sabuni, 2007). Therefore, as people's cultural beliefs and identity are related to their perception of the world and related issues such as health beliefs and behaviours (Gardner, 2005), it is vital that this thesis considered the prevailing norms, values and beliefs that characterised Nigerian immigrants' health-seeking behaviours in the context of an emerging spiritual healing approach through proper integration.

Furthermore, this call for an integrative health approach is in line with the long-standing programmes of integration by the UK governments. All levels of the UK government in the recent past have adopted integration policy as one of their main goals, which is considered as a positive development (Mulvey, 2015). The popularity of these integration policies is based on the aim to make immigrants less different from members of the dominant culture (Kostakopoulou, 2010; Thredgold & Court, 2005). Although, integration policy has been considered as a positive development within the UK social and political structure (Mulvey, 2015), if it is not addressed across other sectors of public life such as health, the policy objectives may risk being unachieved and the situation could lead to further constrains in using available healthcare services. However, if well managed, such policies could become vital sources of access and adherence to medical help among ethnic minorities. Such health benefits could potentially be realised through the collaborative process recommended in this thesis. Other reasons for the urgency in extending the benefits of this government integration programme across the health sector for the health needs of immigrants has been discussed, with particular reference to Nigerians (see 2.1.1.3).

8.4 General Conclusion

Overall, the aims of this thesis were to explore health-seeking behaviours among Nigerians to identify barriers and facilitators to healthcare utilization, both in Nigeria and the UK. It also tried to achieve the set objectives from the perspectives of service users and care providers (clergy, herbalists, spiritual healers, and health workers). Consequently, such aims also explored the potentials for professional collaboration towards a culture-context and integrative healthcare provision. The roles of acculturation, religion, and coping strategies in predicting medical help-seeking were investigated, in

addition to some socio-demographic factors that predicted medical help-seeking. Realising these objectives necessitated a diversity of methodologies to ensure that the issues were adequately investigated from different research approaches and guided by various theoretical principles. The initial triangulation of qualitative studies among the research population (Study 1: from the perspectives of Nigerian service users; Study 2: from the perspectives of Nigerian care providers in Nigeria; and Study 3: from the perspectives of Nigerian care providers in the UK) ensured a holistic and in-depth investigation of the research questions, which were systematically linked to the quantitative study at the end (Study 4).

Health seeking preferences among Nigerians ranged from a combination of methods from medical, traditional, and spiritual/faith healing options, while the traditional and religious methods were presented as the most preferable (effective, accessible, quick, easy and cheap). Subjective norms in the form of beliefs in the role of important others tended to influence health behaviours through the role of religious leaders, while the degree of trust placed on health professionals was not explicitly clear. Hence, religious and cultural beliefs, as well as many personal, cultural, and environmental challenges served as barriers to health services among Nigerians. In addition to religious and cultural determinants, poverty and ignorance were also observable barriers and gender, age and coping strategies were differentially relevant to medical help-seeking. Therefore, the suggestion to integrate religio-cultural methods of cure was deemed adequate as care providers were willing to do so, with due consideration for professional guidelines/regulations and patient individual differences. Contrary to expectation, affiliation to the Christian religion predicted positive attitudes to seeking medical help; thereby strengthening the case to incorporate spiritual methods of cure within formal health system. From this evidence, a successful collaboration between the clergy and

health professionals can curb certain limitations and potential harm derivable from opposing methods of cure being used alone, thereby enhancing access to medical help.

In conclusion, the above findings confirmed some of the hypothesis set within this thesis by confirming religious and cultural factors as important determinants for coping with stress among Nigerian immigrants. Also, as an adherence to heritage behaviours resulted in poor medical help-seeking, the results suggest that more needs to be done at research, policy and practice levels towards integration by encouraging active, instrumental and emotional support for migrants, as this should lead to increased medical help-seeking. In a logical sequence, it could be concluded that the immigration challenges and poor integration processes are related; and linked to increased use of 'behavioural disengagement' and 'self-blame' as coping styles, which culminate into less useful medical help-seeking attitudes. Also, none of the acculturation patterns (assimilationist, traditionalist, integrationist, or separationist) was predictive of medical help seeking; but belonging to a religious group correlated with more acculturative strategies and religious beliefs (traditionalist beliefs, traditionalist behaviours, assimilationist behaviours, integrationist behaviours, and religious beliefs). Particularly, the Christian religion predicted increased attitudes towards medical help-seeking. As already noted therefore, and bearing in mind a few potential shortcomings to this thesis, the results reported here could have useful implications for future research, policy, and clinical practice.

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    related quality of life. *Psychotherapy Psychological Medicine, 55*, 241-246.

Appendix 1 Ethical Approval for Study 1

Middlesex University Department of Psychology

STUDENT Application for Ethical Approval

No study may proceed until approval has been granted by an authorised person. For collaborative research with another institution, ethical approval must be obtained from all institutions involved. Since you need your supervisor approval, the completed form should be emailed to your supervisor from your <u>University</u> email account (...@live.mdx.ac.uk), as this acts as an electronic signature. Your supervisor will then send your application to the Ethics Committee (Psy.Ethics@mdx.ac.uk), as this will act as her/his approval.

This form consists of 8 sections: 1   Summary of Application and Declaration

2   Reviewer's decision and feedback
3   Research proposal
4   Ethical questions
5   Information sheet
6   Informed consent
7   Debriefing
8   Risk assessment (required if research is to be conducted away from Middlesex University property, otherwise leave this blank. Institutions/locations listed for data collection must match original letters of acceptance)

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1   Summary of application (researcher to complete)

Name: ONYIGBUO CHINEME C.   **Student number: M00428762**

Degree: (delete as appropriate)   MPhil/PhD

Title of proposal: An exploration of health-seeking behaviours among Nigerian Christians in the UK: towards enhanced health services utilisation

Supervisor's name (include support email): Prof. Olga van den Akker *(o.vandenakker@mdx.ac.uk),* Dr. Camille Alexis-Garsee (c.alexis-garsee@mdx.ac.uk)

2   Reviewer's decision (ethics committee member to complete)

<mark>**APPROVE**</mark>	X but see comments under 2c
APPROVE SUBJECT TO LETTERS OF AGREEMENT FROM COLLABORATING INSTITUTION(S)	

REVISE AND RESUBMIT	
NOT APPROVED	

Appendix 2. Information Sheets for Study 1

Appendix 2:1. Information sheet for the Interviews

Middlesex University School of Health and Education

Psychology Department

Town Hall, The Burroughs, Hendon, London NW4 4BT

Information Sheet (Introductory note)

I am a postgraduate student of Middlesex University, London researching on the Health-seeking behaviour of Nigerians in the UK. To collect the required data for this doctoral research, I am inviting you to take part in a one-hour, face-to-face interview, at the Youth Club Hall - St. John Fisher Church, Bexley London DA5 1AP.

If you decide to participate, it is important that you know the aims and purposes of the research, as well as how you will be involved as a participant before signing the consent form. Therefore, can you please, take time to read through the attached Information Sheet.

You can discuss this with others if you so wish and feel free to ask me for clarifications if there is anything not clear to you.

Thank you.

Onyigbuo Chineme

Middlesex University

School of Health and Education

The Town Hall

The Burroughs, Hendon

London NW4 4BT

(CO540@live.mdx.ac.uk, 07402224527)

STUDY TITLE: Exploring health-seeking behaviour among Nigerians in the UK.

This study explores how Nigerians in the UK make use of health care services to get well during illness/symptoms, such as the GP/Hospitals, or religious healing services. This knowledge base will inform policy and practice towards possible collaboration between health professionals and complementary health workers, in providing adequate health care services to Nigerians in the UK.

You are free to participate and to withdraw at any time without having to give any reasons. If you decide to take part, you will sign and keep a copy of the consent form and the information sheet (attached), which I will also keep safe with other documents. Then, you will be expected to take part in a one-to-one interview conducted in the English language, for about 1 hour at the Youth Club Hall - St. John Fisher Church, Bexley London DA5 1AP.

Your participation will be kept confidential, as no names or information you give during the interview will be disclosed to any other person or organisation, and real names are changed. All information will be secured in a pass-word protected computer. At the completion of study, we can send you a general summary of the result on request.

There is no financial interest attached to this project, and if you have any questions or concerns please feel free to contact Prof. Olga van den Akker *(o.vandenakker@mdx.ac.uk)* at Middlesex University, School of Health and Education, The Town Hall (TG61); The Burroughs, Hendon London NW4 4BT, or call Tel: 0208 411 6953, Fax: 0208411 4259.

For further assistance*,* you can contact your ethno-cultural group on 07961415558/07903845717 (ncchap@nigcathchap.org.uk), and for health reasons, please contact The NHS 24-hour helpline on 0845 4647.

Thank you for your time.

Chineme Onyigbuo

Middlesex University

School of Health and Education

The Town Hall

The Burroughs, Hendon

London NW4 4BT

(CO540@live.mdx.ac.uk, 07402224527)

Appendix 2:2. Information Sheet for the Focus Group

Middlesex University School of Health and Education

Psychology Department

Town Hall, The Burroughs, Hendon, London NW4 4BT

Information Sheet (Introductory note)

I am a postgraduate student of Middlesex University, London researching on the Health-seeking behaviour of Nigerians in the UK. To collect the required data for this doctoral research, I am inviting you as one of 7 participants in a focus group interview, scheduled for about 2 hours at the Youth Club Hall - St. John Fisher Church, Bexley London DA5 1AP.

If you decide to participate, it is important that you know the aims and purposes of the research, as well as how you will be involved as a participant before signing the consent form. Therefore, can you please, take time to read through the attached Information Sheet.

You can discuss this with others if you so wish and feel free to ask me for clarifications if there is anything not clear to you.

Thank you.

Onyigbuo Chineme

Middlesex University

School of Health and Education

The Town Hall

The Burroughs, Hendon

London NW4 4BT

(CO540@live.mdx.ac.uk, 07402224527)

STUDY TITLE: Exploring health-seeking behaviour among Nigerians in the UK.

This study explores how Nigerians in the UK make use of health care services to get well during illness/symptoms, such as the GP/Hospitals, or religious healing services. This knowledge base will inform policy and practice towards possible collaboration between health professionals and complementary health workers, in providing adequate health care services to Nigerians in the UK.

You are free to participate and to withdraw at any time without having to give any reasons. If you decide to take part, you will sign and keep a copy of the consent form and the information sheet (attached), which I will also keep safe with other documents. Then, you will be expected to take part in a focus group interview conducted in the English language, and lasting for about 2 hours at the Youth Club Hall - St. John Fisher Church, Bexley London DA5 1AP.

Your participation will be kept confidential, as no names or information you give during the interview will be disclosed to any other person or organisation, and real names are changed. All information will be secured in a pass-word protected computer. At the completion of study, we can send you a general summary of the result on request.

There is no financial interest attached to this project, and if you have any questions or concerns please feel free to contact Prof. Olga van den Akker *(o.vandenakker@mdx.ac.uk)* at Middlesex University, School of Health and Education, The Town Hall (TG61); The Burroughs, Hendon London NW4 4BT, or call Tel: 0208 411 6953, Fax: 0208411 4259. For further assistance, you can contact your ethno-cultural group on 07961415558/07903845717 (ncchap@nigcathchap.org.uk), and for health reasons, please contact The NHS 24 hour helpline on 0845 4647.

Thank you for your time.

Chineme Onyigbuo

School of Health and Education

The Town Hall

The Burroughs, Hendon

London NW4 4BT

(CO540@live.mdx.ac.uk, 07402224527)

Appendix 3. Informed Consent Form - Study 1

Middlesex University School of Health and Education

Psychology Department

Written Informed Consent

Title of study: Exploring health-seeking behaviour among Nigerians in the UK: towards enhanced quality of life.

Researcher's name: Onyigbuo Chineme   **(CO540@live.mdx.ac.uk)**

Supervisor's name and email*:* Prof. Olga van den Akker *(*o.vandenakker@mdx.ac.uk*), and* Dr. Camille Alexis-Garsee (c.alexis-garsee@mdx.ac.uk)

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and I provide my consent that this may occur.

_____   _____

Print name   Sign Name

date: _____

To the participant: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Health and Education Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

Appendix 4: Debrief Sheet - Study 1

Middlesex University School of Health and Education, Psychology Department

Town Hall, The Burroughs, Hendon, London NW4 4BT

STUDY TITLE: Exploring health-seeking behaviour among Nigerians in the UK: towards enhanced quality of life.

Thank you for taking part in this research about health-seeking behaviour among Nigerians living in the UK. It is expected that the findings may assist professionals in health, education, integration, as well as policy makers towards an integrative scheme that will involve aspects of Nigerian culture/religion in addressing health inequalities among this group.

At the end of this research, a summary of the result can be made available to you on request. If this happens to be published, your personal details and responses will not be identifiable or shared with any other person(s) or organisation. Furthermore, you reserve the right to withdraw from the research at any stage, by contacting Prof. Olga van den Akker at: o.vandenakker@mdx.ac.uk, or Dr. Camille Alexis-Garsee at: c.alexisgarsee@mdx.ac.uk.

For advice on general issues about life in the UK, please contact the Citizens Advisory Bureau: http://www.citizensadvice.org.uk, and to contact Nigerian ethno-cultural or religious groups please see links to the website for Ethnic Chaplaincies and Faith Groups in the UK. For access to health care services, please contact The NHS 24 hour helpline at 0845 4647, www.nhsdirect.nhs.uk.

Thanks.

Chineme Onyigbuo

Middlesex University

School of Health and Education

The Town Hall, The Burroughs, Hendon

London NW4 4BT

CO540@live.mdx.ac.uk, 07402224527)

Appendix 5. Interview protocol - Study 1

This is an open ended semi-structured interview, with no right or wrong answers. Therefore, you are expected to respond freely according to your personal opinion and experiences.

It is not compulsory that all participants must respond to all questions but please try to air you views on any issues if you feel confident enough to do so. Researcher may use follow-up question to redirect the discussion or to elicit more information where necessary.

Please, before/during the interview, you will be required to provide the following demographic information (optional for inclusive criteria only) to help with data analysis and discussion:

1. Nigeria state of origin

2. Religious affiliation

3. Highest level of education

4. Occupation/profession

5. Age range 20-30 (   ) 31-40 (   ) 41-50 (   ) 51-60 (   ) over 60 (   )

Interview questions

1. Tell me what helps you most while settling to life in the UK.
2. How can you explain your overall understanding of feeling unwell?
3. How would you look for help when you fell unwell?
4. Tell me the most important aspect of your actions to getting treatment/cure during illness.
5. Could you tell me more about your experiences trying to get medical help during illness?
6. What is your opinion about using spiritual healing when feeling unwell?
7. Please tell me what can influence your choices of using either medical or spiritual healing services if unwell.
8. How would you explain any difficulties getting faith-healing services if unwell?
9. Could you please tell me about any other ethod you use in getting well during illness?
10. Please tell me about any aspect of these services you feel could be improved.
11. Please feel free to make your own contributions now.

Appendix 6. Authorisation letter for interview venue (Study 1)

Tel: 01322-524813

CHURCH OF ST. JOHN FISHER,
48 THANET ROAD,
BEXLEY DA5 1AP.

The Ethics Committee
Middlesex University
School of Health and Education
Psychology Department
Town Hall
The Burroughs, Hendon,

London NW4 4BT

25/11/2013

Dear Sir/Madam

Interview Venue: Permission

In view of the above subject matter, permission is hereby granted for the use of our Youth Club Hall at St. John Fisher Church, Bexley.

This is a safe and quiet centre fit for interviews. Health and safety measures are guaranteed as it is a registered centre used for various ethno-cultural, social and religious activities. I hope you will find it useful.

Thanks.

Yours faithfully,

Rev. Christian Onyigbuo
(Administrator)

(R C Diocese of Southwark. Registered Charity 235468)

Appendix 7. ETHICAL APPROVAL FOR STUDIES 2 & 3

Middlesex University Department of Psychology

STUDENT Application for Ethical Approval

No study may proceed until approval has been granted by an authorised person. For collaborative research with another institution, ethical approval must be obtained from all institutions involved. Since you need your supervisor approval, the completed form should be emailed to your supervisor from your <u>University</u> email account (...@live.mdx.ac.uk), as this acts as an electronic signature. Your supervisor will then send your application to the Ethics Committee (Psy.Ethics@mdx.ac.uk), as this will act as her/his approval.

This form consists of 8 sections: 1   Summary of Application and Declaration

2	Reviewer's decision and feedback
3	Research proposal
4	Ethical questions
5	Information sheet
6	Informed consent
7	Debriefing
8	Risk assessment (required if research is to be conducted away from Middlesex University property, otherwise leave this blank. Institutions/locations listed for data collection must match original letters of acceptance)

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1   Summary of application (researcher to complete)

Name: ONYIGBUO CHINEME C.   **Student number: M00428762**

Degree: (delete as appropriate)   MPhil/PhD

Title of proposal: A two-cohort cross-cultural study on the health-seeking behaviours of Nigerians from the perspectives of Nigerian care providers in Nigeria and the UK: challenges for collaboration

Supervisor's name (include support email):   Prof. Olga van den Akker *(o.vandenakker@mdx.ac.uk),* Dr. Camille Alexis-Garsee (c.alexis-garsee@mdx.ac.uk)

2   Reviewer's decision (ethics committee member to complete)

<mark>APPROVE</mark>	X
APPROVE SUBJECT TO LETTERS OF AGREEMENT FROM COLLABORATING INSTITUTION(S)	

REVISE AND RESUBMIT	
NOT APPROVED	

Appendix 8.   Information sheet as amended - Studies 2 & 3

Middlesex University School of Health and Education

Psychology Department

Town Hall, The Burroughs, Hendon, London NW4 4BT

Study Title: A cross-cultural study exploring the process of collaboration among Nigerian caregivers in Nigeria and the UK.

I am a postgraduate student of Middlesex University, London. I am undertaking a cross-cultural study on collaboration among the clergy and health professionals. This will explore, and compare the processes of collaboration among Nigerian Christian clergy and healthcare professionals working in Nigeria and the UK, within the context of their relevance to providing an integrative health intervention that is acceptable and accessible to service users, both in Nigeria and the UK. This is relevant, given the understanding that caregivers might focus more on using the therapy skills within their specialisation. This knowledge base will therefore, inform policy and practice towards an integrative, culture-context health-seeking approach that yields more positive health outcome among the population.

To collect the required data for this study, your help and cooperation is required by agreeing to take part in a 2.5 hours focus group discussion at the Ofu-Obi Africa Centre, Enugu. This will be conducted in the English language, tape-recorded, and subsequently destroyed at the end of the study. Your participation will be kept confidential, as no names or information you give during this process will be disclosed to a third party without your consent. Your real names are not used, and all information will be secured in a pass-word protected computer. However, you are free to withdraw from participation at any time without having to give any reasons.

If you decide to take part, you will sign and keep a copy of the consent form (attached) together with this Information Sheet, which the researcher will also keep safe. You can discuss this with others if you so wish, and feel free to ask me for clarifications if you want to. There is no financial interest attached to this project, and if you have any questions or concerns please feel free to contact Prof. Olga van den Akker *(o.vandenakker@mdx.ac.uk)* or Dr. Camille Alexis-Garsee (c.alexis-garsee@mdx.ac.uk) at Middlesex University, School of Health and Education, The Burroughs, Hendon London NW4 4BT, or call Tel: 0208 411 6953, Fax: 0208411 4259. At the completion of study, we can send you a general summary of the result on request.

Thank you.

Onyigbuo Chineme

Middlesex University

School of Health and Education

The Town Hall, The Burroughs, Hendon

London NW4 4BT **(c.onyigbuo@mdx.ac.uk, 07402224527)**

Appendix 9. Informed consent (Studies 2 & 3)

Middlesex University School of Health and Education

Psychology Department

Written Informed Consent

Title of study: A cross-cultural study exploring the process of collaboration among Nigerian caregivers in Nigeria and the UK.

Researcher's name: Onyigbuo Chineme **(c.onyigbuo@mdx.ac.uk)**

Director's name and email*:* Prof. Olga van den Akker *(*o.vandenakker@mdx.ac.uk*)*

Supervisor's name and email: Dr. Camille Alexis-Garsee (c.alexis-garsee@mdx.ac.uk).

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and I provide my consent that this may occur.

_____   _____

Print name   Sign Name

date: _____

To the participant: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Health and Education Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

Appendix 10:1

Debriefing for the Nigerian participants (Study 2).

Middlesex University School of Health and Education

Psychology Department

Town Hall, The Burroughs, Hendon, London NW4 4BT

DEBRIEF SHEET

Study Title: A cross-cultural study exploring the process of collaboration among Nigerian caregivers in Nigeria and the UK.

Thank you for taking part in this research about the process of collaboration among Nigerian Christian caregivers and healthcare professionals both in Nigeria and the UK.

Spirituality is largely beneficial for people's health and wellbeing. But, health professionals have difficulties integrating it into their support skill. Hence, the likelihood that professionals might focus more on their treatment skills while assisting patients, necessitates the need for collaboration. It is expected that findings from this study may assist the clergy and professionals in health, education, integration, as well as policy makers towards an integrative scheme that will involve aspects of Nigerian culture and religion in addressing health inequalities among this group.

At the end of this research, a summary of the result can be made available to you on request. If this happens to be published, your personal details and responses will not be identifiable or shared with any other person(s) or organisation. For help with any personal issues arising from this focus group discussion, please contact your local doctor or spiritual leader for help.

Thanks.

Chineme Onyigbuo

Middlesex University

School of Health and Education

The Town Hall

The Burroughs, Hendon

London NW4 4BT

(CO540@live.mdx.ac.uk,07402224527)

Appendix 10:2

Debriefing for the UK participants (Study 3).

Middlesex University School of Health and Education

Psychology Department

Town Hall, The Burroughs, Hendon, London NW4 4BT

DEBRIEF SHEET

Study Title: A cross-cultural study exploring the process of collaboration among Nigerian caregivers in Nigeria and the UK.

Thank you for taking part in this research about the process of collaboration among Nigerian Christian caregivers and healthcare professionals both in Nigeria and the UK.

Spirituality is largely beneficial for people's health and wellbeing. But, health professionals have difficulties integrating it into their support skill. Hence, the likelihood that professionals might focus more on their treatment skills while assisting patients, necessitates the need for collaboration. It is expected that findings from this study may assist the clergy and professionals in health, education, integration, as well as policy makers towards an integrative scheme that will involve aspects of Nigerian culture and religion in addressing health inequalities among this group.

At the end of this research, a summary of the result can be made available to you on request. If this happens to be published, your personal details and responses will not be identifiable or shared with any other person(s) or organisation. For further advice if you need to talk to someone about more personal issues, please contact the Samaritans on www.samaritans.org phone number: 08457909090, or the Churches' Ministerial Counselling Services (CMCS) on www.cmincs.net/for-counsellors, phone number: 01235517715.

Chineme Onyigbuo

Middlesex University

School of Health and Education

The Town Hall

The Burroughs, Hendon

London NW4 4BT

([CO540@live.mdx.ac.uk,07402224527](CO540@live.mdx.ac.uk))

Appendix 11

Interview Protocol (Studies 2 & 3): An Introduction

This is an open ended semi-structured interview, with no right or wrong answers. Therefore, you are expected to respond freely according to your personal opinion and experiences. All participants must not respond to all questions but please try not to keep back any responses whenever you feel you have something to contribute. Researcher may use follow-up question to redirect the discussion or to elicit more information where necessary.

For the purpose of this interview, the term 'caregiver' is used to represent all persons who are consulted/contacted by patients seeking to regain good health and wellbeing; and they in turn could use any means to help these patients. The term 'healthcare provider' is used for professionals trained within the medical and/or psychological sciences (doctors, nurses, psychologists, etc.) as distinct from other caregivers who are regarded as gatekeepers (clergy, herbalists, homeopaths, etc).

Before continuing with the interview, please provide the following demographic information to help put the responses into context.

1. Age.

2. Gender

3. Profession

4. Length of time in the profession

5. Length of stay in the UK   (for UK residents only)

6. Christian denomination

7. State of origin

Sample Questions:

1. Please explain various methods Nigerians use to get well when ill.
2. What are the main illnesses/health problems people bring to you for help?
3. Explain the level of training/skill and preparedness you have in providing a cure to Nigerians, and what factors can influence this?
4. Please explain the method(s) you use to help patients who come to you during illness

   4b. could you tell me your experiences of applying other treatment methods to patients apart from your specialty? What can influence this decision?

   4c. please describe to me what can influence your choice of prescribing medical/psychological services or spiritual healing/prayer for patients who come to you for help.

5. What is your opinion of Christian clergy/religious ministers providing cure/healing for patients in Nigeria or the UK?
6. What is your understanding of the activities of health professionals towards helping patients in Nigeria or the UK?
7. What challenges do health workers and Christian religious ministers encounter while providing cure/healing to patients in Nigeria or the UK?
8. How can you explain the factors influencing Nigerian patients choosing healthcare or spiritual treatment?

   11a. what other methods do they use?

9. Please explain the level of willingness among health professionals to accommodate/incorporate spiritual healing in their treatment technique and what can influence this?
10. Could you explain your experiences of working with other professionals (healthcare providers or clergy) outside your field?
11. What are the challenges of working with other care providers who use other approaches different from yours?
12. Please tell me your experiences of referral to and or from other caregivers. What can influence such cross referrals?
13. Could you explain your view of combining medical, psychological, herbal, and spiritual methods for treatment?
14. What are the challenges of combining medical, psychological, spiritual, and herbal medicine to help Nigerian patients and how can we overcome them?
15. What can be done to provide a better treatment system for patients in Nigeria and the UK?
16. Please feel free to make your contribution if you would like to.

Appendix 12. Permissions to use venues (Studies 2 & 3)

Appendix 12:1. Authorisation letter for interview venue in Nigeria – Study 2.

Ofu Obi Africa Centre

3-5 Ofuobi Street
Independence Layout
Enugu

The Ethnics Committee
Middlesex University
School of Health and Education
Psychology Department
Town Hall
The Burroughs, Henldon
London NW4 4BT

20/11/2013

Dear Sir/Madam,

PERMISSION FOR INTERVIEW VENUE

In view of the above subject matter, permission is hereby granted for the use of our mini conference hall at the Ofu-Obi Africa Center, (CIDJAP) Enugu, Nigeria.

This is a safe and quiet multi-purpose centre fit for interviews. Health and safety measures are guaranteed as it is used for various ethno-cultural, social and religious activities. I am confident you will find it useful for your purpose.

Thanks.

Yours faithfully,

Everistus Onyigbuo
(Manager)

Catholic Institute for Development,
Justice, Peace and Caritas   CIDJAP

Appendix 12:2. Authorisation letter for UK interview venue – Study 3.

Tel: 01322-524813

CHURCH OF ST. JOHN FISHER,
48 THANET ROAD,
BEXLEY DA5 1AP.

The Ethics Committee
Middlesex University
School of Health and Education
Psychology Department
Town Hall
The Burroughs, Hendon,
London NW4 4BT

15/08/2013

Dear Sir/Madam

Research Interview Venue

In view of the need for a safe and neutral centre for the above subject matter, permission is hereby granted for the use of our Youth Club Hall at St. John Fisher Church, Bexley.

This is a safe and quiet centre fit for interviews. Health and safety measures are guaranteed as it is a registered centre booked for various ethno-cultural, social and religious activities.

Thanks.

Yours faithfully,

Rev. Christian Onyigbuo
Parochial Administrator

(R C Diocese of Southwark. Registered Charity 235468)

Appendix 13

Ethical Approval - Study 4

Middlesex University Department of Psychology

STUDENT Application for Ethical Approval

No study may proceed until approval has been granted by an authorised person. For collaborative research with another institution, ethical approval must be obtained from all institutions involved. Since you need your supervisor approval, the completed form should be emailed to your supervisor from your <u>University</u> email account (...@live.mdx.ac.uk), as this acts as an electronic signature. Your supervisor will then send your application to the Ethics Committee (Psy.Ethics@mdx.ac.uk), as this will act as her/his approval.

This form consists of 8 sections: 1   Summary of Application and Declaration

         2   Reviewer's decision and feedback
         3   Research proposal
         4   Ethical questions
         5   Information sheet
         6   Informed consent
         7   Debriefing
         8   Risk assessment (required if research is to be conducted away from Middlesex University property, otherwise leave this blank. Institutions/locations listed for data collection must match original letters of acceptance)

---

1   Summary of application (researcher to complete)

Name: ONYIGBUO CHINEME C.   Student number: M00428762

Degree: (delete as appropriate)   MPhil/PhD

Title of proposal: A Survey on the impact of acculturation, religion, and coping methods on seeking medical help among Nigerians in the UK.
Supervisor's name (include support email):   Prof. Olga van den Akker *(o.vandenakker@mdx.ac.uk),* Dr. Camille Alexis-Garsee (c.alexis-garsee@mdx.ac.uk)

2   Reviewer's decision (ethics committee member to complete)

APPROVE	X
APPROVE SUBJECT TO LETTERS OF AGREEMENT FROM COLLABORATING INSTITUTION(S)	

REVISE AND RESUBMIT	
NOT APPROVED	

Appendix 14. Information sheet (Study 4)

Psychology Department

Hendon

London NW4 4BT

Chineme Onyigbuo

(CO540@live.mdx.ac.uk, 07402224527)

15/072015.

Title: A survey on the impact of acculturation, coping methods, and religion on health seeking behaviours of Nigerians in the UK.

I am a doctoral research student at Middlesex University, London and I would like to invite you to participate in this study on the impact of acculturation, coping methods and religion/culture on seeking medical help among Nigerians in the UK. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, discuss it with others and ask me for clarifications if you wish. It is expected that the findings from this study will assist professionals in health, education, integration, as well as policy makers to enhance adequate health services utilisation among Nigerians living in the UK. This may involve aspects of integrating Nigerian cultural and religious life in addressing health inequalities among this group. To take part, you will be required to complete a set of questionnaires on your experiences of integration into the UK culture, actions taken to cope with the challenges of coming to live in the UK, as well as willingness to seek medical help in the circumstance that you become ill. It can take about 45 minutes to complete the questionnaire at your convenient time and place. Each questionnaire is identified by a unique reference number (serial numbers: 01-500) which should be noted by you, the participant, for reference purposes. If you decide to participate, your completion of the questionnaire will imply your informed consent; which I will keep safe.

Your participation is confidential since all data will be treated as group data only, and will be published at the end of analysis. Your participation is entirely voluntary, and you are free to withdraw at any time during your participation without giving any reasons. To do this, you will have to contact me (CO540@live.mdx.ac.uk, 07402224527) before data analysis begins in December 2015, indicating your intention to withdraw your data and citing your questionnaire reference number. There is no risk known to be associated to this study, and it has been reviewed by The Middlesex Psychology Department's Ethics Committee.

Thanks.

Chineme Onyigbuo

Appendix 15.   Debriefing (Study 4)

Psychology Department

Hendon

London NW4 4BT

Chineme Onyigbuo (CO540@live.mdx.ac.uk, 07402224527)

15/072015.

Title: A survey on the impact of acculturation, coping methods, and religion on health seeking behaviours of Nigerians in the UK.

Thank you for taking part in this survey about acculturative factors and determinants of health-seeking behaviour among Nigerians living in the UK. This study is designed to investigate if the level of acculturation, coping styles and religiosity do influence attitudes to seeking medical/psychological help among Nigerians in the UK.

It is anticipated that participants who express high level of integration into the UK culture will show more intentions to use professional coping styles and seek medical help than those who rely more on their heritage culture. Consequently, those who maintain the African/Nigerian religious and cultural attitudes to illness, or those who are more religious will show lesser intention towards using professional coping styles or medical help in cases of stress/illness. Therefore, this outcome will show that religion is a stronger predictor of healthcare utilisation than acculturation and coping styles; irrespective of length of residence in the UK, religious affiliation, and educational qualification.

This finding will contradict recent suggestions that traditional African beliefs and their influences on illness attribution and health seeking behaviours are consigned to history due to the influences of globalisation and Western education. It is hoped this study will assist professionals in health, education, integration, as well as policy makers to enhance adequate means of making the health services more attractive to minority immigrants groups. This will be beneficial to Nigerians as it may involve aspects of integrating Nigerian cultural and religious life in addressing health risks and inequalities among the UK population.

For advice on general issues about life in the UK, please contact the Citizens Advisory Bureau: http://www.citizensadvice.org.uk; and further medical help, please contact The NHS 24 hour helpline at 0845 4647, www.nhsdirect.nhs.uk. Should there be any concerns arising from the manner in which this study is conducted, please feel free to contact the project director – Prof. Olga van den Akker (o.vandenakker@mdx.ac.uk, 0208 411 6953).

Once more, thank you for the time and effort in being part of this research.

Thanks.

Appendix 16. Questionnaire Package (Study 4)

16:1. Instructions and socio-demographic information

This is a questionnaire containing 58 items in 3 sections dealing with acculturation, coping styles, and attitudes toward seeking medical Help. Each section has a specific instruction to help you in answering the questions. By completing this questionnaire, you are accepting that you have understood the details of the research as explained by the researcher, and confirm that you have consented to act as a participant. You understand that your participation is entirely voluntary, the data collected during the research will not be identifiable, and that you have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so. You also accept that the data you provide may be used for analysis and subsequent publication.

If you wish to continue, please provide the following demographic information before moving over to the next section. And please seal and return your completed questionnaire in the envelope provided.

- Your gender: F (   ) M (   )
- How long have you lived in the UK?   …………..
- What is your age range: 18-30 (   ) 31-40 (   ) 41-50 (   ) 51-60 (   ) 61- 70 (   ) 71– 80 (   ) 81 – above (   )
- What is your religious affiliation/denomination? ………………..
- What is your level of education? Graduate (   ), non-graduate (   )
- What is your profession? ……………………..

16:2. The MASPAD

Instructions: This section tries to understand the relative preference of you maintaining your African religious and cultural values as a Nigerian compared to your preference for participating and adopting the British way of life. Please answer each question as honestly as you possibly can by identifying the responses that best reflects your agreement/disagreement to each item:

Strongly disagree (1) disagree (2) slightly disagree (3) slightly agree, (4) agree, (5) strongly agree (6)

There are no right or wrong answers. Provide only one response to each item by choosing the number that represent each statement (1 to 6) in the bracket provided.

1. I take a great deal of pride in being a person of African ancestry (African, African American, Black Cuban, Black Brazilian, Trinidadian, and Jamaican). (   )
2. If I have children, I will give them an African naming ceremony. (   )
3. I do not feel connected to my African heritage. (   )
4. If I have children, I will raise them to be British first and a person of African ancestry second. (   )
5. I was raised to maintain cultural practices that are consistent with people of African descent. (   )
6. I have difficulty accepting ideas held by the Black community. (   )
7. I tend to generate friendships with people from different racial and cultural backgrounds. (   )
8. I was socialized to treat my elders with respect. (   )
9. I am comfortable putting on the *mask* in order to fit in. (   )
10. Despite facing potential discrimination, it is important for me to maintain my cultural beliefs. (   )
11. I behave in ways that are consistent with people of African ancestry even if other cultural groups do not accept it. (   )
12. The way that I behave in public (work, school, etc.) is different than hw I behave at home. (   )
13. I consider myself to be a spiritual person. (   )
14. I consider myself to be a religious (Christian, Catholic, Muslim, etc.) person. (   )
15. I prefer to be around people that are not black. (   )
16. I actively support Black owned businesses. (   )
17. People should modify many of their values to fit those of their surroundings. (   )
18. My beliefs are largely shaped by my religion (Christianity, Catholicism, Islam, etc.). (   )
19. I believe festivals maintain spiritual and physical balance in my community. (   )
20. I perform various rituals for my departed ancestors. (   )
21. I see no problem assimilating into other cultural values in order to be financially successful. (   )
22. People of African descent should know about their rich history that began with the birth of humanity. (   )
23. I am actively involved in an African spiritual system. (   )
24. I use words from n African language when participating in my spiritual practices. (   )
25. I do not purchase products from Black owned businesses. (   )
26. I will probably marry someone that is not Black. (   )
27. Members of my culture should have an appreciation for African art and music. (   )
28. I expose myself to various forms of media (television, magazines, newspapers, internet, etc.) in order to keep up with current events that impact my people. (   )
29. I choose not to speak out against injustices that impact people of African descent. (   )
30. I express different cultural values in order to fit in. (   )

16:3. The Brief COPE

The Brief COPE: Instructions: Items in this section deal with ways you've been coping with the stress in your life since you came to live in the UK. Because individuals are different, we deal with things in different ways, but I want to know how you've tried to deal with the challenges of living in the UK as an immigrant. Each item says something about a particular way of coping, and I'm interested in how much or how frequently you've been doing what the item says. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Please try to rate each item separately in your mind from the others; and make your answers as true FOR YOU as you can, choosing from the response choices below (1- 4).

1. = I haven't been doing this at all   **2. = I've been doing this a little bit**
3. = I've been doing this a medium amount   **4. = I've been doing this a lot**

1. I've been concentrating my efforts on doing something about the situation I'm in. ( ).
2. I've been saying to myself "this isn't real." (   ).
3. I've been getting emotional support from others. (   ).
4. I've been giving up trying to deal with it. (   ).
5. I've been taking action to try to make the situation better. (   ).
6. I've been refusing to believe that it has happened. (   ).
7. I've been saying things to let my unpleasant feelings escape. (   ).
8. I've been getting help and advice from other people. (   ).
9. I've been getting comfort and understanding from someone. (   ).
10. I've been giving up the attempt to cope. (   ).
11. I've been criticizing myself. (   ).
12. I've been expressing my negative feelings. (   ).
13. I've been trying to find comfort in my religion or spiritual beliefs. (   ).
14. I've been trying to get advice or help from other people about what to do. (   ).
15. I've been blaming myself for things that happened. (   ).
16. I've been praying or meditating. (   ).

16:4. The action/intention medical help-seeking sub-scale

<u>Instructions:</u> These items deal with your intentions or actions towards finding professional medical help if you should become ill. The aim is to know how you've tried to deal with illnesses in the past or what you may do if it happens in the future. Most items have something about what you may do in a particular case of ill health and possible reasons for such action, and I'm interested in knowing the extent you agree or disagree with such statements applying to you. Don't answer on the basis of what you think is proper to do, but what you have actually done or believe you could do in the case of the condition actually happening. Please try to rate each item separately in your mind from the others; and make your answers as true FOR YOU as you can, using the following response choices: **(3)** *Agree, (2) partly agree, (1) partly disagree, and (0) disagree.*

1. I would rather live with some physical problems than go through a lot of medical tests and check-ups   (   ).

2. I would want to get medical help right away if I had a health problem that was worrying me (   ).

3. If I have what I think is a medical symptom (such as continuous pain or a suspicious lump), I go to the doctor right away to have it checked (   ).

4. Considering all the time and expense connected with medical check-ups, and the inconclusive results they come up with, routine check-ups are hardly worth the bother (   ).

5. I always have a doctor that I trust, who knows me and my medical situation thoroughly ( ).

6. When I have doubts or questions about my physical health I find out what is wrong from a medical professional (   ).

7. I would never go for more than a year without seeing my doctor, at least for a check-up ( ).

8. If I had a physical problem that I thought could be serious I would contact a doctor or go to a hospital emergency room without hesitation (   ).

9. I would willingly talk about personal problems with a doctor if I thought it could help me, or a member of my family (   ).

10. If I have a serious symptom such as continuous pain, bleeding, or coughing, I call for an appointment right away (   ).

11. Even when I know I probably should go to the doctor, I tend to put it off (   ).

12. If I believed I had a potentially serious medical problem my first action would be to get professional attention for it (   ).

Appendix 17:1

Permission to adapt and use the MAPAD Scale (Personal communication)

This makes sense to me and you have my permission to make the necessary modifications.

Best,

Dr. Obasi

Ezemenari M. Obasi, Ph.D.
Associate Professor

Department Chair, **PHLS**
University of Houston

491 Farish Hall

Houston, TX 77204
emobasi@uh.edu

http://hahdl.coe.uh.edu

Appendix 17:2

Permission to use the Attitudes towards medical help-seeking Scale (Personal communication)

Dear Chineme,

I appreciate your interest in our measure and am happy to provide permission to use it.

I would be interested in learning the results of your study. Please send me an update once

you have analyzed your data.

Good luck with your project.

Best Regards,

Terry DiLorenzo

Terry DiLorenzo, PhD

Chair, Committee on Academic Standards

Associate Professor of Psychology

Stern College for Women, Yeshiva University

245 Lexington Avenue

New York, NY 10016

dilorenz@yu.edu

212-340-7879

Appendix 18:1 Published Article (Study 1)

Content removed due to third party copyright issues. Article: Onyigbuo, C.C., Alexis-Garsee, C. and van den Akker, O., 'An exploration of health-seeking behaviours among Nigerian Christians in the UK: towards enhanced health services utilisation', *Mental Health, Religion and Culture* (2016), 19:3, 255-267.

http://dx.doi.org/10.1080/13674676.2016.1166357

.

Appendix 18:2 - Published article (Study 2)

Content removed due to third party copyright issues. Article: Onyigbuo, C.C., van den Akker, O., and Alexis-Garsee, C. 'A cross-cultural study of the health-seeking behaviours of Nigerians from the perspective of Nigerian care providers: challenges for collaboration', *Humanities and Social Sciences Review,* (2015), 4:3, 537-554.

Appendix 19

Study 3 IPA analytic process: steps 1-3

Step 1. Importing and coding of data set into the Nvivo software (Nvivo not included)

Step 2: Identification of themes using the Nvivo references in step 1.

Participant 1:

Eni: (Internals\\Interviews\\IPA Interview with Eni> - § 23 references coded [42.49% Coverage]

Reference 1 - 1.32% Coverage

Lines 4-5: When you talk of Nigerian Christians we are basically based, treat-based people, and the first thing the Nigerian will think of when they are sick is prayers (Methods)

Reference 2 - 2.42% Coverage

Lines 11-14: Well its mainly personal conviction that will influence it. Personal conviction of 1) the person that is sick and also the influence one has on them. If you have influence on your members or people coming to you they basically will listen to you and follow what you are saying. (Determinants)

Reference 3 - 1.02% Coverage

Lines 16-17: General, generally except if it is terminal. Most times Nigerians will not say they are sick until it is serious. (<mark>Barriers</mark>)

Reference 4 - 0.90% Coverage

Lines 21-22: our attitude to health check is not so good. (<mark>Barriers</mark>)

Reference 5 - 0.60% Coverage

Line 34: Well basically it's more of counselling, counselling and prayers. (<mark>Practices</mark>)

Reference 6 - 0.59% Coverage

Line 39: Well if you, basically you are talking of our faith-based method. (<mark>Practices</mark>)

Reference 7 - 1.12% Coverage

Lines-45-46: No am not a medical practitioner, all I do is pray for people and counsel them to go and seek medical attention in the hospital. (<mark>Practices</mark>)

Reference 8 - 2.61% Coverage

Lines 49-52: Ya it depends on the, like I said earlier it depends on the personality, the person that comes to you and their faith belief. The level of faith, some will come up and they don't have faith, they just want to rely on what you are telling them, and if you are not careful you can influence them negatively. (<mark>Determinants</mark>)

Reference 9 - 4.37% Coverage

Lines 56-61: Well it is in two fold. There are some ministers that are medically trained, so there are some men of God who are medically trained which you can't, you can't, you know, exempt them from, you know, doing both. Then there are some that are in the hospital, like we call them, what do you call them now? Hospital chaplains, (Integration)

Reference 10 - 1.44% Coverage

Lines 66-67: Well I think in the UK for instance, because of the standard way of doing things medically, so it is more regulated (Challenges)

Reference 11 - 1.45% Coverage

Lines 75-76: Well, basically challenges that could come could be, you know, the attitude of the patient. Some patients will not want you to, because of their beliefs, religious beliefs. (Barriers)

Reference 12 - 1.74% Coverage

Lines 79-81: …dying because of that foolish belief, sorry to say. And then, then it also depends on the personality of the person. Some because of plain, low plain threshold, they will not allow you to treat them fully, (Barriers)

Reference 13 - 4.42% Coverage

a. Lines 85-90: Well I don't know now, maybe it's changing in both because of the spiritual level of the country we are in the UK. The spiritual level of many people here now is so low and then their belief in God is so low and so the willingness to incorporate spiritual healing is…. at its lowest ebb. (Challenges)

b. But am glad that recently I went to visit Queen Elizabeth in Lewisham, em, in Woolwich and I discovered that there is a chaplain there. And then he gave me good and beautiful testimonies of what God is doing through him in the hospital, (Integration)

Reference 14 - 2.02% Coverage

Lines 94-96: Anticipated challenges! Just the belief, I believe strongly in the power of God to heal you and that's what I hold unto. If anything, if anything happens to me or those around me the first thing I do is to pray, because prayer works. (Provider's beliefs)

Reference 15 - 1.29% Coverage

Lines 97-98: But don't condemn them, all you need do is believe in what you are doing and when they see that it's working they will probably join you later. (Provider's beliefs)

Reference 16 - 2.04% Coverage

Lines 102-104: Well like I said earlier, we still refer people, believers and members that come to us, parishioners and say, 'look, we've prayed, but go to the hospital and get checked and the experiences has, combining both has been quite encouraging.

(Integration)

Reference 17 - 1.21% Coverage

Lines 105-106: usually I point them towards that area because I believe that, for instance, as a faith man - a pregnant woman, I can't deliver a pregnant woman (Integration)

Reference 18 - 0.94% Coverage

Lines 109-110 Q. And are there cases of referral to you may be from the medical, or herbal or traditional? No. no (Challenges)

Reference 19 - 2.02% Coverage

Lines 112-114: Well it's depending on the type of sickness that the person is involved in. May be just, maybe is terminal, there is no, no other option but to look on God and see people come to God at that point in time; and they…please pray for me. (Integration

Reference 20 - 2.21% Coverage

Lines 121-123: Well, you know, an average Nigerian believes in God, an average Nigerian believes in God. And so an average Nigerian also believes in, you know, taking herbs or taking medicine. So working together to treat Nigerian patients in that regard is not so difficult. (Methods)

Reference 21 - 2.59% Coverage

Lines 124-127: Ya, but especially when they see that what we are doing is working. So Nigerians are always easy people to please, they can always flow with what you are doing as long as you tell them, explain to them, and you carry them along. So collaborating is not a difficult issue.

(Integration)

Reference 22 - 2.71% Coverage

Lines 130-133: Ya, it is just the belief. The two parties should understand that they are all working towards the betterment of the person involved. So it is just the belief from both end, that look, they are working to have the common goal. So if there is no belief, if there is no common ground there will not be any result. (Challenges)

Reference 23 - 1.45% Coverage

Lines 140-141: neither do we go for yearly medical check-up until we fall sick and so on and so forth. So I will advise that even before the sickness itself, we should, you know, prevent it (Barriers)

Step 3: Individual clustering of themes

Cluster 1: Acts of help-seeking (Ref. 1, 20)

Cluster 2: Influences and Barriers (Ref. 2, 3, 4, 8, 11, 12, 23,

Cluster 3: provider's personal beliefs (Ref.15)

Cluster 4: Potentials for Integration (Ref. 9, 13b, 16, 17, 19, 21)

Cluster 5: Challenges (Ref. 10, 13a, 14, 18, 22)

Cluster 6: healthcare practices (Ref. 5, 6, 7)

Participant 2

Fatima: Internals\\Interviews\\IPA Interview with Fatima> - § 25 references coded [33.22% Coverage]

Reference 1 - 1.34% Coverage

Lines 3-5: Few methods that Nigerian Christians usually use is, first of all most of them go to God in prayers. First is the prayers and they access the hospitals as well. They go to the hospital to get help, cure and some of them go to traditional medicine to get help. (Methods)

Reference 2 - 1.35% Coverage

Lines 7-9: What influence their choices sometimes is financial, isn't it. It's financial because some may be very ill and may be from the religious effects of it because as Christians there are Christians that think that when they are sick they don't need any medical help (Barriers)

Reference 3 - 0.64% Coverage

Lines 10-11: So they go into prayers, fasting, and all to get better. And they believe that that makes them better, it depends on belief, ya. (Methods)

Reference 4 - 1.08% Coverage

Lines 11-13: So, and then some will go to spiritual, cultural, traditional, because traditional is more cheaper they think is more cheaper to them than going to the hospital because in Nigeria you have to pay for the hospital bill (Determinants)

Reference 5 - 2.28% Coverage

Lines 19-23: Yes, I expect that people in UK with free hospital care you can access hospital when you want. It boils down to belief again, if the, this thing is free, the hospitals are free and then, it boils down to religion as well, if you believe that hospital doesn't heal you, no matter what it offers you whether it is free or not you don't go to it, you stay with your belief and you just pray or you choose to stay with your belief to get better. **(**Barriers**)**

Reference 6 - 0.92% Coverage

Lines 75-77: by referring to my other colleague or telling them the way they would be able to access help in the hospital setting. I advocate for them (practices).

Reference 7 - 0.64% Coverage

Lines 81-82: What I normally do is just psychological reassurances, and then tell them direct them where they could get help, to access health.(practices).

Reference 8 - 1.08% Coverage

Lines 89-91: I don't think this is allowed in the United Kingdom so, and I have my profession. I go by my code of conduct of my profession which is NSC. So I follow that guideline in giving anybody, you know, advice (Challenges)

Reference 9 - 1.80% Coverage

Lines 97-100: Clergy, religious people, I believe that they are there to, you know. They are ministers, they are people from God. But I don't think they are…. They are human, so it is God that gives perfect healing. So people should not like, say 'oh, I have to go to my pastor he is going to heal me'. He can only pray and it's God that brings the healing. (Provider's beliefs)

Reference 10 - 0.65% Coverage

Lines 100-101: I will still advise people to access the hospital as and then, it is very, it's good to go to your clergy, your minister. (Integration)

Reference 11 - 1.33% Coverage

Lines 102-104: there are some clergy and minister that they think that they can heal people ya, they believe that they can heal people, so but sometimes, me I don't really believe that. The only thing I believe is that a clergy can pray for me and God can heal through him. (Provider's beliefs)

Reference 12 - 0.36% Coverage

Line 108: Ya, I think that health care professionals, is a gift from God. (Integration)

Reference 13 - 1.24% Coverage

Lines 121123: And then other challenges like may be you need equipment to work with. Like back home in Nigeria you don't have the latest equipment to give care to patients with it, (Barriers)

Reference 14 - 0.85% Coverage

Lines 124-125: Proper medication, people like in Nigeria, they do fake medication and sell it so when you give it to patients, patients don't get better because it is not, you know. (Barriers)

Reference 15 - 3.17% Coverage

Lines 128-134: …in Nigeria there is no, you have to pay for your own health, and you could see some of the people go to ministers may be expecting them to give them money to go and access help, (Barriers)

Reference 16 - 0.66% Coverage

Lines 143-144: I don't think so. Spiritual healing in their treatment technique. All what we know is, is you start from the hospital (Challenges)

Reference 17 - 1.32% Coverage

Lines 146-148: …medically so we don't encourage spiritual, or any other method of healing, because even when you come to the hospital, we give you treatment, we tell you, 'don't take traditional and take hospital treatment at the same time because it is not good'. (Challenges)

Reference 18 - 2.32% Coverage

Lines 153-157: I don't know it, I don't know if it is from my background, all I, you know, family background and upbringing, I never, never, believe in traditional or spiritual things. If I don't go to the hospital, I pray to God. Put everything in prayer, and I still follow it up with going to the hospital anyway. So that has influenced my, this thing, profession as well, I don't, I don't go to spiritual healing and the rest. I just believe in medical. (Provider's beliefs)

Reference 19 - 2.16% Coverage

Lines 172-175: the challenges is some of the medical, that is back home in Nigeria, is some of them, the multidisciplinary team, some of them wrongly advise patients to go to spiritual or traditional medicine which is very wrong and then, ya. (Challenges)

Reference 20 - 1.09% Coverage

Lines 186-188: Em, well, my, my referral is mainly in the medical field. So I can't tell you much about somebody, me referring to spiritualist or cultural thing like that. I don't believe in that so I hardly do that. (Challenges)

Reference 21 - 1.02% Coverage

Lines 191-193: I think the, the health care providers, they always, I've seen, I've seen where, they always give respect to ministers, you know; …..and they listen to them, listen to what they are saying**, ==(Integration)==

Reference 22 - 0.23% Coverage

Line 196: I know they always work together. ==(Integration)==

Reference 23 - 1.90% Coverage

Lines 198-202: I think it is good because ministers they deal with, eee, with people and the medical they deal with people as well. So you could see that people under the ministers, you know, eee having some medical problems sure, it is good to work with them because their congregation sees them as their own, you know, doctors or something, so we need to work with them. . ==(Integration)==

Reference 24 - 2.25% Coverage

Lines 207-211: Ye, like I, is it here, ya; like I said to you earlier on, too many Nigerians use faith. ==(Methods)==

b. So the, when people, the challenge is that the minister and the health care providers; I don't know if they can like have in the ministry, may be like they have medical, medical set-up in a ministry where I know there are some medical professional that could be

worshipping in that ministry and if they could like set up something like first aid <mark>(Challenges)</mark>

Reference 25 - 1.54% Coverage

Lines 214-217: Ya, first treatment and then be manned by this medical within the, within the ministry. If people like they have minor injuries, minor illness so that government can medically provide help before the ministry now transfer to the hospitals. Like primary health care within the ministry. . <mark>(Integration)</mark>

Step 3: Individual clustering of themes

Cluster 1: Acts of help-seeking (Ref. 1, 20)

Cluster 2: Influences and Barriers (Ref. 2, 3, 4, 8, 11, 12, 23,

Cluster 3: provider's personal beliefs (Ref.15)

Cluster 4: Potentials for Integration (Ref. 9, 13b, 16, 17, 19, 21)

Cluster 5: Challenges (Ref. 10, 13a, 14, 18, 22)

Cluster 6: healthcare practices (Ref. 5, 6, 7)

Participant 3

Fifi: Internals\\Interviews\\IPA Interview with Fifi> - § 48 references coded [46.82% Coverage]

Reference 1 - 0.97% Coverage

Lines 4-6: In my experience they use faith-based methods, their religion is very important especially at times of sickness and vulnerability. The vast majority would seek orthodox medical intervention. Some will use self-help methods, over the counter method. So it is a combination really. (Methods)

Reference 2 - 0.46% Coverage

Lines 8-9: I think it's the level of awareness; so the social economic level, the level of education, the exposure, previous experiences. (Determinants)

Reference 3 - 0.90% Coverage

Lines 9-12: I find that the more, unfortunately, the more educated people are, the more likely they are to seek orthodox medical help, and, well depending on their spiritual beliefs and practices. Whereas those who are not so educated seek alternative methods in my view. (Determinants)

Reference 4 - 0.24% Coverage

Line 14: I think as for me as a professional, ignorance does a lot of harm (Barriers)

Reference 5 - 0.73% Coverage

Lines 18-19: I believe that there is a place for the spiritual support when people are feeling threatened, feeling weak and vulnerable when they are unwell. But I think that not seeking appropriate medical help is detrimental. (Provider's beliefs)

Reference 6 - 0.56% Coverage

Lines 36-37: Very often it is a relative who comes and says, 'look am bothered by this, this is what is happening to this person and then you give advice. Yes I do get that. (Determinants)

Reference 7 - 1.27% Coverage

Lines 40-43: Absolutely, I mean only yesterday I met up with a friend who was saying to me that her husband was not feeling very well. And his sister had telephoned that she was having dreams that he's under some spiritual attack, they can see 'early death' for him, and that is so typical of the Nigerian way of thinking. Every illness is down to some spiritual intervention (Illness cognition)

Reference 8 - 1.07% Coverage

Lines 70-73: Am, obviously I am a medical professional and that is on the basis on which people come to me and that is how I treat them. That is the basis on which I treat them. And we have code of professional conduct practising in this country, which means that that is the remit under which you treat your patients. (Challenges)

Reference 9 - 1.10% Coverage

Lines 73-76: But for me from a personal point of view, my faith, my spirituality underlies everything I do. But that is personal to me. I don't know if you understand what am saying? So that I do my work as a professional, but take away with me that work, come home, I speak, seek spiritual help and guidance for me and my patients. (Provider's beliefs)

Reference 10 - 0.74% Coverage

Lines 83-85: Oh yes! I mean, we, for example 'coaching for health'. So my patients with long term condition especially where there is not very much medicine can do. 'Coaching for health' I find to be very empowering. (Integration)

Reference 11 - 0.88% Coverage

Lines 90-92: Em that is what I do with the patients, but like I said for me personally there are times when I really struggle and I believe that there is always some spiritual intervention in what I do, always, especially when it is a very difficult case. (Provider's beliefs)

Reference 12 - 1.21% Coverage

Lines 98-100: I found that really difficult on a personal level, it was challenging physically. …and I came back it was terrible and I had a good priest that I went and spoke with.

When he sees me he knows what I've been going through and I think that, you know, he talks to me we pray and I feel calm. <mark>(Provider's beliefs)</mark>

Reference 13 - 1.37% Coverage

Lines 103-107: So there are things that I see and I know that there is a force bigger than me that is using me to heal these children; and I, the difficulty I have is that it is only a personal thing to me. <mark>(Provider's beliefs)</mark>

b. It's not something I can share with the patient it's not something I can share with the parents and it's just for me. Sometimes I think I should write a book. And I could give you many many examples, so. <mark>(Challenges)</mark>

Reference 14 - 0.54% Coverage

Lines 110-111: Well because it is out of bounds. As a medical practitioner in this society it is not my place to bring religion in. In fact it is against the law <mark>(Challenges)</mark>

Reference 15 - 0.68% Coverage

Lines 111-113: I somehow do think that for people who have no faith, that the time when you are struggling, and you know, totally vulnerable, not too sure, not themselves; is the right time to evangelise any way. <mark>(Provider's beliefs)</mark>

Reference 16 - 0.73% Coverage

Lines 115-117: So even when you see families, you see Christian ornaments around the child, say there's a picture of Padre Pio and Rosary or whatever, you cannot talk to parents on that level because it is simply not allowed. (Challenges)

Reference 17 - 0.50% Coverage

Lines 121-122: Interesting!   Do I have those options?   The way the practice is and because I am a specialist I do not have those options unfortunately. (Challenges)

Reference 18 - 1.85% Coverage

Lines 123-128: yes there are patients who come in with physical symptoms and you can see they are troubled. The physical symptom is just an underlying, an expression of what is underneath. They need psychological help. So yes, in that situation, I make referrals to the psychologist, (Integration)

Reference 19 - 0.42% Coverage

Lines 132-133: Em, not so far, not so far.   Although sometime you are thinking that spiritual healing would be helpful here. (Integration)

Reference 20 - 0.28% Coverage

Line 136: My opinion! I believe that there is a place for the spiritual in healing. (Provider's beliefs)

Reference 21 - 2.51% Coverage

Lines 137-143: However, we have to be really very careful to make sure that those who we are, people whom we are trying to heal spiritually do not come to harm. By this I mean for instance, people who say they are healing spiritually somebody who is diabetic, and say, 'don't take your medication and you are healed' (Challenges)

b. My view is that they go hand in hand. God the Lord who heals gave the knowledge of medicine, therefore, they are not one against the other. The fact that you are taking your medication does not mean you do not have faith. (Integration)

Reference 22 - 1.61% Coverage

Lines 149-151: Em, I think generally there is em, it doesn't matter what sector including health, sadly and shamefully there is this 'us and them attitude', I do not want to use the 'R' word. …whether you the healthcare provider you are prejudiced or not, you cannot, cannot discriminate against people. (Barriers)

Reference 23 - 1.02% Coverage

Lines 159-162: They are huge, am talking about my own. Em, you know judging from my own experience, because of their ambivalence about orthodox medicine, Western medicine because they seek other sources of health care, they do not keep their appointment, they are not compliant with their medication (Barriers)

Reference 24 - 0.43% Coverage

Lines 165-166: Rather they want to go and seek that spiritual help that will make the tumour disappear suddenly and they do not want to engage. (Barriers)

Reference 25 - 0.79% Coverage

Lines 172-174: Em, which is where some of my colleagues, who are Caucasian who do not understand the culture tend to struggle with the Nigerians. Em, and yes. So there is a lot of fear, there is a lot 174. of fear and there are other issues too. (Barriers)

Reference 26 - 0.72% Coverage

Lines 178-1180: What was happening? There were immigration problems, the father was stuck in Nigeria and this woman had absolutely no support at all. So that makes things a bit more difficult and they need extra support, (Immigration challenges)

Reference 27 - 0.77% Coverage

Lines 187-189: I think it's a belief system. When you believe in something strongly and all your life that's all you have known and now you are an adult and someone is telling you there is a different way, it is just difficult. (Barriers)

Reference 28 - 0.43% Coverage

Lines 198-199: Ha, Ha! (Laughter). I don't know and in this country, the way things are and the way they are going, I cannot see. (Challenges)

Reference 29 - 0.53% Coverage

Lines 199-200: Ok, I rephrase. There is recognition certainly in mental health that the spiritual is important, that the spiritual plays a role in the healing of the mind. (Integration)

Reference 30 - 2.24% Coverage

Lines 200-207:

a. Well, medicine is going to be medicine, and in the, especially in these conditions which are not where, you do not, where you expect a patient to get better, am sure that the profession is going to say, 'let us do our thing, keep the spiritual out of this'. (Challenges)

b. When it comes to end of life care, that is the palliative care where the spiritual is really important, and I think that's an area where, yes there will be good collaboration, there will be pulling together for the benefit of the patient. (Integration)

Reference 31 - 1.86% Coverage

Lines 208-213: But em ya, those are the areas - mental health, end of life care, the palliative and of course if…it, at the moment each hospital has a chaplain and patients are encouraged to engage with their chaplains, the chaplains are welcome all the time…. Yes, so we respect people's religion and their spirituality and their spiritual beliefs. (Integration)

Reference 32 - 0.56% Coverage

Lines 213-215: But say, having a physician sitting side by side a spiritual person like a clergy man or a healer or something, em may be, but I don't know of it at the moment. (Challenges)

Reference 33 - 1.25% Coverage

Lines 217-220: Am not sure it's a no-go, but at the moment the way the set up works, because this is a nation of a significant proportion of people of no faith, of no religious background, of absolutely of no spirituality, it, this is what you see, this is what you get, this is what life is about, and it's such a democratic society that you're balancing all of the time. (Challenges)

Reference 34 - 0.88% Coverage

Lines 222-224: Professionally I fell, oh, what lost opportunity. Em, professionally I feel that we can harness this to make what we do even more worthwhile, so the patients will believe, a patient who has faith, you know, I see absolutely nothing wrong with it. (Integration)

Reference 35 - 2.25% Coverage

Lines 232-239: Well conflict of, is it conflict of interest, or conflicts of methodology is the big worry. Therefore, if they are going to work together everybody must know their limitation; (Challenges)

Reference 36 - 0.29% Coverage

Line 243: Well the only experience I have is to a psychiatrist, from me to a psychiatrist (Integration)

Reference 37 - 0.72% Coverage

Lines 245-247: So sent him along and in the intervening 12 months the family broke up. His mother oh, it's a complete shambles, complete; and you are thinking yes, maybe this family does need a spiritual delivery or deliverance. (Integration)

Reference 38 - 0.61% Coverage

Lines 249-251: for me I do not understand that. So I have to seek help from other health care providers, be they like I said, psychiatrist who may work with the spiritual healers (Integration)

Reference 39 - 1.30% Coverage

Lines 253-257: the reason you refer a patient to, to another healthcare giver or healthcare provider is when what you can offer will not solve the problems… Two, an awareness that there is this sort of person somewhere with whom you can work and also being able to trust the work that they do. (Integration)

Reference 40 - 1.41% Coverage

Lines 266-270: Em, I think in this country anyway, 'collaboration' is not the word I would use. Everybody is doing their own thing, and the patient is in the middle and getting from

either side. Sometimes they are taking fully from a side and sometimes they come to a

point where those pills that you are giving them are not taken because the minister is

saying 'you don't need them', they're praying and praying. (Challenges)

Reference 41 - 0.57% Coverage

Lines 270-272: What is very typical of Nigerians is, if there is a Nigerian in hospital, the

pastor and the entire church almost would come and visit them on Sunday after service,

(Barriers)

Reference 42 - 0.85% Coverage

Lines 278-280: I think that the Nigerian medical professional in this country is bound by

the rules and regulations that govern every other medical practitioner. So how they can

form a, how they can formally collaborate with spiritualists, I don't know. (Challenges

Reference 43 - 0.47% Coverage

Lines 280-282: However, I know that something, you know, in some shape or form, the

government and the medical regulatory bodies might be interested (Integration)

Reference 44 - 1.92% Coverage

Lines 283-289: Because there is a recognition in the medical world, although people find

it totally em, unbelievable, that there are pastors and religious people who are praying for

em, their Christian flock who have medical conditions and telling them 'chalk, put your medicine away'. (Barriers)

b. So the medical profession sees an opportunity to feed into that, to collaborate so that people do not suffer. So that the pastors understand that they can work with us and we can, for the benefit of the patient; to understand that people do come to harm the way things are at the moment (Integration)

Reference 45 - 0.60% Coverage

Lines 293-294: Ok. They would be huge. I) because in medicine there are probably more people who have no time in the day for spirituality. So bringing them in would be not very easy. . (Challenges

Reference 46 - 0.70% Coverage

Lines 295-297: However, if you and people who are doing this sort of work that you are doing can get in touch with the spiritual healers, be they Christian be they traditional or whatever and gain their confidence . (Challenges

Reference 47 - 0.39% Coverage

Lines 299-300: No Body, they are not regulated, that is the big thing. So if we can see some form of assessing what they are doing. (Challenges)

Reference 48 - 2.63% Coverage

Lines 317-325: Personally I respect that, I respect the fact that cultures are different and things, but when you are in a foreign land and you start to isolate yourself in this way, 'this is us and this is our need' you have to be very careful because you have a way of pulling yourself out of the mainstream. (Challenges)

Step 3: Individual clustering of themes

Cluster 1: Acts of help-seeking (Ref. 1)

Cluster 2: Influences and Barriers (Ref. 2, 3, 4, 6, 22, 23, 24, 25, 27, 41, 44)

Cluster 3: provider's personal beliefs (Ref. 5, 9 11, 12, 13a, 15, 20)

Cluster 4: Potentials for Integration (Ref. 44b, 43, 39, 38, 37, 36, 34, 31, 30b, 29, 21b, 19, 18, 10)

Cluster 5: Challenges (Ref. 8, 13b, 14, 16, 17, 21, 35, 40, 42, 45, 46, 47, 48)

Cluster 6: Immigration challenges (Ref. 26) vs. 2

Cluster 7: Illness cognition (Ref. 7) vs. 2

Participant 4

Moyi: Internals\\Interviews\\IPA Interview with Moyi> - § 40 references coded [36.99% Coverage]

Reference 1 - 0.94% Coverage

Lines 8-10: I mean Nigerian Christians, you know, will go a long way using their faith, you know to try and get over their illnesses. And for those who are true Christians, they tend to, I mean, they believe in the power of prayer to get over their illnesses. (Methods)

Reference 2 - 0.47% Coverage

Lines 13-15: But then overall I believe Nigerians will use, I mean, the Christians you know do believe in the power of prayer. I do myself (Provider's belief)

Reference 3 - 0.88% Coverage

Lines 19-21: Well, it depends on how, how strong the faith, how strong the faith of the individual person is. You know, it's, if somebody, I mean there are people who believe that prayers can cure them and I believe that prayers can cure. (Determinants)

Reference 4 - 1.20% Coverage

Lines 28-30: I mean what influences their choices will be on how strong the person's faith is and also whether the person has some knowledge of medicine. (Determinant)

Reference 5 - 0.47% Coverage

Lines 34-35: I mean I believe in the power of prayer and I also believe yes, if you are unwell you should be able to use medication. (Provider's belief)

Reference 6 - 1.18% Coverage

a. Lines 35-36: I mean from where from when I was very young, I mean from my very early days in medical practice I have always believed that one should use medication (Provider's belief)

b. Lines 37-38: The reason being that whatever knowledge we have is from God and God has given us the knowledge and the power to be able to, to, for these drugs to be made (Integration)

Reference 7 - 0.80% Coverage

Lines 68-69: limiting this to Nigerians, you got to consider when they first came into this country, how long they have been in this country, consider if they have had these problems in the past. (Immigration challenges)

Reference 8 - 0.55% Coverage

Lines 77-78: Em, well I presume you know, in dealing with people you got to, I mean in practice in medicine, you got to apply the principles of medicine. (Challenges)

Reference 9 - 0.81% Coverage

Lines 78-80: Outside the principles of medicine, there is physical health, there is mental health, you know. When you get to mental health you tend to use something like counselling which I do a lot, you know, I do a lot of counselling. (Integration)

Reference 10 - 0.98% Coverage

Lines 82-85: Outside medicine itself, one has to be a bit careful, you know, in; not that am afraid you know, not that I cannot express my faith. But we know that people, you are dealing with a variety of people, you are dealing with people who don't believe that God exists (Challenges)

Reference 11 - 1.30% Coverage

Lines 89-92: If at the end of the day I find out that the person is a practising Christian, I sometimes will advise about using the power of prayer, you know, to pray <mark>(Provider practices)</mark>

Reference 12 - 1.06% Coverage

Lines 97-100: I mean, the main influence is, I mean there are people who present with various problems which you cannot explain, you know medically or physically for that matter. And you reckon that you may well be able to go through the Christian way which may well further on counselling <mark>(Integration)</mark>

Reference 13 - 0.78% Coverage

Lines 110-112: I mean there are, I mean, I strongly believe that yes they should be able to do that, I mean I try to do that myself. I, like I said am not a pastor or a Reverend but I believe that prayer does work <mark>(Integration)</mark>

Reference 14 - 1.54% Coverage

a. Lines 114-118: But again you got to, they may, I mean like I said before, God has the power to cure any illness. But I think that there may well be limitations to what a Reverend can do or a pastor can do. <mark>(Challenges)</mark>

b. I said before, that God has created or has given us the knowledge to practice medicine and we should use this knowledge you know to go and help people <mark>(Integration)</mark>

Reference 15 - 1.02% Coverage

Lines 124-127: But I think there must be, I mean there ought to be some limitation to what people can or cannot or what a pastor should be doing. I have absolutely no doubt in my mind that, yes a pastor can offer, or a Reverend can be very very useful in helping patients who are unwell. (Integration)

Reference 16 - 0.78% Coverage

Lines 138-140: there are Nigerians who will have difficulty believing you know, again like I said it depends on the faith of the person. There are Nigerians who believe yes you can be cured you know by the power of prayer (Challenges)

Reference 17 - 1.78% Coverage

Lines 140-145: I personally know whether I have faith or not, you don't know about whom you are dealing with whether the person has faith or not and then or the person's method of trying to practice his or her Christian belief. (Challenges)

Reference 18 - 0.48% Coverage

Lines 145-146: The other challenge we have is that many Nigerians do all sorts of jobs and are reluctant to actually go out to seek medical advice (Barriers)

Reference 19 - 0.52% Coverage

Lines 151-152: And you have people, you have Nigerians who believe in this traditional medicine, you know. What we call 'juju' in Yoruba land you know. (Barriers)

Reference 20 - 0.98% Coverage

Lines 160-162: I mean this one will depend on whether the person believes in God or not. There are, I know a lot of Nigerians who don't believe or who are not sort of practicing Christians and they are not likely to incorporate this into their management of their patients **(**Challenges**)**

Reference 21 - 0.98% Coverage

Lines 163-165: There are Nigerians who will not adhere to incorporating that in any treatment of the patient mainly because you have no idea whether the patient or how the patient is gonna take it you know, is this patient going to be angry if I mention anything like Christianity **(**Challenge**)**

Reference 22 - 0.71% Coverage

Lines 165-167: I mean we have a case of a doctor who was taken before the governing body the general medical council because he was, the person, the doctor was actually trying to get the patient to believe, (Challenge)

Reference 23 - 0.45% Coverage

Lines 170-171: I mean I do that here from time to time you know, and mainly amongst Nigerians because I know they won't sort of report me (Provider practices)

Reference 24 - 0.91% Coverage

Lines 173-174: So I use it mainly amongst Nigerian patients. I use that also in other ethnic groups it depends, (Provider practices)

Reference 25 - 0.56% Coverage

Lines 182-183: It's gonna be very difficult, generally it's gonna be very difficult indeed you know. Like I said it is not something that many people will do, (Challenge)

Reference 26 - 0.55% Coverage

Lines 190-191: Not that am afraid to declare my faith, yes many people know that I am a Christian, they already see that (Provider's belief)

Reference 27 - 0.45% Coverage

Lines 199-200: Ya I mean I believe that there is I believe that there is a power, I mean, if I may say, an evil power somewhere, (Provider's belief)

Reference 28 - 0.86% Coverage

Lines 200-202: My great grandfather, my grandfather was a herbalist and I have some of my uncles you know, did practice these alternative medicine like…like herbalists you know. And I have come to see some of the powers they possess you know ==(Provider's belief)==

Reference 29 - 1.03% Coverage

Lines 208-211: I know that some of them do exist, you know, in places like Brixton, or Peckham, ==(Barriers)==

Reference 30 - 1.76% Coverage

a. Lines 217-221: Em, I don't think, I don't think, I mean I've never seen a set up where you, ive never seen a set up where you have doctors and Reverends or pastors working together. I mean you may have that in Nigeria where you have these Christian hospitals but here it doesn't exist, such collaborations you know, don't exist; ==(Challenges)==

b. but if you are asking whether I will be prepared to do that, yes I will be prepared to do that if I find a setting where, I will be prepared to do that. ==(Integration)==

Reference 31 - 0.94% Coverage

Lines 134-137: I think that is based on the freedom which we enjoy in a country like this where people in their, people who are unwell, and especially people who are in their later lives, you know, people who may well be terminally ill will like to seek solace in God ==(Integration)==

Reference 32 - 0.91% Coverage

Lines: 242-244: So, there are chapels, you know, but I mean there is no close collaboration between the, between some of the medical practitioners and the minsters. <mark>(Challenges)</mark>

Reference 33 - 0.90% Coverage

Lines 247-249: But the patients do have, you know, the the chance to go chapels or speak to the Reverend, they may need prayers, you know. Even in the hospital where they don't have mosques, they do, they can arrange for an Imam to come through <mark>(Integration)</mark>

Reference 34 - 0.77% Coverage

Lines 252-254: Oh simple, because you cannot force any doctor to practice, to practice Christianity, no. It depends on your background, you know, you cannot, I mean if you try to do that you may get into trouble. <mark>(Challenges)</mark>

Reference 35 - 0.83% Coverage

Lines 261-263: I mean, I don't, we are not allowed to refer, I mean, we have strict guidelines when making referral, you know. So you cannot, you cannot really make a referral to any other body apart from a medical organisation. (Challenges)

Reference 36 - 1.48% Coverage

Lines 264-268: I think is all based on money you know, it is all based on money and the belief by some powers to be, that these herbal medicines don't work. (Challenges)

Reference 37 - 1.18% Coverage

Lines 270-273: Oh ya, people, when people, when people visit all these other groups outside medicine, they may, I mean, the person treating may say, 'oh, I don't think I know what exactly is wrong with you'. Then you, I mean, they would likely by themselves send back to the GP and say 'go back to your GP to be investigated' (Integration)

Reference 38 - 0.38% Coverage

Lines 273-274: we do the referrals, but these are, these are done privately and then we take it from there, you know. (Integration)

Reference 39 - 2.30% Coverage

Lines 292-298: If you …in any practice even where you have Nigerians, Caucasians, Asians, the chances are that Nigerians would like to see Nigerian doctors: (1). It may be because of the language, you know <mark>(Barriers)</mark>

Reference 40 - 0.48% Coverage

Lines 300-302: So, Nigerians would be more comfortable when they speak, I mean when they see a doctors who they think belong to their own group <mark>(Integration)</mark>

Step 3: Individual clustering of themes

Cluster 1: Acts of help-seeking (Ref. 1)

Cluster 2: Influences and Barriers (Ref. 3, 4, 16, 18, 19, 29, 39)

Cluster 3: provider's personal beliefs (Ref. 2, 5, 6a, 26, 27, 28)

Cluster 4: Potentials for Integration (Ref. 6b, 9, 11, 12, 13, 14b, 15, 23, 24,30b, 31, 33, 37, 38, 40)

Cluster 5: Collaboration challenges (Ref. 8, 10, 14a, 16, 17, 20, 21, 22, 25, 30a, 32, 34, 35, 36)

Cluster 6: Immigration challenges (Ref. 7) vs. 2

Participant 5

Sule: <Internals\\Interviews\\IPA Interview with Sule> - § 35 references coded [23.80% Coverage]

Reference 1 - 0.54% Coverage

Lines 9-11: great majority of people when they get sick, especially back home, given my apostolate back home they tend to turn to the church first, and the second, next level would be probably; instead of the church I think the next remedy is self-medication. (Methods)

Reference 2 - 0.39% Coverage

Lines 11-13: People who just say its medical, but its self-medication and then from the self-medication then the hospital, and then from hospital probably, then other cultural traditional means <mark>(Methods)</mark>

Reference 3 - 0.34% Coverage

Lines 15-17: The issue of people even trusting to be able to come out to say this is what is wrong with them. So it takes a lot, people try to just keep it to themselves. <mark>(Barriers)</mark>

Reference 4 - 1.35% Coverage

Lines 27-31: One reason I think for me: the economic situation because a number of times people have come to me and they say to me 'father please pray for me am sick' <mark>(Barriers)</mark>

Reference 5 - 0.39% Coverage

Lines 39-41: Then, the second part is because people just believe that look the spiritual thing is more important, that if they turn to God it will help then much better and it will be faster, <mark>(Belief)</mark>

Reference 6 - 0.45% Coverage

Lines 45-47: There is what prayer can do and what, and when you pray God is to direct you, he may not easily come to bring you healing. When you pray because you are sick, God may decide ok, he supplies Mr. B, or Doctor A (Integration)

Reference 7 - 1.05% Coverage

Lines 60-65: So the economic factor will still play here because if you tell somebody now 'go to the hospital', the person will start calculating, 'I will not have a pay'; (Barriers)

Reference 8 - 1.04% Coverage

Lines 74-79: (laughter)…. Well I smile because ….., whether it is cockroach, whether it is pain in the leg, whatever, people will just come to you, 'father must…' because you know where we grew up, the traditional priest, especially given the type of the early missionaries. The early missionaries which we have also inherited the same thing, as a priest you are an accountant, you are an artisan, a carpenter, you are everything. (Methods)

Reference 9 - 0.35% Coverage

Lines 87-88: I've never been trained on the issue of health matters, even though I supply in some voluntary organisations and I can give little as First Aid, but that is not enough. (Provider's preparedness)

Reference 10 - 0.33% Coverage

Lines 90-92: There is what I feel I can do, and there is what I think I cannot do, and that which I cannot do I cannot deceive you to say I will supply it for you. <mark>(Challenges)</mark>

Reference 11 - 0.61% Coverage

Lines 104-107: Ya when people come to me actually I say, ya when they come to me, I know sometimes this is like is psychological, ok. They just believe if they are in the hospital, if they are before a priest, they are in the church they just get well. So you also have to satisfy that aspect. <mark>(Barrier)</mark>

Reference 12 - 0.21% Coverage

Lines 111-112: so when people come they believe that as long a 'Father' lays hands on them they will get well. <mark>(Belief)</mark>

Reference 13 - 0.71% Coverage

Lines 136-139: for me it will be disheartening to see a spiritual, a minister rendering medical assistance. If it is in terms of a duty we owe to each other, I can understand. <mark>(Integration)</mark>.

Reference 14 - 0.45% Coverage

Lines 142-144: But of course I know of hard cases they said of somebody will keep a HIV patient and then is praying for that patient and say there is nothing wrong, it's just prayer, and eventually the person will still die (Challenges)

Reference 15 - 0.64% Coverage

Lines 162-165: let me ….mostly back home. I may be in a parish you find medical professionals in the parish, 'oh no come let's start a clinic whereby one of us will come every day and come and give some assistance or attend to people, and then that has also helped a great deal in saving a lot of people (Integration).

Reference 16 - 1.62% Coverage

Lines 171-179: And then once in a while also they try to give people, they give lectures in terms of medical health awareness, encouraging people the need to patronise, go to hospital, the need to open up because some persons don't really open up when they are having issues. (Integration).

Reference 17 - 0.59% Coverage

Lines 186-188: First challenge is not even the patient. It is the medical professional and the minister, and it is either out of ignorance of people not knowing their own and their boundaries, (Challenges)

Reference 19 - 0.63% Coverage

Lines 194-197: may, some will tell you ok, ….they don't want to see you even when they say you are a priest, then of course if they are not even from your church, your denomination they will not want to see you, (Challenge)

Reference 20 - 1.69% Coverage

a. Lines 224-232: Ok. Well you know by and large, a real medical professional would not want to refer you to something else. I possibly see here, they want to tell you they can treat everything, and the worse thing they can do is quarantine you at a point in time. (Challenges)

b. But back home quite ok, you have quite a few doctors who will tell you sorry this is not a medical issue, it is a spiritual issue, ok. That is because the doctor is talking from his own background, cultural background …but even they can't say that openly because if they do it affects their medical, their licence. (Integration)

Reference 22 - 0.39% Coverage

Lines 252-253: know that, or some will say well we cannot do this, I cannot advise because they are being guided by some code of conduct, ya. (Challenges)

Reference 23 - 0.57% Coverage

Lines 256-258: Ya, as I said, here you permit me to make a distinction with due respect to every denomination. I think this can also be based on two factors. The denomination of the person, and secondly the level of enlightenment, the level of literacy matters a lot. (Challenging barriers)

Reference 24 - 1.17% Coverage

Lines 259-264: So what do I mean by denomination because you find some like the Pentecostals who believe that look, they can cure, so whatever it is, 'bring him to me, bring her to me I will pray for her, it will be cured', ok… <mark>(Challenging barriers)</mark>

Reference 25 - 0.54% Coverage

Lines 269-271: You may even have a pastor or a priest who is in a catholic church and yet if his level of literacy is so shallow, he will still just not want to refer everything, and you know today, it is about fame. <mark>(Challenging barriers)</mark>

Reference 28 - 0.16% Coverage

Line 295: .… also sometimes the medical care giver would always see my method as fetish <mark>(Challenges)</mark>

Reference 29 - 1.71% Coverage

Lines 344- 352: So whichever way, cross experiences I think I can only encourage it, that is very important. <mark>(Integration)</mark>

Reference 32 - 0.73% Coverage

Lines 405-409: I think on one side, the seminar is necessary on both sides, both the health worker and the religious minister should be given a kind of seminar, either separately or even together, (Integration)

Reference 33 - 0.29% Coverage

Lines 432-433: but you know those who have already made up their mind about something they have already made up their mind, it will be difficult. (Barriers)

Reference 34 - 0.62% Coverage

Lines 483-486: But interestingly, when you tell them I have prayed about your situation, and the spirit kept telling me, tell this person to go to the hospital, if they trust you, they will always say 'ah is divine inspiration I will go to the hospital because the Lord has directed them through me (Beliefs)

Reference 35 - 1.07% Coverage

Lines 490-495: then the NHS itself, maybe they should be able to come up with certain programmes, …because you may be surprised may be somebody doesn't want to go maybe because he goes there he does not understand the English ok, and the fear of intimidation (Barriers)

Step 3: Individual clustering of themes

Cluster 1: Acts of help-seeking (Ref. 1, 2, 8)

Cluster 2: Influences and Barriers (Ref.3, 4, 5, 7, 12, 33, 34, 35)

Cluster 4: Potentials for Integration (Ref. 6, 13, 15, 20b, 32)

Cluster 5: Collaboration challenges (Ref. 10, 14, 17, 19, 20a, 22, 23, 24, 25, 28)

Cluster 6: Challenging barriers (Ref. 23, 24, 25) vs. cluster 2

Cluster 7: Provider's preparedness (Ref. 9) vs. 4

Participant 6

Uju: Internals\\Interviews\\IPA Interview with Uju> - § 21 references coded [42.04% Coverage]

Reference 1 - 1.14% Coverage

a. Lines 4-6: Em, well most Nigerian Christians, I would say most of them would normally seek medical help. (Methods)

b. But I think this also depends on what the illness is, what their background is and what type of Christian denomination they are (Determinants)

Reference 2 - 1.99% Coverage

a. Lines 6-10: Em, most of the Nigerians that go to Pentecostal churches especially their long term medical problems would tend to put most of their faith in their, in their church leaders or pastors. (Methods)

b. Em most Nigerians are well read would tend to stick with the medical profession. But also if they are religious would also have faith and their faith would keep them going in combination with the medical profession (Determinants)

Reference 3 - 1.75% Coverage

Lines 10-14: I also feel that depend on what their backgrounds are or/were their upbringing, this also influences them a lot. If they are used to, if they are brought up using traditional healing methods even though they've come to different country they still tend to use those traditional healing methods and sometimes detrimentally, sometimes successfully. (Determinants)

Reference 4 - 2.72% Coverage

Lines 16-21: As a professional you know that it is also important for your patients to have faith in what treatment they are taking ok. (Integration).

Reference 5 - 2.19% Coverage

Lines 26-30: Some of them are brought up with certain, you know, religions or certain factors where they seek traditional help, which yes great, sometimes it helps. Others if they are members of like Pentecostal churches sometimes not all of them, but sometimes they are told things that are completely wrong and sometimes this puts them at risk. (Determinants)

Reference 6 - 1.13% Coverage

Lines 37-39: I think a lot of time they see it as a curse, you know it's a curse, either themselves or somebody has done something wrong in the past and this is the punishment they are getting for it. (Illness cognition)

Reference 7 - 0.83% Coverage

Lines 53-54: But without exploring what the patient perceives as the problem and perceives as the cause of the problem, it might just, it might just be futile trying to treat it. (Integration).

Reference 8 - 1.04% Coverage

Lines 67-69: Ya, I mean depending on what the problems are. Sometimes we employ counsellors, behaviour therapists, just other you know, ancillary professions to help with the psychological part of the problem. (Integration).

Reference 9 - 0.35% Coverage

Lines 77-78: Em, when it comes to spiritual healing/prayer, I don't really do that (Challenges)

Reference 10 - 4.70% Coverage

a. Lines 81-90: I suppose it depends on what context you put the cure in. I think that they can help in the sense of you know, people that have problems causing a lot of anxiety, and a lot of you know, that is affecting perhaps family, they can intervene and provide some counselling.   (Integration).

b. But in the past I've heard of religious ministers telling people that they can cure their problems in terms of things like infections or chronic illness, they've often been told that, you know, they don't need to take their medicines anymore because the lord has healed them, and in lots of cases this has proved, you know, fatal… and they need to know their limits. Challenges)

Reference 11 - 1.36% Coverage

Lines 103-106: However, a lot of education still needs to be done, because a lot of them still misuse the system, and we do still need to get a lot of education out there. (Barriers)

Reference 12 - 2.78% Coverage

a. Lines 123-128: Well I think the main challenge is getting the patient to understand the problem, because…. Also a lot of the time they don't even come for regular checks, regular health checks. And even when they do come and the problem is identified they don't often come back for the regular checks. . (Barriers)

b. And also a lot of a lot of our young men are doing a lot of shuttling between here and Nigeria as well so that also makes it difficult to provide regular, em, regular checks on them (Immigration challenges)

Reference 13 - 2.03% Coverage

Lines 142-146: I suppose you could explore the patient's beliefs and they could, you know, go and have a chat or talk with the spiritual leaders or healers. But then that means the spiritual healer I suppose can give them faith or counsel them to have faith in the medical profession**. (Integration).**

Reference 14 - 2.07% Coverage

Lines 156-160: What the spiritual healers are going to do, the question would be 'do they have to understand the medical problem in order to provide the spiritual healing' (Challenges)

Reference 15 - 2.68% Coverage

Lines 164-169: But it is interesting that these are about being integrated into the system such that if a patient is felt to need any of these ancillary providers, they get referred to them. Em, but at the moment, as far as am aware nobody gets referred to a spiritual healer. (Challenges)

Reference 16 - 0.67% Coverage

Lines 176-177: It depends on what the problem is you may then refer to maybe counsellors, or physiotherapists and sometimes even alternative medicines (Integration).

Reference 17 - 3.53% Coverage

Lines 179-186: The difficulty then is how to combine it safely for the patients…But I suppose then again the spiritual healing and counselling; is there a possibility that that might happen as well, you know referring someone to a counsellor and also to spiritual healer (<mark>Challenges</mark>)

Reference 18 - 1.12% Coverage

Lines 200-202: But then again that, it will all be a difficult area because there are so many different religions, and there are so many different standards of spiritual healing I would assume and so it is a difficult one to standardise. (<mark>Challenges</mark>)

Reference 19 - 1.91% Coverage

Lines 208-212: but then I think there should be collaboration there, there should be education there really of the minister. (<mark>Integration</mark>)

Reference 20 - 2.68% Coverage

Lines 224-229: Is it possible to educate the ministers, is it possible to educate the patients, is it possible to meet with the ministers and express our concerns, and vice-versa, you know? I mean, these are all options. (<mark>Challenges</mark>)

Reference 21 - 3.36% Coverage

Lines 234-241:

a. In terms of more chronic problems, it is always worth investigating and exploring the patient's belief because obviously we know that faith does play a strong role in cure. (Integration)

b. But I think we also have to be quite weary and not make matters worse by the patients being exposed to non-supportive, I should say, non-supportive care givers. We call them non-supportive care givers or rogue care givers there are different ways of looking at it. (Challenges)

Step 3: Individual clustering of themes

Cluster 1: Acts of help-seeking (Ref. 1a, 2a)

Cluster 2: Influences and Barriers (Ref. 1b, 2b, 3, 5, 11, 12a)

Cluster 3: Immigration challenges (Ref. 12b) vs. 2

Cluster 4: Potentials for Integration (Ref. 4, 7, 8, 10a, 13, 16, 19, 21a)

Cluster 5: Collaboration challenges (Ref. 9, 10b, 14, 15, 17, 18, 20, 21b)

Cluster 6: Illness cognition (Ref. 6) vs. 2