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

**Abstract**

Migration of peoples from different cultures carries with it some additional acclimatisation challenges, particularly where religio-cultural differences are marked between the old and new cultures. In the UK for instance, studies show ethnic differences in healthcare utilisation, with Black Minority Ethnic groups (BME) showing significantly lower access and satisfaction with the NHS compared to their UK counterparts. This is partly because of existing evidence that individuals from various ethnic backgrounds use different cultural and religious methods as coping strategies for ill health. Nigeria has a legacy of colonisation and evangelisation, with consequences that have impacted on their health behaviours. Therefore, this study aimed to explore their experiences of health-seeking as immigrants, and identify potential barriers and facilitators to health services utilization.

This is a qualitative study using interviews and focus group (FG) conducted in the English language, lasting 60 and 90 minutes respectively. Ten adult male and female participants (Interviews: n = 6, FG: n = 4) took part in the study. Data were transcribed and analysed using thematic analysis. The result revealed four main themes: Immigration challenges, Barriers to health care utilisation, Facilitators to health care utilisation, and Acculturation, with a conclusion that religious and cultural beliefs formed the basis for prevailing illness perceptions and responses to illness. The implication is that religious leaders and health providers from Nigeria can become influential in health decisions within this community, following from research evidence that patient-clinician cultural matching can influence service use and outcome.

**Key words:** Nigerian immigrants, health-seeking, culture, religion, healthcare utilisation

**(Word count: 298)**

## **Introduction**

Following the WHO (1946) definitional template on the concept of health many scholars have proffered variants of the definition, which are important in the understanding of health related behaviours. From this, the rights and responsibilities of the patient and the physician became more refined, with increased momentum in health research that focused on the patients' role in taking up positive and effective action towards getting well.

Health also involves cultural, psychosocial, economic and spiritual aspects, where health related decisions can have moral implications regarding illness aetiology, possible treatment approaches and outcome. Patient health behaviours therefore, need to be contextualised in understanding their proper meaning and impact (Hausmann et al., 2003). For instance, the context of immigration raises new challenges for immigrants, who can become vulnerable and socially isolated. Also, additional acclimatisation challenges that impact immigrants' health and wellbeing, raises issues about vulnerability and equity in access to available health services (Hausmann-Muela & Riberia, 2003), as well as the promotion of health strategies that strengthen immigrant communities. The implications 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. Yet little has been done in terms of research on Nigerian immigrant's healthcare. 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). Also, few studies among immigrants show a significant rate of health care underutilisation (Sue & Sue, 2004); due to their reliance on cultural and religious methods (Aldwin, 1994).

The WHO showed a positive response through the Alma Ata Declaration in 1978; in recognising 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 (WHO, 1978). However, the rising trend of the Pentecostal religious movement in Africa and the diaspora poses a significant means of spiritual or faith-based healing among Nigerians above African traditional medicine. Available evidence shows that 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 implication is 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). For instance, the study by Agbonyitor (2009) among the Plateau people of Nigeria shows that a successful home-based intervention for people living with HIV/AIDS (PLWHA) in such endemic region was faith-based (Gospel Health and Development Services). Also, church-based health programmes for mental health among African-Americans is shown to have received increased attention as an approach to mental health management (Hankerson & Weissman, 2012). 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 behaviour. The aim of this study therefore, was to explore the perceptions, attitudes and responses to symptoms/illnesses of Nigerians in the UK.

## **Methods**

Qualitative analysis and interpretation of themes followed the processes of Thematic Analysis (TA). This research approach was used to identify, analyse, and report themes derived from the data set (Braun & Clarke, 2006). This was adopted as most suitable for exploring emerging themes during an initial study of this kind, and for the purpose of 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 NVivo 10 software.

## 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 in order to avoid the loss of vital, salient points during analysis (Brocki & Wearden, 2006). Inclusion criteria was based on 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 represented various tribes from the 6 geo-political zones of Nigeria. Ten participants (females  $n = 5$ , males  $n = 5$ ) were recruited, representing 4 geo-political zones - North-East, South-East, South-South, and South-West of Nigeria. Six of the participants formed the focus group and 4 were involved in the face-to-face interviews. The number of years participants lived in the UK varied from 3 to 40, (mean number of years = 12.6). Other participant characteristics and demographic distributions are shown in Table 1.

(Table 1 here)

## Procedure

Ethical approval was granted by the Department of Psychology, Middlesex University Ethical Committee. Participants were given the details of the research schedule and were interviewed in English. To select participants, initial contact was made with ethno-cultural and religious gatherings of Nigerians in London, and a total of 35 individuals were finally

contacted through the snowballing process. Thirty-one individuals showed an interest, but 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). Of the 26 who were initially included, 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). Therefore ten (10) participants completed the study (Figure 1). Two participants indicated preference for a one-to-one interview, and two confirmed their willingness to participate in the focus group only, while six were willing to take part in either one-to-one or the focus group. 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 arrived at four participants for the in-person interviews (n = 4) and six for the one focus group discussion (n = 6).

(Figure 1 here)

Before the interview, participants' freedom to participate or withdraw was made known through the Information Sheet. They were also informed ahead of time about the aims and purposes of the research, as well as aspects of confidentiality and anonymity. Two detachable Consent Forms were signed by the participants who kept their copies while the researcher retained the duplicates. Data collection took place between May and September, 2013; with the individual interviews lasting for about 60 minutes each and 2.5 hours for the focus group discussion. Interview recordings were later transcribed verbatim for analysis. Participants were each identified with virtual names (pseudonyms) for the purposes of anonymity and confidentiality, as well as for easy referencing during the analysis.

## Analysis

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 resulted to global themes derived from the basic themes using identifiers from the data that are necessary for analysis (see Table 2). This aspect also draws on the relationships between the data set, while exploring possible inconsistencies, contradictions, and tensions within and between the data.

(Table 2 here)

## **Results**

From the analytic process, four main themes emerged: Immigration challenges, Barriers to health care utilisation, Facilitators to health care utilisation, and Acculturation issues.

### **Theme 1. Immigration Challenges**

This theme describes the challenging experiences of Nigerian immigrants in the UK, and their initial responses while trying to adjust to the new environment. These challenges and consequent responses derived from three sub-themes – the *environment*, *financial issues*, and *copying strategies*:

#### *(1) 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, 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 confirms available evidence that factors such as cultural differences are among the major challenges encountered by immigrants (LaFeur, 2010). 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).

## *(2) Finance*

The concept of cost/perceived benefits as determinant to health-seeking has been reflected among Nigerian immigrants through insufficient funds, questions around employability and actual difficulties getting a job. This feeling of financial difficulties (perceived and actual sense of poverty) seemed to run through the entire data as shown in the few quotes below:

*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 because I was thinking that when I came in I will just get a job since they are looking for nurses that things will be very easy for me but when I came in is not like this, as I thought. (FG: lines 213-216).*

*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).*

A wider impact of financial difficulties among African immigrants becomes clearer in the context of African culture of extended family network, which forms part of their religious obligation bedecked with moral, social and economic responsibilities (Mbiti, 1969). These responsibilities compound the financial stress faced by these immigrants in terms the obligations they owe to their poor families in Nigeria,

*Chyomi:*

*...ya; 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).*

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.

### *(3) Coping through social support*

This theme discussed various responses to challenges they experienced and from unexpected circumstances from within the individual and from the environment. 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:

*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).*

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., 2000). 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. However, where responses from the focus group showed more reliance on formal means of social support - 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).*

## **Theme 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 personal coping strategies already adopted. This theme was derived from three sub-themes: *Alternative methods, Beliefs, and Past experiences (pre-migration and post-migration)*.

### (1) 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, or patronised non-conventional therapists/spiritual healing:

*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. 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 (Bekele, Flisher, Alem, & Bahiretebeb, 2009; Kilonzo, & Simmons, 1998). 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 some experiences of failures. The easy accessibility and availability of traditional alternative methods compared to the conventional Western method, contribute to poor health care utilisation,

*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).*

## (2) 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).

*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).*

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).

This study illustrates similar influences as reported in both personal interviews and focus group discussions:

*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. 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. 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 affiliation as participant opinions reflected dominant beliefs among two main Christian groups – Pentecostal/charismatic and mainline Christians

(Catholics/Anglicans). Based on this distinction, the Pentecostal/charismatic group reported more of strict dichotomy with spiritual emphasis for dealing with health and other problems compared to the mainline group:

*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).*

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).

### (3) 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:

*Ujama:*

*...in Nigeria usually that mentality is still carrying me over here.... (FG: lines 546-558).*

Also are those emanating from the use of available healthcare system in the host country – in this case the NHS:

*Ugochi:*

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

Previous knowledge is a relevant index as previous studies among immigrants from Africa show poor knowledge of certain illnesses prior to migration (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 (Mupepi et al., 2011; Odetola, 2011). Similarly, the positive experiences that accompany the use of traditional/spiritual healing has positioned it as a better sought and patronised alternative than Western medicine (Leach, 2000; Nuwuha, 2002); with over a third of West Africans reported to seek treatment from African traditional healers (Folb, 2000). In the same vein, the experiences of traditional healing methods among Africans resulted to a feeling that it is more effective, and its practitioners more humane when compared to orthodox methods (Comoro, Nzimba, Warsame, & Tonson, 2003)

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 already noted above. This factor and its implications are further concretised by the following quotes from both focus group discussion and personal interview:

*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)*

*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)*

### **Theme 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 the next two sub-themes of the framework: *Positive experiences of using the NHS, and Illness conditions.*

#### **(1) Positive experiences of using the NHS**

Respondents reported positive experiences that can encourage the use of the medical method, in spite of 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 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. 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 provided a better insight on this.

## (2) 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, according to a BBC report (BBC News, 2011), Nigerian immigrants in the UK were found to be sourcing spiritual healing as a cure for HIV/AIDS, which casts some doubts as to the degree to which illness severity can compel them to use the medical services. For instance, in a personal interview with Hajiya, (living with a heart condition at the time), the motivation

for preferring a particular treatment method was to achieve a permanent cure

*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).*

This 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:*

*...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).*

#### **Theme 4. Acculturation issues**

This theme is based on two sub-themes derived from the data showing that the challenges encountered in adjusting to the new environment by Nigerian immigrants slowed the process of their smooth integration: *Health provider collaboration and Behaviour change*. It also represented participants' opinions on possible actions needed to enhance integration into the larger British culture; as it can help to resolve some of the challenges, especially poor doctor-patient relationship and communication (Das, Olfson, McCurtis & Weissman, 2006):

*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.... (FG: lines 872-887).*

*(1) Health provider collaboration*

To address such important issues as doctor-patient relationship and communication participants suggested improvements that can facilitate the process of integration and consequently, adequate access to healthcare services:

*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 (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 method of cure with

other alternatives, especially the spiritual approach. This suggestion is in line with available study on church-based home care providing patients with the benefits of personalised and culturally appropriate care in a familiar environment (Young, et al. 2005) as contrasted with the experiences of neglect from government-based health care system (Dossou-Yaro, Amalaman, & Carnevale, 2001):

*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.

## *(2) 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 change their behaviours and 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). 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; such 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).*

## **Discussions**

This qualitative study of applied thematic approach has been useful in providing insight to the different factors useful in investigating health seeking behaviour 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 bio-psychosocial 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 analysis yielded four major themes for discussion.

The theme on challenges of immigration reflected both obstacles and motivators to health care utilisation resulting from the physical and socio-cultural environments, as well as attitudinal differences in response to western medication when compared between black and white patients (Miranda, & Cooper, 2004; Cooper et al., 2003). These combined with past experiences of illness and its management to influence health seeking behaviour. Immigration challenges and health care utilization has relevance to the reported emphasis on social support mainly from families and religious groups. This is consistent with research reports on African reliance on families for health advice, especially the elders and significant others which included family heads and spiritual leaders/religious ministers (Abubakar, et al., 2013).

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 perception, 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 influence health-related decisions. However, some reports of pre-migration factors did not preclude the quest for acclimatisation and integration into the British culture through acculturation and collaboration. 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). For instance, relying on spiritual

healers has conversely influenced the proliferation of spiritual healing method 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 implication is that Nigerian immigrants should change their attitude towards sourcing health information, with the overall aim of changing negative health-seeking behaviours. Consequently, there is need for enhanced communication with the health professionals who must command patient's trust because such compromise could result to fear and '...distrust towards the system, and lack of confidence in health professionals' (Howerton et al., 2007 as cited in Nsereko et al., 2011, p. 1).

### **Strengths and limitations**

This study highlights the risk factors associated with poor health-seeking behaviours among one of the minority ethnic groups in the UK, not yet explored. Moreover, it is not a disease-specific study (Kendall-Taylor, 2008; 2009; Nwanesi, 1995), instead it explored a combination of both physical and mental illnesses. To do this, it draws on the strengths of one-to-one interviews and focus group discussions (de Visser & Smith, 2007; Wilson, 2014). This combination used individual interviews to enable participants to discuss personal and sensitive issues; and also utilized the dynamics of group discussion to foster interactive participation in the focus group, thereby allowing participants to build on each other's points (Stewart & Shamdasani, 1990). This was mainly evident as participants' opinions were divided on what should be the appropriate health seeking approach. For instance, where participants of Pentecostal/charismatic orientation viewed illness and cure from a strictly spiritual dimension, those of the mainline denominations expressed both spiritual and secular dimensions. These debates and tensions were possible in the focus group, but not with individual interviews. This aspect adds to the depth of information on the research by

highlighting the disparities of opinions among Christians. This is consistent with previous studies (Leavey, 2010) showing an interplay between cultural beliefs and theological interpretation of events in life, especially among the Black Pentecostal Churches. These differences in theological, philosophical, and anthropological views of the human person, and consequently of illness aetiology and cure arise from differences between Protestant, fundamentalist, evangelical, traditional and liberal Christian denominations (Malony, 1998).

However, this study has some limitations as most of the responses reflected only the experiences and views of Nigerian Christian immigrants. Also, considering that participants have been in the UK for many years with potential for some level of integration, this report cannot be used to make generalisations about the overall experiences of all Nigerian immigrants in the UK. 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).

In spite of these limitations, this study has explored how the interplay between culture-based illness perceptions and religious beliefs can influence health-seeking behaviours and hinder favourable health outcomes among Nigerian immigrants. The implication is that adequate motivations has been provided for another study (currently in progress) towards enhanced health services utilisation by further exploring these factors from the perspectives of service providers (clergy and health professionals) from Nigeria. This is with the hope that a process of collaboration among different care providers can be achieved in the face of a reorganised NHS; as research shows that adequate understanding of patients' culture by the clinician is necessary for successful therapeutic outcomes.

**(Word count: 5975)**

## Tables and figure

Table 1: Participants/demographic background

Participants	Gender	Age range	State of origin	SES/Religion
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

\* P/I = Personal Interview, FG = Focus Group.

Figure 1: Recruitment process

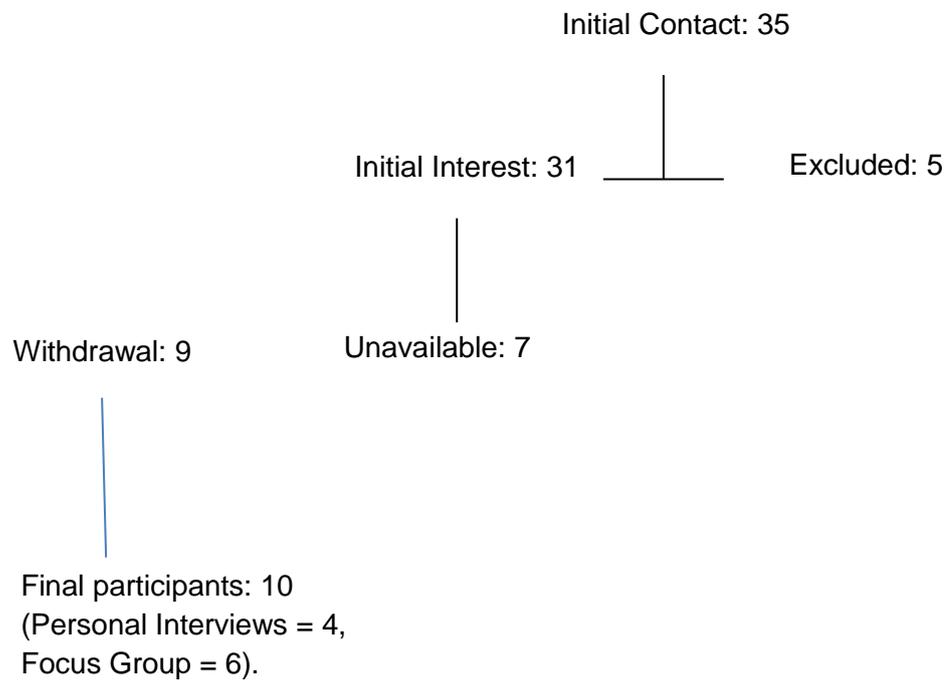


Table 2: Identification of themes

Basic themes	Organising themes	Global themes
<p>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.</p>	<p>Challenges and coping strategies.</p>	<p>Immigration challenges</p>
<p>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)</p>	<p>Illness perception/beliefs, physical and structural factors, other treatment options, past experiences, financial aspect.</p>	<p>Barriers to health care utilisation.</p>
<p>Health-seeking methods and experiences: medical, spiritual, alternative medicine, self-efficacy, positive experiences, illness condition, structural factors, the</p>	<p>Positive experiences, illness condition.</p>	<p>Facilitators to health care utilisation.</p>

environment		
Contribution and opinion from participants, needs for improvements, regulation against abuses, and barriers, collaboration, attitude change needed.	Health provider collaboration, behaviour change.	Acculturation

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