Nigerian clergy and healthcare professionals' perceptions of health-seeking behaviours among Nigerian immigrants in the UK

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Abstract:

Healthcare underutilisation due to religio-cultural differences has been recorded among immigrant groups. The diversity in patient populations due to immigration in the UK has implications for adequate understanding of a patients' culture by the clinician as well as patient-clinician cultural matching for enhanced service use and outcome. This qualitative study investigated how Nigerian clergy and health professionals perceived health-seeking behaviours among Nigerians in the UK; while considering the impact of their own beliefs and values as care providers. Six participants were interviewed (clergy, n = 2; health professionals, n = 4). Data was analysed using Interpretative Phenomenological Analysis. Results showed that the clergy and health professionals themselves use religious/cultural cure and formal healthcare methods, and believed Nigerian immigrants as predominantly using religious / cultural methods which can affect healthcare utilisation, although differences between the professionals were reported. The potentials for integrating other cure methods into the formal healthcare services was considered, while highlighting the challenges that may arise from such collaborative effort.

Key words: Nigerian immigrants; religion; healthcare utilisation; collaboration.

Introduction

The diversity in patient populations and the lack of awareness regarding immigrants' religious and cultural sensitivities is consistent with existing research (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). Observable health inequalities among the UK population show poorer access to health services (Sue & Sue, 2004) and increased use of faith-based methods among immigrants. Religion and culture form the basis for the prevailing health-seeking behaviours among Nigerian (James & Gashinki, 2006) immigrants, with consequences for health services underutilisation.

Research has shown that faith-based treatment options for the most can be unorthodox, misguided and may lead to harm as religious leaders may not have adequate skills in handling severe health conditions; which has morbidity and mortality consequences. Also, existing studies show that health workers' experiences and skills in dealing with clients' spirituality in therapy are inadequate (Smiley, 2001), with poor incidents of cross-referrals to other therapists suitable to deal with client's religious beliefs. This gap in the UK healthcare system necessitates an urgent need for a health system with an integrative and culture-sensitive outlook through collaboration between the religio-cultural and healthcare professions to enhance healthcare utilisation. This need becomes even more urgent due to increasing influences of the Black Majority Churches (BMC), which is the only Christian denomination experiencing growth in England (British Religion in Numbers, 2011). Most of these churches have Nigerian origins, a country with the largest population of Pentecostal population in Africa (Christian News, 2014); with recognisable influence among Nigerians in the UK (Olofinjana, 2010).

There is therefore a need to explore the experiences and values/beliefs of Nigerian care providers in the UK 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. The aim of this study was therefore to highlight the potentials for an integrative healthcare system through collaboration between the clergy and healthcare workers. To achieve this, it was important to understand the health-seeking behaviours of Nigerian immigrant care providers as research confirms that patient-clinician cultural matching can influence service use and outcome (Chinman, Rosenheck & Lam, 2000; Mathews et al., 2002).

Method

This qualitative study used semi-structured interviews for primary data collection (Saunders, Lewis & Thornhill, 2007). The interview approach was adjudged most suitable for data collection allowing for privacy in focusing upon their potentially sensitive experiences as immigrants. Moreover, the use of interviews in the present study was for convenience, as it was easier to agree on specific times suitable for individual participants. The Interpretative Phenomenological Analysis (IPA) was chosen for data analyses as it is deemed more suitable with interviews where personal experiences can be better expressed without group influences as in the case of focus group discussions (FGD).

Participants

Participants were drawn from a population of Nigerian-born clergy and health professionals who were Christians living/working in London. The participants were adults actively engaged as qualified Christian clergy and or healthcare professionals in the UK (N = 6; 3 men and 3 women). A small homogenous sample size was used to avoid the loss of vital, salient points

during analysis (Brocki & Wearden, 2006). Homogeneity was based on nationality, professional status, and place of abode; all participants were represented in this study with pseudonyms for the purposes of anonymity and confidentiality.

Procedure

Data collection was based on in-person interviews. Recruitment of participants was carried out through the snowball process by contacting leading clergy from various Christian denominations and healthcare professionals in the UK, who in turn helped to recruit their colleagues. This research therefore adopted a 'purposive sampling' approach (Willig, 2001, p. 58) by choosing participants with criteria relevant to the research question. The interview protocol contained the information sheet, consent forms and debriefing sheet with details of the research schedule informing participants about the aims and purposes of research, aspects of confidentiality, anonymity, and freedom to participate or withdraw at any time without having to offer any reasons. Ethical requirements were fulfilled, and permission was granted by the University Ethical Committee. The interviews lasted between 80 to 90 minutes, and were recorded using two tape recorders which were later transcribed verbatim by the researcher. The IPA method of analysis was adopted with the aid of the NVivo 10 software.

Analytic process

The analyses followed the 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). 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).

The process 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 thoughts were recorded on the right margin of transcripts with the corresponding quotes imported from the dataset unto the Nvivo node structure, where reference numbers were automatically generated for each quote, which represented the basic themes from all 6 participants. The second step involved 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, which were designated with relevant reference numbers for each participant. These concepts were written out in an organised form beside each participant's references and colour-highlighted for easy identification.

The third step involved the integration of these basic themes (grand-child nodes) within each script into clusters based on their similarities in meaning. 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. The fourth step involved the generation of a summary table for all the clustered themes from each script, so that similar themes from each script were integrated into a more concrete and representative theme known as the constituent theme (child node), using relevant 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. Hence, the fifth step aimed at integrating all similar constituent themes, while considering the contents of all the basic themes generated within each cluster to arrive at the superordinate/master themes, with a more global concept representing an overarching interpretation of participants' experiences. This process resulted in three super-ordinate themes that guided the analyses (Table 1).

Table 1 here

Results

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

This master theme emerged from the descriptions of 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 upon the use of available healthcare services. This theme further 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:

1.1 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 influenced by individual beliefs (religious/cultural) and illness perceptions. Despite confirming that Nigerian immigrants utilised both the health services and alternative methods, participants discussed how Nigerian immigrants tended to use spiritual or faith-based methods as the first choice, which is supported in the following quotations 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)

Most participants reported faith based advise was sought first, and their intimate knowledge and experience of working within the community, and being Nigerians and Christians themselves, were probably responsible for this. However, as the religious affiliation of health workers are not usually disclosed and, the choice of consulting a particular health worker may not be accessible to the patient, this theme is important based on the degree of precedence it occupies among participants’ order of health seeking preferences, given the availability of a free NHS, especially at the point of entry. 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)

However, one participant (a GP) was less willing to generalize. He believed that type of illness, pre-existing background, and religious affiliations particularly the strong influence of one particular Nigerian religious denomination, the ‘New Age’ Pentecostal group, determined the preferred choice of therapy as shown in the quote below:

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)

Such reliance on spiritual methods of cure and the religious leaders in some Nigerian immigrants may put the Nigerian clergy in a position of power, influencing health-related decisions within the community. Moreover, the level and direction of such influence can be determined by personal dispositions of the religious leader ranging from socio-psychological, religious, cultural, and cognitive factors, that can determine healthcare utilisation as was found in the next constituent theme.

1.2 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 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, such as spiritual/supernatural causes, and preferred treatment methods (Okello, 2007) prevalent within the Nigerian community were reported to determine health seeking behaviours.

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).

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 can become influential in their personal and professional lives as well;

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)

Although most participants expressed their religious beliefs as important in their profession, the health professionals showed a degree of variation in their attitudes towards religious cure as they tried to maintain a balance between their religious-cultural beliefs and professional practices. This suggests the need for cultural training among health workers in addressing the health behaviours of ethnic immigrants (LaVeist & Carroll, 2002), and provided an important basis to further explore the issues of collaboration among care providers.

2. Master Theme 2: Issues in collaboration

This theme emerged in the attempt to harness the roles of religious leaders and health workers towards an integrative healthcare provision. Issues raised within this master theme were viewed from two perspectives: (1) the readiness among various care providers to accommodate each other and (2) the anticipated challenges barriers experienced. As in previous studies, the processes of collaboration have been explored with the aim of improving health outcomes (Meylink & Gorsuch, 1988) as well as managing the challenges and barriers resulting from differences in beliefs and practices among care providers (Leavey, 2010).

2.1 Openness to collaboration

This sub-theme considered the potential for collaboration between the clergy and health professionals as a means of complementing each other for the benefit of service users. These were further explored through cross-referrals between the clergy and health professionals. As reported below, both groups appreciated the need for cross-referrals;

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)

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)

The quotes above confirmed the clergy's willingness to refer to medical practitioners, but also demonstrated there was some hesitation for corresponding referrals from health workers due to professional constraints; suggesting a unidirectional flow of referrals - from the clergy who were regarded as 'gatekeepers' within the mental health system (Meylink & Gorsuch, 1988), as shown in the quote below;

MOYI (medic):

'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)

However, despite the variations in the degree and mode of integration preferred among the professionals, this constituent theme concluded that both the clergy and health professionals agreed on the need to collaborate. The reasons for such differences were found

to be based on differences in personal, religious, and professional beliefs/practices, as discussed in the next constituent theme.

2.2 Personal and professional challenges

This theme discussed 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 on providers' personal lives and consequently reflect on the ways they carry out their duties of care. However, although the health workers were bound by their professional training and felt unable to make official referrals to a spiritual healer/clergy, they did this unofficially; as reported by one of the doctors in the following quote;

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).

Nigerian health care providers are therefore, compelled to influence the therapeutic process or health-related advice in private, irrespective of the demands of their regulatory bodies. This sub-theme further explored personal attitudes (impacted by religious and professional beliefs, level of awareness and skills needed in therapy, personal and professional interest, etc.), and how this directly or indirectly influenced their practices in relation to being members of a broader cultural group. The issues of 'beliefs' and 'interests' continued to resonate among participants as represented by the 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 noted above, referred 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 as discussed previously. In this regard, participants reported on the challenges arising from differences in the underlying principles of care which reflects on differences in the objectives, underlying motivations and philosophies that define religious and medical approaches to cure. However, despite these challenges and barriers, participants noted that some areas of the healthcare system were amenable to integration with the spiritual method of cure as discussed in the next master theme.

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 (Leavey *et al.*, 2007) that the clergy might not be well equipped to handle physical health conditions as noted previously, 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.

3.1 Interface for spirituality and health

As reported earlier 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. Consequently, all health professionals in this study suggested that ideally a more appropriate 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):

'When it comes to end of life care that is the palliative care where the spiritual is important, and I think that's an area where, yes there will be good collaboration, …mental health, end of life care, the palliative' (Lines 200-213).

The meeting point between spirituality and medicine therefore, appears to occur 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. This finding addresses

an age-long suggestion for a more prominent model where health professionals can fully interact with faith-based practitioners (Meylink & Gorsuch, 1986; Gorsuch & Meylink, 1988). For instance, adopting such initiative has led to a collaborative relationship where psychologists formed part of supervisory teams for pastoral counsellors and vice versa (Coyle, 2010).

Discussion and conclusion

From the themes presented within this study, the analysis showed a full (100%) agreement among participants that religious coping styles formed the predominant approach to cure among Nigerians in the UK. This trend implies the popularity of spiritual healing, evident in the rapid proliferation and public relevance of such methods orchestrated by the current forms of African Christianity - The Black Minority Churches (BMC) (Adogame, 2007). Apart from the religious and cultural determinants reported in this study, other factors such as poverty and ignorance have been identified in a similar study in Nigeria (Onyigbuo et al, 2015), which confirms the role of social capital in health seeking among developing countries (Gerrish, Chau, Sobowale & Birks, 2004), with unavailable, inadequate, expensive or unaffordable medical services. However, the importance attached to the pre-migration impact of poverty in healthcare utilisation among immigrant Nigerians was based on its continued role in view of a free medical service (NHS) at the point of entry. Moreover, the importance of religious and cultural beliefs in response to illnesses were shown in relation to responses among immigrant Nigerian care providers, who expressed similar religious/cultural beliefs, although with variations due to factors relating to professional care contexts, differences in levels of religious commitment and affiliation, educational levels, and the levels of integration within the host culture.

With the dominant role of culture and religion as well as the vantage position occupied by the clergy in patients' health-seeking decisions, this study explored the potentials

for collaboration among care providers towards an integrative and culture-sensitive approach. An interface between spirituality and psychology was identified by participants as a possible context for collaboration, which is consistent with existing research carried out ….. (Benes et al., 2000). Although the need for collaboration was commonly reported by all participants, the clergy showed a more practical approach than the health workers who welcomed it in principle but felt constrained by the regulations within the NHS. Such differences of opinion are consistent with existing studies regarding difficulties among healthcare providers to incorporate spirituality in their therapy protocol (MacDonald & Holland, 2003). The study also identified potential risks to effective health care treatment such as the informal/private referrals to spiritual methods by healthcare workers based upon the personal health beliefs and illness perceptions which are influenced by their own heritage religion and culture. This confirms existing research on the impact of therapists' beliefs and values on therapy processes and outcomes (Herschkopf & Peteet, 2016). Successful collaboration can only benefit minority ethnic migrants who may be inclined to consult therapists from their own cultural background only, usually the spiritual leaders/healers. The benefits identified in this study comes from the practice of clergy working within the healthcare setting who could attract hard-to-reach groups in an effort to improve healthcare utilisation, as previous studies conclude that cordial patient-clinician relationship enhances therapy use and outcome (Mathews et al., 2002). This process can benefit Nigerians immigrants particularly, as the Black Minority Churches (BMC) in the UK are dominated by Nigerians (Olofinjana, 2010). In particular, the need to collaborate with the clergy was based on the importance of their role within this community, where they are perceived as the people's 'doctors' and relied upon in the dynamic process of decision making.

This study therefore highlights the impact of pre-migration factors in migrants' health seeking behaviours, both as care providers and as clients, such as religious and cultural

beliefs, irrespective of the dominant role of the host culture. This finding necessitates a review of the sources of health information available to Nigerian immigrants, following the pivotal role of religious groups in their health-related choices. To this effect, there is a need for enhanced collaboration among clerics and health professionals to improve mutual trust and increase cross-referrals between both methods. Religious ministers are in an ideal position to become an important source of medical referral for hard-to-reach immigrant groups who otherwise would not avail of available healthcare services, contributing to the continuing widening gap in the UK health inequalities records unabated.

Strengths and limitations

This study has highlighted the risk factors associated with inappropriate health-seeking behaviours across all kinds of illnesses, rather than a disease-specific study. However, it is limited in that the sample was drawn from members of the Christian religion alone. Also, the use of a second language (the English) in the interview may have led to poor expressions of experiences among participants and consequent misinterpretations by researcher (Temple, 1997). Despite these limitations, this study successfully explored the interplay between culture-based health-seeking behaviours and religious beliefs of Nigerians within the UK health services providers of care and patients alike.

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