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“What a dog will see and kill, a cat will see and ignore it”: an exploration of health-related help-seeking among older Ghanaian men residing in Ghana and the United Kingdom

Lailah Alidu¹, Elizabeth A. Grunfeld²

1. Population Evidence and Technology, University of Warwick Medical School, Coventry
2. Department of Psychological Sciences, Birkbeck College, London.

Corresponding author:

Elizabeth Grunfeld

Department of Psychological Sciences,

Birkbeck College,

London.

e.grunfeld@bbk.ac.uk

Abstract

Background: Healthcare utilization rates are lower among men, however, little is known about how men's healthcare utilization is affected by migration. The aim of this study was to explore health-related help-seeking decisions among older Ghanaian men residing in the United Kingdom and in Ghana.

Methods: Twenty-six men aged 50 years or over were recruited from community locations within two large cities in the UK and Ghana. Face to face semi-structured interviews were undertaken to explore the illness and help-seeking experiences of older men.

Results: Help-seeking experiences differed among the Ghanaian men living in the UK and in Ghana. Three themes were identified that impacted on help-seeking decisions: (1) pluralistic approaches to managing health and illness and (2) perceptions of formal health services in Ghana and UK and (3) financial constraints and masculinity norms as barriers to help-seeking.

Conclusion: This is the first study to look at help-seeking decisions among older men residing in the UK and Ghana. Findings highlight how older migrant men's explanatory models of their health encompass enduring faith-based beliefs around causation of illness and approaches to management, as well as the use of pluralistic approaches to managing health. This study supports the call for culturally sensitive community-based interventions to increase engagement and facilitate improved health outcomes for migrant populations, particularly older men.

Keywords: help-seeking; Ghana; United Kingdom; migration; self-regulation model

INTRODUCTION

The process of migration can increase vulnerabilities to acute and chronic disease due, in part, to underutilization of healthcare. Within African countries lower rates of health-related help-seeking are influenced by issues of intersectionality, whereby adults who are at increased disadvantage are of older age, male gender and lower socioeconomic status (Ahmed et al., 2000; Ahmed et al., 2005). People who migrate to another country are often healthier than those who do not, which is known as the *healthy migrant effect*, however, this health advantage diminishes over time. Migration can result in the loss of the social, cultural, and economic connections forged in one's country of origin. Migrants may also experience challenges around using a new language in the host country, which can impact on engagement with healthcare services. In fact, it has been proposed that language and health-related preferences are stronger predictors of healthcare utilization than socioeconomic status (Klein et al., 2018).

The acculturation process is an additional factor that may adversely impact health outcomes, not only through heightened stress but also through changes in lifestyle and adoption of unhealthy behaviours, such as a sedentary lifestyle and high fat diet (Alidu and Grunfeld, 2018). Furthermore, the socio-demographic characteristics of migrants (e.g. lower level of education and higher unemployment) and acculturative demands (such as normative orientation towards poor health behaviours) also play a role in shaping health outcomes and health-related behaviours, such as healthcare utilisation (Hernández-Quevedo and Jiménez-Rubio, 2009). In addition, there is a role for individual expectations, including perceptions of whether healthcare services are available or accessible (Fung and Wong, 2007). Evidence suggests that lower help-seeking rates among ethnic minorities, compared to non-minority patients, may be a consequence of mistrust, fears of discrimination and prior negative interactions with healthcare professionals (Gaskin et al., 2009). Furthermore, management of illness in the African context is often pluralistic (Kroeger, 1983; Farnes et al., 2011) and not dependent solely on seeking-help through medical channels; people use multiple sources of assistance such as herbal medicine (use of herbs to treat illness/disease), spiritual healing (healing that targets the body, mind and spirit), and allopathy (use of medical/pharmacological approaches).

Herbal medicine is commonly used worldwide. Around 25% of the UK population are thought to have used complementary and alternative therapies, including herbal medicine,

naturopathy and homeopathy (Ritchie, 2007). Use is substantially higher in African countries; the World Health Organization estimates that 80% of the population across Africa use herbal medicines (Tilburt and Kaptchuk, 2008). Herbal remedies are often based on general folk knowledge, or prescribed by local healers. The practise of traditional medicine varies region by region but it is common within Ghana for people to sell traditional medicine and herbal products on the street, through door to door selling, aboard buses and within schools or health centres (Kretchy et al., 2014). The reasons why individuals choose specific medical, complementary or alternative treatments may depend on their previous experiences, perceptions of the efficacy of particular methods, as well as the perceived cause of their illness.

In countries with constrained resources (including limited health infrastructure) decisions regarding healthcare utilisation and treatment are often based on cost and affordability. In Ghana, men are often the higher earners and are perceived as overseers of family finances and therefore likely to make decisions about the affordability of medical consultations and treatment for family members (Buor 2004). However, men themselves are less likely to utilize healthcare services, compared to women, and this impacts on health outcomes. For, example, longer help-seeking intervals (time period between first identifying a symptom to seeking medical help) may lead to later diagnosis, which in turn impacts on treatment outcomes. This may account, in part, for higher mortality rates observed among men across a range of conditions (Hale et al., 2010). The international literature (mostly conducted in Europe, Australasia and the USA) suggests that the longer help-seeking intervals observed among men are a consequence of misinterpretation and minimisation of symptoms (Fish et al., 2015; Yousaf et al., 2015), as well as strong negative emotions, such as embarrassment and fear (Fish et al., 2015; Smith et al., 2005).

In addition, traditional masculine norms, such as a tendency towards self-reliance, emotional control and stoicism are associated with delayed help-seeking (Fish et al., 2015; Courtenay, 2000). Traditional masculine attributes, including perceived invulnerability and endurance of pain, may deter men from seeking professional help (Courtenay, 2000; White, 2002). Furthermore, men's social experiences play a role in shaping their attitudes and beliefs towards help-seeking (Galdas et al., 2005). However, help-seeking role models may not be as readily available to men as female role models are to women, given that men are less likely to disclose an illness diagnosis (Gray et al., 2000).

Ghanaian women living in Ghana or in the UK share similar perspectives regarding healthcare services and help-seeking (Mills et al., 2012; Bastard et al., 2013). However, health decisions among men and women from Ghana may differ (Alidu and Grunfeld, 2017) and it has been shown that men residing in Ghana are three times more likely to use complementary or alternative medicines than women (Kretchy et al., 2014). There is also preliminary evidence for gendered differences in help-seeking among Ghanaian men living in the UK, with Ghanaian men less likely to report help-seeking behaviour than Ghanaian women (Alidu and Grunfeld, 2017). Furthermore, as it has been shown that men of all ages, ethnicities, and nationalities seek help less frequently than women, regardless of country of residence (Addis and Mahalik, 2003). However, the factors that influence men's help-seeking within a Ghanaian, or African context, are currently not well understood. This study utilised a qualitative approach and focused on older Ghanaian men residing in London, (UK) and made a comparison with a similar cohort of men residing in Kumasi (Ghana). The aim was to explore approaches to managing symptoms and health-related help-seeking among older Ghanaian men.

METHODOLOGY

Ethical approval was obtained from a UK University Research Ethics Committee and applied to data collection both in the UK and Ghana.

Participants and procedures

Eligibility criteria for the study included being (1) born in Ghana, (2) male, (3) aged 50 years or over and (4) residing for a minimum of 12 months in either in London (UK) or Kumasi (Ghana). Over 96, 000 Ghanaians reside in the UK (Office of National Statistics 2018) and London is home to the largest Ghanaian migrant (defined in this study as a person who was born outside of the UK but who had resided in the UK for 12 months or longer either legal or illegally, voluntarily or involuntarily) population in UK. Kumasi is the second largest city in Ghana (with a population of over 1.7 million) and is considered to have strong traditional and cultural roots alongside modern infrastructure and values (Ghana Statistical Service 2013). This paper uses 50 years and above as the definition of older adults. This cut-off has been used previously to describe the older population in Africa across multiple studies including *The Minimum Data Set (MDS) Project on Ageing* (supported by the World Health Organization) and the *Study on Global Ageing and Adult Health* (World Health Organization,

cited 2020; Kowal et al., 2010). Furthermore, the U.S. National Institute on Aging utilises 50 years and above as the cut-off to refer to the older population in Africa. Respondents were purposefully sampled according to key socio-demographic factors including age (aged 50-60 and aged over 60) and marital status (married, not married). Recruitment took place through posters placed in community locations including churches and community centres. Participants were asked to identify other potential participants from their social network and pass on details of the study. If their contacts were interested in taking part, they then contacted the researcher. This “snowballing” technique is effective in identifying participants from “hard to reach” groups (Browne, 2005). All potential participants were provided with written information about the study and had the opportunity to ask the researcher questions. Following this, those who were interested signed a consent form before the start of the interview. Participants were made aware (both in the information sheet and verbally) that their participation was voluntary, that they were free to stop the interview at any time without providing a reason and that they could withdraw their data from the study prior to publication.

Interview schedule

Individual, face to face semi-structured interviews were conducted at participants’ homes by one researcher (LA) in English. The first part of the interview schedule was based on the self-regulation model (Leventhal et al., 2016), which proposes that patients form schemas about symptoms (known as illness perceptions) based on previous experiences, knowledge and input from others - these illness perceptions then drive coping responses. Of specific interest to our study is that the self-regulation model also outlines a dynamic appraisal process, whereby patients evaluate the appropriateness and efficacy of their coping and, on the basis of that appraisal, may modify their illness perceptions or try new coping responses. We felt this model to be relevant to our study as it allows exploration of how the men adapted their appraisal and coping responses in different contexts. Therefore, the schedule explored experiences of ill-health and subsequent actions (coping strategies) and the appraisal of these. However, the interview was broad and did not focus on a particular illness in order to allow participants to narrate instances of ill-health based on their personal experiences and definitions of ill-health. In addition, participants residing in the UK were asked to reflect on differences in experiences, perceptions and choice of coping behaviours in Ghana compared to the UK.

Data Analysis

Interviews were recorded, transcribed verbatim and analysed using the Framework analysis approach (Ritchie and Spencer, 2002). This approach was originally developed for applied qualitative research and is now widely used within the UK. Despite using the broad concepts of appraisal and coping from the self-regulation model to guide the interviews, we chose an inductive approach to analysis. The inductive approach allowed findings to emerge from frequent or significant themes within the interviews and reduced the likelihood of obscuring key themes due to preconceptions imposed by the researchers. This was felt to be important given that we were exploring the role of culture and migration on the experiences of a relatively under-researched population. Therefore, the study applied a hybrid approach to qualitative research, in that both inductive and deductive approaches were used (Swain, 2018).

Following completion of all interviews, each transcript was analysed by noting relevant units of meaning and creating free codes. Free codes were then grouped into coherent themes. A matrix was developed, with emerging themes and sub-themes highlighted, which facilitated the identification of themes that spanned across participants. All themes emerged from the data (inductive coding). Once themes had been identified for each participant, these were integrated across participants to generate a list of superordinate themes that captured the participants' shared experiences. The next level of analysis involved the examination of relationships and interactions between the themes. Two researchers (LA and EAG) read the first four transcripts independently and undertook an initial coding process separately to identify meanings. These original codings were discussed and ordered into themes that were then used to produce a preliminary framework to guide the remaining analysis. This preliminary framework included all the coding and initial themes that were identified by the two researchers. The remaining analysis was undertaken by one researcher (LA) with continued discussion throughout the analysis process with the second author. Any differences were discussed and a consensus reached between the two researchers; the differences that emerged were around the naming of new themes and whether the coding of the new text fitted with existing themes.

RESULTS

Twenty-six participants were interviewed; 13 in London and 13 in Kumasi. The average age was 58 (range 50 to 78). Eleven participants (5 UK participants, 6 Ghana participants)

reported having a chronic condition including hypertension, diabetes, emphysema and asthma. No participant reported more than one comorbid condition. The Kumasi sample had a mean of six children compared to three among the London sample (see Table 1). None of the Kumasi sample had ever travelled to the UK. Three themes were identified that impacted on help-seeking decisions: (1) pluralistic approaches to managing health and illness, (2) perceptions of formal health services in Ghana and UK and (3) financial constraints as a barrier to help-seeking (see Table 2).

Pluralistic approaches to managing health and illness

Symptom attributions were accompanied by variability in management choices. Ghana's healthcare system is said to be pluralistic in that it combines both traditional (e.g. herbalists, priests and traditional healers) and biomedical approaches to healthcare. The men in this study spoke of the role of pluralistic approaches to managing their own health.

Use of herbal medicine

Although the men in the study had previously used herbal medicines the UK based participants did not currently utilise herbal medicine. This was a consequence of lack of availability of preferred herbs, not being able to identify a trusted practitioner and because other sources of support within the UK were perceived to be quicker to access. Practitioners selling herbal treatments were perceived by some men in both countries to be unqualified and herbal treatments were viewed as untested and lacking safety approvals. In contrast, biomedical approaches were viewed as more effective and able to produce faster results. However, amongst the Ghana based participants herbal medicines were still widely used because they were cheaper and readily available.

I used herbal mixtures in Ghana but , ever since I have been here (UK) I haven't mainly because I cannot get some and also, even if I do, I don't know who made it. Perhaps if I get the original herbal mixtures here in the UK, I will gladly use them.
(AB, UK)

There are other forms of treatment but for malaria, if you don't go to hospital, it wouldn't go faster. Herbal medicines and other forms of treatment are very slow when you use them. (W, Ghana)

However, some participants did reveal a preference for herbal medicines that they produced themselves, although participants in the UK spoke of difficulty in obtaining ingredients that were readily available in Ghana. Furthermore, all participants had experience of herbal medicines and there was a common perception that herbal treatments, although not always effective, were natural and were unlikely to cause harm.

Because of the condition I have, I am already using a lot of these chemical formulations. A lot of them. Within a day, you take this, you take that, in the morning, afternoon, and so I do not want not to add more of those things. If there is herbal substitute for those things which could do similar things I would prefer to go for the herbal substitute. (Y, Ghana)

Self-management of symptoms

Help-seeking is part of a process that involves multiple responses including symptom perception (awareness), interpretation or labelling the symptom, appraisal of the seriousness and decision-making around whether to seek help from a healthcare professional. This process is part of a self-regulation loop whereby individuals may undertake multiple responses, or behaviours (including self-management), prior to seeking help. Participants attributed delayed help-seeking to individual differences regarding how an individual might (mis)interpret the seriousness of symptoms, which would then impact on how they responded.

What a dog will see and kill, a cat will see and ignore it. (J, Ghana)

Self-management was often the first approach tried for commonly experienced symptoms (e.g. headache) that were appraised as not requiring professional healthcare support and men spoke about holding adequate knowledge of symptoms and experience of how to manage these. Self-management (particularly among the UK based sample) included purchasing medicines that they had previously obtained for similar symptoms, which they viewed as “tried and tested” remedies for recurrent illnesses or symptoms

I will not go to the GP if it's a cold or a cough. With the cough, I have my tried and tested remedies for cough. (M, UK)

For me can tell if I really need to go to the hospital. Sometimes when I am not well I can tell the cause of it, may be the food I ate or haven't had enough rest. In these cases I will give myself time to get a good rest and I am alright. (K, Ghana)

Spiritual or faith-based healing

All participants in this study held religious beliefs (69% identified as Christian and 31% as Muslim) and all had knowledge of the role of spiritual healing. Participants in London spoke of spiritual healing as complementary to Western medicine. There was a belief expressed that God not only heals but that God gave the doctors their knowledge to heal others, therefore, although one might seek treatment from a doctor, prayer was often included alongside. When asked about spiritual healing, one respondent explained that even though illnesses are expressed in a physical form, the cause could be spiritual and as such prayers were needed for protection and recovery.

I pray, I am a Christian so I pray a lot and I also ask people back at home to pray for me, because I know from the Bible that a lot of things can go on [spiritual]. I know sickness is physical, but spiritually too one can get you some boosted immunity. (B, UK)

In Ghana spiritual healing was sometimes used as an alternative to medical sources. Some participants spoke about illness as attributable to spirits or caused by the supernatural and therefore required spiritual healing as the only treatment option.

I pray that I don't get sick such that I will need to seek spiritual help. (H, Ghana)

Perception of differences in formal health services in Ghana and UK

Participants in the UK made comparisons between healthcare provision in Ghana and the UK, based on own experience of both systems. There were no clear differences in the experiences of men related to the time that they had spent in the UK. In the UK men spoke of the healthcare system as having an active role in both preventive and curative initiatives; general practitioners were perceived to be easily accessible and walk-in health centres as available to all. Some participants explained how in the UK older men were routinely sent invitation and reminder letters about regular check-ups, which one participant described as an "MOT" (UK test undertaken annually to determine a car's road worthiness) for older men. This was viewed as a positive factor in promoting the health of older men.

Back at home, they will not even be forcing you to have tests. But here, you are routinely invited. Even if you refuse, they will send a reminder. Assuming you forget it they send reminders. At times they send it far in advance. Getting to the time, they prompt you, if you refuse to come; they change the date for you. So over here you are

always on your toes. They will always be on your toes to be checking your health status. And some of the things that they do on me here, back at home they don't do. (I, UK)

There are opportunities to check on your health here and this include checking if you are in good health or not. There are like GP, what you call MOT for the over 50's and for every 6 months we are reminded to check on our health, which may include checks on your prostate or health in general. This is something which is not available in Ghana. (AJ, UK)

Among men in Ghana (none of whom had experience of the UK healthcare system) there was a common preference to seek advice from pharmacists, rather than doctors. Although pharmacists are also a first port of call for over the counter medicines in the UK, the Ghanaian based sample in this study reported that pharmacists were viewed as more accessible than doctors and appropriately knowledgeable to provide diagnosis and treatment. In Ghana medical information and medicines are frequently sourced from pharmacies and over the counter medical shops (OCMS), which are commonly used in urban areas, as well from hospitals and doctor's surgeries.

When I feel that my illness is becoming worse I go to the pharmacy. I then describe my condition to the pharmacist and from the drugs I am given, I can deduce that I have malaria. (G, Ghana)

Financial constraints and masculinity norms as barriers to help-seeking

The majority of participants in both Ghana and the UK attributed men delaying help-seeking, at least in part, to financial constraints. However, the drivers behind the financial constraints varied between the two countries. For participants in the UK financial constraints were related to taking unpaid leave to attend medical appointments. This was of particular concern for men in hourly paid occupations, those with casual contracts (zero hour contracts) and self-employed men. There was perceived to be a different attitude in the UK, compared to Ghana, in terms of working through ill health, which although participants accepted, there was still a clear separation between attitudes and behaviours of the migrating and of the host populations.

Here, you have to go to work even if you are not well. You simply have to do what you have to do. This exposure is one of the first thing I became aware of and I realized

that, these people see responsibility differently. When all of these sickness and other things come, you need to take them into account. You may have a cold and not want to go to work but you don't get paid if you don't go to work. (AH, UK)

In Ghana, participants spoke about being the “breadwinners” of the family and the main providers for their families. As a consequence of limited financial resources, spending money on their own health was seen as secondary to their primary role as a father and family provider and therefore was not prioritised. Men spoke of needing to be in “control” and self-manage, rather than seek professional care.

Some is because of money problems, right now, I have no money. I have to look after these children. One day I woke up and I have to go to the hospital, I have to find a drug to buy. Money to buy that drug is not available. How can I buy it? I have to control myself. (Q, Ghana)

Some participants in Ghana also attributed the lack of help-seeking among men to perceptions of the traditional role of a man as self-resilient. These responses reflect masculine norms that are in line with masculine role socialisation models (Addis and Mahalik, 2003; Courtenay, 2000), which are focused on the importance being in control or stoic, on self-reliance (e.g., monitoring symptoms) rather than seeking professional support. One participant made a comparison with women’s help-seeking behaviour stating that women (i.e. his wife) were likely to seek help more promptly. Furthermore, women were seen as more likely to have a shared network of health knowledge that could facilitate help-seeking.

It is women who move from one doctor to the other, especially when they hear that they are good at treating any disease they are the first to get there and try. Especially my wife, just a few days ago she went to a place for herbal treatment for body pains, she said people say they are very effective. (D, Ghana)

However, there was greater variability amongst the UK sample and some participants felt that gender differences in response to health threats were less pronounced, with one participant suggesting that both men and women would seek help to manage ill health or pain.

Sickness is sickness whether you are a man or woman, we all look for solutions when we are in pain. (AK, UK)

DISCUSSION

The aim of this study was to explore approaches to managing symptoms and health-related help-seeking decisions among older Ghanaian men. This is the first study to explore help-seeking beliefs and behaviours utilising a sample of Ghanaian men from the UK and Ghana. Findings suggest that health beliefs are not changed or overwritten following migration but instead are expanded to incorporate experiences of healthcare provision within the host community. As outlined by Leventhal, this suggests that illness representations are cumulative, with information being adopted, discarded or adapted as necessary (Leventhal et al., 2003).

Men in London reported utilising primary healthcare services as the main form of help-seeking, which were viewed as easily accessible in comparison to primary healthcare services in Ghana. Ghana has a National Health Insurance System, which provides universal access to healthcare to individuals who pay a yearly qualifying contribution (Mills et al., 2012). There are a wide range of barriers known to impede enrolment, including the high cost of premiums, distance to health facilities, poor quality of care, and other behavioural and social factors (Chankova et al., 2008; Akazili et al., 2014). Furthermore, a low doctor-patient ratio has made it increasingly difficult to obtain an appointment with a general practitioner in Ghana (Gobah and Liang, 2011) and there is a growing preference for traditional and faith-based remedies rather than seeking an appointment with a health professional. This ‘doctor shopping’, or ‘healer shopping’ (de-Graft Aikins, 2005; Kroeger, 1983) is known to be a common occurrence.

Our sample of Ghanaian men in London reported little use of traditional medicine and healers, partly due to the perception of a lack of reputable healers in London and difficulty obtaining the ingredients for traditional remedies. Help-seeking among Ghanaian migrants in the Netherlands, however, has been shown to be pluralistic with migrants seeking help from traditional healers as well as accessing healthcare centres (Jehu-Appiah et al., 2012). There is evidence that minority groups in high income countries may use channels other than primary healthcare because of limited previous exposure to healthcare services (O’Donnell et al., 2013), minimal understanding of public health messages and enduring cultural and language barriers (Rechel et al., 2013). Furthermore, although use of traditional healers was limited amongst the men residing in London our research did reveal that older Ghanaian men, in both

London and Kumasi, hold strong beliefs regarding spiritual healing and that prayer is a common form of healing often used alongside other approaches. This is in line with the widespread use of faith healing among Ghanaian migrants in the Netherlands (Knipscheer et al., 2000). Among our participants choices around coping responses, such as whether to seek help or self-manage, were strongly influenced by the symptoms each experienced and how the individual interpreted these. In support of this it has been shown that, among Ghanaian women residing in Ghana and the UK (Owusu-Daaku and Smith, 2005), duration of medical help-seeking intervals are associated with perceptions of the cause of symptoms. For example, if symptoms are perceived as spiritual in origin then prayer, rather than medical care, will initially be sought. This fits with the self-regulation model, whereby illness representations (including symptom interpretation) guide coping responses, although it should be noted that established coping responses, such as using faith healing on a regular basis, could drive illness representations (specifically the label given to symptoms) – so that symptoms are appraised in a way that fits with preferred sources of help (Leventhal et al., 2003).

Despite free access to healthcare services in the UK, help-seeking among the London sample in was also influenced by financial concerns, specifically the financial impact of taking time off work to seek medical attention. This finding has also been reported for Ghanaian women living in the UK, with longer help-seeking intervals associated with a reluctance to lose working hours and associated pay (Owusu-Daaku and Smith 2005). The self-regulation model does not make specific predictions about the role of financial barriers, or other barriers, to the choice coping strategy. However, work-related or financial concerns may directly, or indirectly, affect coping behaviours, such as help-seeking. Within Ghana, traditional medicines may be more affordable because herbal products are cultivated within local areas and individuals can self-apply (van den Boom et al., 2008). Furthermore, traditional healers may adapt payment according to the patient's resources including options such as payment in kind or by instalment (Leonard and Zivin, 2005; Stekelenburg et al., 2005) whereas, healthcare services charge a flat rate regardless of socioeconomic status (Dalinjong and Laar, 2012). Evidence from Ghana suggests that individuals with strong financial resources are less likely to use traditional forms of care (Peltzer et al., 2008) whereas individuals with limited financial resources use traditional herbs (Tabi et al., 2006).

An enduring finding in the research literature is that men are less likely to seek medical help than women; a consequence of men not habitually using healthcare facilities, not wanting to appear “weak” and fearing a negative diagnosis (Griffith et al., 2010; Alidu and Grunfeld, 2017). Self-medication was the first approach to managing symptoms among men in both Ghana and the UK. In the UK self-medication commonly involves using over-the-counter medicines from supermarkets and pharmacies to treat minor ailments. Patients, regardless of gender, self-diagnose and select what they believe to be suitable medical treatment, which can have the effect of reducing the burden on healthcare services. Self-medication is also widely used in LMICs (Sclafer et al., 1997; Geissler et al., 2000; Shankar et al., 2002) and medication may be available without a prescription (Gyssens, 2001). Self-medication may occur due to the inability to afford the cost of seeking medical care (Donkor et al., 2012) or long waiting times to see a healthcare professional (Awad et al., 2005; López et al., 2009).

We acknowledge that qualitative studies come with their own limitations (Pope and Mays, 2013). The use of qualitative interviews may have resulted in participants selecting specific experiences to narrate, which may not reflect their overall experience. The participants in this study were urban dwellers who might have reported different experiences to rural populations - where more negative attitudes towards help-seeking have been observed (van der Hoeven et al., 2012; Grunfeld and Kohli, 2010). However, the results of this research provide useful insights into how Ghanaian men approach the management of their health. Our results challenge the simplistic dichotomy of traditional vs modern but rather highlights pragmatic concerns that influence choices around managing illness and seeking help. The findings build on the literature on men’s help-seeking by highlighting the enduring pluralistic approach to symptom management following migration, which is not accounted for within models of help-seeking. For instance, within the self-regulation model the appraisal process does not explicitly account for pluralistic approaches, whereby multiple sources of help are tried simultaneously, rather than sequentially through a process of reappraisal. It is important for health psychologist’s to have an enhanced understanding of older migrant men’s explanatory models of their health and their engagement with a pluralistic approach to health management; this would support the development of effective programs and health services for African migrant men. Behaviour change interventions, such as those promoting prompt help-seeking, must acknowledge the ways in which migrant and ethnic minority populations appraise and manage their health. Some authors have advocated a closer working model

among stakeholders, with liaison between healthcare providers, traditional/faith-based healers and patient groups (Knipscheer and Kleber, 2008). An acknowledgement of the role of prayer and faith-based healing could provide a point of access to African men. For example, working with church leaders or community faith groups could facilitate the dissemination of health information and perhaps, more importantly, provide a context in which to deliver culturally relevant health interventions. Health Psychologists have a key role to play in such multi-partner initiatives by bringing to the table a strong evidence base around theoretical aspects of help-seeking and also by applying competencies to develop interventions that account for not only psychological, but also social and cultural enablers of help-seeking.

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Table 1: Socio demographic characteristics of participants

	UK sample N=13	Ghana sample N=13
Age group		
50-60	5	5
61-70	5	5
71+	3	3
Married	7	7
Highest educational level		
Primary	7	6
Secondary	6	6
Tertiary	0	1
Time since migrating to the UK		
Up to 5 years	1	
Over 5 up to 10 years	5	
Over 10 years	7	
Work status		
Working	11	10
Retired	2	3
Self-reported chronic condition (hypertension, diabetes, emphysema, asthma)	5	6

Table 2: key themes from the analysis

Theme	UK sample	Ghana sample
Pluralistic approaches to health		
Herbal remedies	Lower use of herbal medicine Limited access to herbs and healers	Utilised Herbal approaches perceived to be slower to see results
Faith healing	Spiritual healing complementary to Western medicine	Spiritual healing sometimes used as an alternative to medical sources For some illnesses, spiritual healing/prayer the most appropriate treatment option
Self-management	First approach to treat common symptoms	First approach to treat common symptoms
Formal healthcare services	For both treatment and preventative medicine	Use pharmacists and over the counter medicine providers, rather than general practitioners
Financial issues	Type of employment contract (Needing to take time off work) acts as a barrier to healthcare utilisation	Costs associated with accessing healthcare Treatment costs
Masculinity	Breadwinner	Breadwinner Not prioritising own health Self-reliance

Ethics approval and consent to participate

Ethical approval was given by the local University Research Ethics Committee (reference ERN_14-1138).

Consent for publication

Consent for publication was sought from all the participants involved in the study as part of the standard consent form.

Availability of data and materials

The dataset used during the current study are not publicly available due to issues concerning confidentiality and anonymity (participants did not consent to this) but may be available from corresponding author on reasonable request

Competing interest

The authors declare they have no competing interests

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Authors' contribution

Both authors conceived the study design, contributed to the analysis and interpretation of the findings, wrote and approved the final manuscript.

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