HEALTH CARE CHOICES OF GHANAIAN IMMIGRANTS IN CALGARY, ALBERTA, CANADA

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ABSTRACT

Many African immigrants moving to Canada tend to experience deterioration of health with time in their host country due to the influence of multiple factors on their health care decisions. The purpose of this study was to understand the problems and decision dynamics relevant to Ghanaian adult immigrants' health care choices with the first five to ten years of arrival in Calgary, Alberta. This research used a qualitative naturalistic approach with ten Ghanaian adult immigrants. Thematic analysis revealed that participants' healthcare choices were influenced by their pre-and post-migration experiences, which informed their pathways to care. Participants provided insights about tensions among themselves and with health providers in making healthcare choices as they settled in a new environment. Further, there is a need to provide health education programs and a strong supportive system to facilitate better health choices and encourage health care service use among recent newcomers.

ACKNOWLEDGEMENTS

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CHAPTER ONE: INTRODUCTION

Immigrants who come to Canada for education, work, or permanent residency have access to a variety of healthcare services. The Canadian healthcare system offers immigrants both preventive and treatment health services. These include emergency medical care, mental health, and pharmaceutical services. Alberta is one of the provinces in Canada with a large population of immigrants from African countries, including Ghana.

Many factors account for immigrants coming to Canada. Ghanaian immigrants' reasons include the search for better quality of life, education, and better health services, (Latukha & Nintuona Soyiri, 2018; Schans, Mazzucato, Schoumaker & Flahaux, 2018). Migrants seek higher wages, employment prospects, peace, safety, better quality of life, and better healthcare services (Ortega & Peri, 2013; Parkins, 2010).

The use of existing healthcare services by immigrants is a matter of choice. Health care choices refer to the act of choosing among health care options (Baumeister,& Tice, 2018; Redfern, Briffa, Ellis, & Freedman, 2009). These choices may be dependent on many factors such as beliefs and values, language barriers, level of education, social determinants, preference for traditional approaches, and health status (Guruge, Birpreet, & Samuels-Dennis, 2015; Thomson, Chaze, George, & Guruge, 2015; Whittal & Lippke, 2016). Perhaps due to the same reasons, immigrants may find it difficult to choose among health care options available in their new home (De Maio & Kemp, 2010).

Many cultural, religious, spiritual, social, ethnic, and personal challenges face African immigrants in Canadian cities and influence their healthcare choices. A review of African immigrant healthcare literature reveals that many researchers emphasized investigation of healthcare utilization experiences in traditional societies and the

westernized environment (Lassetter & Callister, 2009).The impact of sociocultural difference on making healthcare decisions in their country of origin compared to the country of destination of Ghanaian immigrants is worthy of study.

According to qualitative research on sub-Saharan Africans in general or Ghanaians living in Canada and/or other foreign countries more specifically, there is a wide range of determinants of healthcare choices (Gyasi & Phillips, 2018). It is unclear how these aforementioned determinants or factors influence their health choices. The focus of the current study is to evaluate the major determinants of healthcare choices of Ghanaians living in the city of Calgary, Alberta,

Problem Statement and Study Rationale

Sub-Saharan Africans, including Ghanaians, constitute a significant portion of more than 29,355 immigrants (Statistics Canada, 2013) living in Calgary, Alberta, Canada. Despite the availability of sophisticated healthcare services, many Ghanaian immigrants have poor health status and hesitate to access the services available to them. Factors that influence Ghanaian adult immigrants' healthcare choices in Calgary are not well studied. Furthermore, there is a need for better understanding of how cultural beliefs, health status, and social determinants influence the healthcare choices of newly arrived adult Ghanaian immigrants. Most research studies have been cross-sectional in nature (Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008). To date, the array of sizable qualitative naturalistic studies of Ghanaian immigrants' healthcare choices is limited. Qualitative research is necessary to fully understand the problems and decision dynamics relevant to Ghanaian adult immigrants' healthcare choices. Improved understanding may contribute to the enhancement of public health services with respect to this population in

Alberta. My study was confined to the city of Calgary, a large city in the western

Canadian province of Alberta, because of limited resources available to me.

Purpose of the Study

Factors such as cultural beliefs, health status of the immigrants, and social

determinants (e.g., income, employment status, and gender) may influence the healthcare

choices made by recent Ghanaian immigrants living in Alberta, Canada. A thorough

understanding of these factors is necessary to reduce or prevent adverse effects on

immigrant health and to implement strategies to enhance health. The purpose of this

research is to explore the influence of such factors on Ghanaian immigrants' healthcare

choices using a qualitative naturalistic approach. Such an approach will allow me to

collect data from participants about experiences in their natural setting.

Research Questions

1. What factors influence newly arrived Ghanaian adult immigrants' healthcare

choices in Calgary?

2. How do cultural beliefs, health status, and social determinants influence newly

arrived Ghanaian adult immigrants' healthcare choices in Calgary within the first

five to ten years?

Objectives

This study is an exploration of factors that influence Ghanaian adult immigrants'

healthcare choices in Calgary, Alberta, Canada. The goal was to better understand the

following areas: (a) factors that influence healthcare choices among Ghanaian immigrants

during the first five to ten years post-arrival to Calgary, Alberta, Canada; and (b) the

effect of beliefs, health status, and social determinants on Ghanaian immigrants'

healthcare choices. The overall objective of this study was to provide suggestions to

improve health outcomes for immigrants, particularly Ghanaian immigrant newcomers to Calgary, Alberta, Canada.

Thesis Outline

The thesis comprises five chapters. Chapter 1 provides a brief introduction, the problem statement and objectives of the research study. The second chapter presents an extensive literature review of the Canadian healthcare system, the use of healthcare services by Ghanaian immigrants, and the known factors that influence their healthcare choices, as well as the knowledge gaps that the present research addressed. Chapter 3 outlines the methodology and strategies of the research study, and discusses the ethical considerations of the study. The empirical findings of the in-depth analysis of Ghanaian immigrants' healthcare choices appear in detail in Chapter 4. Chapter 5 concludes with a discussion of the major findings of the study, the significance of those findings, recommendations made to improve policies regarding Ghanaian immigrants' healthcare, and proposals for future research.

Ghanaian Association Calgary

My research topic was developed as a result of a concern in the Ghanaian-Canadian Association in Calgary (GCAC). Upon several consultations with the gatekeepers of the GCAC, several issues were identified, including what factors influence health-related decisions made by newcomers from Ghana. Further literature readings revealed no study done specific to the Ghanaian immigrant population in Calgary. The health care challenges experienced by Ghanaian immigrant and my personal experience as an immigrant influenced my decision to undertake this study.

CHAPTER TWO: LITERATURE REVIEW

Many sub-Saharan Africans, including Ghanaians, migrate to Canada looking for better professional opportunities, education, living status, and health status. As of 2011, the Ghanaian immigrant population in Canada was more than 29,355 people (Statistics Canada, 2013). Calgary, Alberta is home to approximately 4,500 Ghanaians, according to the president of the Ghanaian-Canadian Association of Calgary (GCAC). The maintenance of adequate healthcare practices for this large population depends on appropriates provincial health services and government policy-making. Barriers to Canadian healthcare access for immigrants have been a major issue for decades. Thus, they are the focus of many studies regarding ways to address and resolve these issues (McKeary & Newbold, 2010).

Federal legislation, such as the Canada Health Act, provides insurance that allows access to various care services for immigrants (Madore, 2005). Nevertheless, many cultural, religious, spiritual, social, and ethnic aspects of healthcare access and personal challenges of immigrants living in Canadian cities make it difficult for the government to provide equal opportunity for access to every immigrant (Guruge, Birpreet, & Samuels-Dennis, 2015; Kalich, Heinemann, & Ghahari, 2015; Kwak & Rudmin, 2014; Thomson, Chaze, George, & Guruge, 2015; Whittal & Lippke, 2016). These factors influence immigrants' perceptions of the healthcare system and thereby affect their healthcare choices.

Many such issues are generalizable and apply to all immigrants, including Ghanaians; however, some healthcare choices reflect geographic origin (e.g., Asia, Africa). For instance, proximity of health care facilities may influence participation or utilization. Studies addressing factors that affect healthcare choices of Ghanaian

immigrants living Canada are scarce. Therefore, this chapter includes a summary of healthcare challenges that African immigrants in Canada experience and highlights those that are specific to Ghanaians.

Immigrants' Reasons for Immigration

Globally, there have been mass movements of people from one country to another, especially since the 1990s, with another surge during the last decade (Boniface, Cooper, & Cooper, 2016; Nevitte, 2017). Most migrants seek better opportunities for themselves and their families, due to various push-pull factors. Push factors are those that motivate immigrants to move from their country to another (e.g., low productivity, unemployment, underdevelopment, poor economic conditions, lack of opportunities for advancement, exhaustion of natural resources, and natural calamities) (Parkins, 2010). Migration may also be pushed by political persecution or wars, health reasons, or education. Economic factors that exist in low income countries are a prime push factor identified in the literature (Boserup, 2017; King, 2015). Pull factors are those that attract immigrants to another country (e.g., better living conditions, higher wages, employment prospects, peace, safety, education, better healthcare, political security, and higher quality of life (Ortega & Peri, 2013; Parkins, 2010). Economic factors lead many immigrants to migrate to high-income countries such as Canada (Casey & Dustmann, 2010).

The migration process of many immigrants includes stressful events. Stressors can be short-term or long-term. Short-term stressors may include waiting for medical results during the visa application process. An example of a long-term stressor is the need to care for a sick family member for a long period of time (Carlsson & Sonne, 2018; Kim, Schwartz, Perreira, & Juang, 2018). Other stressors include getting a passport, applying for a visa, dealing with middlemen from various offices of immigration, and application

fees. This is usually a very expensive process and immigrants pay large sums of money to get through it. The impact of these stressors on mental health varies; some lead to more serious mental conditions. Some immigrants take out loans, barter/trade, or sell their properties/personal belongings to travel to the country where they hope to escape their suffering.

Immigration systems are not decentralised (i.e., there is no delegation of duties) in the home countries of most migrants, including Ghana; therefore, applicants must rely on one central immigration office to process all visa applications (Umezurike & Isike, 2013). Immigration systems are complex. There are many agents at different levels who may cause long delays and refusal of visas. In sub-Saharan countries, like Ghana and Nigeria, immigration offices are controlled by political parties, pressure groups, and powerful individuals who dictate reasons for migrants' travel. These issues result in migrants travelling long distances to the national immigration centre for document processing. Unfortunately, communication between migrants and immigration officers is inconsistent and unreliable (Alfaro-Velcamp, McLaughlin, Brogneri, Skade, & Shaw, 2017). Networks of fraudulent connections influence which applicants receive approval, and poor technological advancements adversely affect access to and sharing of information (Skeldon, 2014). Poor attitudes of immigration officers towards immigrants create another stressor. Some immigration officials in the immigrants home country add extra charges to fees either for personal gain or to cover duties during the processing of documents. Economic hardship may result in corruption among state officials (Wu, Sun, & Smith, 2011).

After settling in host countries, immigrants often find it challenging to repay loans from banks, friends, or family and struggle to support dependents in their home country.

These concerns compel some immigrants to work extra hours. The stress of settling and adjusting to the new country could lead to regret, especially if expectations are not met, which can cause stress and depression for immigrants. These unexpected outcomes can lead to serious anxiety, depression, posttraumatic stress disorder (PTSD), and substance abuse among migrants (Yakushko, Watson, & Thompson, 2008), and can result in the decline of the initially strong health status of immigrants.

Traditionally, long-distance migration is most common for males; females dominate short-distance migration (Bhagat, 2016; Skrbiš, 2017). However, women have been migrating more often since the 1980s and do so more independently than males (Boyd & Grieco, 2003). Female migration can be stressful and challenging as it results in changes to economic and family roles. Female migration often affects marital relationships (Boyle, Cooke, Gayle & Mulder, 2016). Both men and women require social support, which can affect their general health and wellbeing. A lack of support could lead to psychological problems and emotional burdens on migrants (e.g., separation from spouse or ending marriages or relationships) (Nomaguchi & Milkie, 2017).

Healthcare in Canada

Canada is a land of immigrants; many come to Canada for education, work, or permanent residence. The Canadian healthcare system provides healthcare to all residents, including immigrants. These services include preventive and treatment services (e.g., dental care, mental health, community care and support, family health, sexual health, emergency care, physiotherapy, immunization, pharmacy, child health, and parental care) (Health Canada, 2010). The healthcare services that are available in each Canadian province fall under the federal Canada Health Act, the basic principles of which are public administration, comprehensiveness, universality, portability, and accessibility (

Madore, 2005). These principles ensure that all Canadian residents, including immigrants who are eligible to receive provincial health insurance, receive healthcare services. Healthcare facilities that are available to immigrants depend on the territory/province of Canada in which they live. Regardless of the province/territory, all immigrants are entitled to free emergency medical services (Caulford & Vali, 2006; Gagnon, 2002). Alberta has two programs, the Alberta Child Health Benefit (ACHB) and the Alberta Adult Health Benefit (AAHB), that provide medical support including for low-income families, emergency ambulance services, optical services, dental services, and prescription drugs.

Unfortunately, there is a three-month waiting period before immigrants can receive health insurance. This uninsured period often leads to health concerns for newcomers; their options are to either acquire private health insurance, pay for healthcare services out-of-pocket, or pursue cheaper alternative health services (Caulford & D'Andrade, 2012). After an immigrant receives his/her provincial health card, he/she can access all healthcare facilities. Yet, many immigrants do not utilize them (Hyndman, Schoolman, & Fiedler, 2006). Their choice to use healthcare reflects their beliefs, health status, and the influence of other social determinants.

Immigrant healthcare in Alberta and Calgary. Immigrants residing in Alberta for more than three months receive coverage under the Alberta Healthcare Insurance Plan (AHCIP), which provides a wide range of services in the province. Prescribed medications, ambulance services, dental services, and complementary health services (e.g., acupuncture) are not covered by AHCIP (Heller, 2009). Many employers provide enough health insurance to cover many of the services that the AHCIP fails to cover. Alternatively, immigrants may purchase private health insurance plans. Immigrant

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Services Calgary provides a newcomer program that provides information to new immigrants in 70 languages (David Este & Ngo, 2011). However, language barriers are often still an issue when immigrants seek healthcare. Newcomer support centres facilitate access to necessary resources and make referrals to healthcare clinics on behalf of immigrants.

Healthy Immigrant Effect

The Canadian immigration policy generally requires immigrants to be healthy, which contributes to the documented Healthy Immigrant Effect (HIE). The concept of HIE posits that some immigrants have health advantages due to health practices in their country of origin that deteriorate in their new country of residence (Vang et al., 2015). This may be due to immigrants' healthcare choices and lifestyle after immigration (McDonald & Kennedy, 2004). Many cultural, religious, and social factors limit immigrants' access to healthcare services in Canada. Language issues, poor understanding of Canadian healthcare facilities, and strong cultural beliefs lead to under-utilization of health services, which could contribute to the deterioration of immigrant health over time.

The deterioration of Ghanaian immigrant health may also be due to their acculturation into Canadian health practices over time (Barimah & van Teijlingen, 2008). Ng and Team (2011) evaluated the HIE based on age-standardized mortality rates and found that all immigrant males in Canada showed evidence of the phenomenon. Women from sub-Saharan Africa showed otherwise in Toronto, Montreal, and Vancouver. The age-standardized mortality rates for women from sub-Saharan Africa showed rates similar to Canadian-born women. This suggests that male immigrants from sub-Saharan Africa are healthier than female immigrants in the initial period following migration, although

this may deteriorate within a year or two. However, cancer-related deaths were significantly higher a year after arrival for both male and female immigrants from sub-Saharan Africa compared to the Canadian-born in all three metropolitan areas (Ng & Team, 2011).

Some immigrants tend to self-assess their health in a positive light to avoid seeking healthcare support for their illnesses (Newbold, 2005). Many older sub-Saharan African immigrants living in Calgary prefer to do their own research on illnesses through Internet searches, discussions with other patients or nurses, and self-diagnosis (Anokye, 2014). Some of them also prefer not to have a family doctor because they want to have more control over their own health (Lee, Kearns, & Friesen, 2010; McDonald & Kennedy, 2004). Immigrants' health status often changes or declines following migration. Immigration health policies serve an important role in selecting healthy immigrants; however, it is up to migrants to keep their health in good condition after their arrival. Consequently, it is important to know what might influence such changes to health status among immigrants to facilitate conditions that support the maintenance of health in their new country.

The Impact of Migration Trauma on Immigrants' Health

Traumatic events may be single or repeated experiences that overwhelm a victim and occur beyond his or her control, causing physical stress, horror, terror, fear, and helplessness (Klinic Community Health Centre, 2013). Brach (2011) defined trauma as "when we have encountered an out of control, frightening experience that has disconnected us from all sense of resourcefulness or safety or coping or love" (p. 7). Immigrants who leave their country and seek safe settlement in another country are likely to experience trauma or distress prior to arrival or upon arrival to the new country

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(Gonzalez, 2015). Types of trauma may include child abuse, spousal abuse, sexual trauma, interpersonal experiences, violence, and discrimination (Gonzalez, 2015; Klinic Community Health Centre, 2013).

Since Desjarlais (1995) first reported that immigrants' trauma may occur before, during, or after migration, advancements in this field revealed immigrant trauma through: (a) pre-migration trauma in the home country that may be the reason for leaving (e.g., imprisonment, torture, threat to life, sexual abuse, or murder of a loved one); (b) transit trauma during migration; (c) trauma during resettlement and asylum-seeking; and (d) post-migratory trauma while inhabiting the host country (e.g., discrimination, lower living standards, financial issues, unemployment, difficulty accessing social services, or repatriation) (Desjarlais, 1995). Any type of trauma or stressor may have severe long-term consequences such as mental health issues, depression, suicide ideation or PTSD (Kirmayer et al., 2010; 2011). However, the social and cultural stigma of mental health issues are very high for Ghanaians and other sub-Saharan African societies; therefore, most cases go unreported and untreated (Este et al., 2009; Gardezi et al., 2008).

Traumatic experiences, their severe consequences, and reduced access to healthcare together affect the health status of immigrants and influence their healthcare choices. Several Canadian studies have suggested that some immigrants may misuse health benefits (i.e., overbilling of health benefit) (Reitmanova, Gustafson, & Ahmed, 2015). Such activities may occur due to prior or ongoing trauma, or other health determinants such as economic and social status, financial security, and education. Researchers have also identified a gender orientation to some immigrants' trauma. For example, the Canadian Task Force (1988) reported that immigrant women experienced more trauma than male immigrants. Ghanaian or sub-Saharan African female immigrants

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may experience such trauma due to male dominance, violence, sexual abuse; and strain related to gender roles and marginalization (Hyman, 2001; Mulvihill & Mailloux, 2000; O'Mahony & Donnelly, 2007b). There is the need to ascertain how the aforementioned factors may influence health decision making.

African immigrants can choose between modern medical care or Traditional Medicine (Barimah & Teijlingen, 2008). Many immigrants experience culturally and religiously insensitive healthcare services in Canada and the United States respectively (Grewal et al., 2008; Reitmanova & Gustafson, 2007) and must respond to strong family influences (e.g., male dominance or community pressure) as they attempt to make healthcare decisions. Additionally, many immigrants are hesitant to use available resources (Pottie et al., 2008; Zanchetta & Poureslami, 2006). Mental healthcare is very rare due to cultural beliefs, naivety, and sociocultural influences/stigma within the African immigrant community. The lack of sensitivity displayed by some healthcare professionals further compounds this problem (Bauldry & Szaflarski, 2017).

Determinants of Immigrants' Health in Canada.

Mikkonen and Raphael (2010) identified 14 social determinants of health in Canada: income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, aboriginal status, gender, race, and disability. Evans and Stoddart (1990) identified other determinants of healthcare choice: social environment, physical environment, economic environment, and lifestyle. Social determinants of health interact with one another to influence peoples' health including the healthcare choices of immigrants (Evans & Stoddart, 1990). Several of

these factors may be relevant to immigrants; therefore, it important to investigate how these factors may affect health decisions.

According to Zhao, Xue, and Gilkinson , (2010), social capital is the network of social relations that potentially provides individuals and/or groups with resources and support. The way people develop, experience, and maintain social capital varies among different societies/cultures (Lalji, 2012). Three types of social capital exist: bonding, linking, and bridging social capital (Zellweger, Chrisman, Chua, & Steier, 2019). Bonding social capital occurs within immigrant communities and bridging social capital occurs when immigrants attempt to establish connections with individuals of the native community. Linking social capital in many ways is not much different from bridging social capital; however, it occurs entirely outside one's community. According to Hyman et al. (2011), immigrants who share the same culture, values, norms, or country often focus on social capital for survival. All the three forms of social capital have benefits and are especially valuable for the social integration of newcomers into Canadian society (Hyman, Meinhard, & Shields, 2011).

Social capital may influence health outcomes by spreading health information, enhancing access to healthcare, giving emotional support to individuals, and reinforcing health norms (Zhao et al., 2010). Few studies have directly addressed how social capital affects the health of immigrant populations. However, Zhao (2007a), Newbold (2009), Daoud et al. (2016), and Subedi and Rosenberg (2014) provided some insight regarding ways that social capital improves the integration process. Social capital plays an important role in health choices; social networks influence immigrants' health outcomes. The social network is under social capital. Thus, people who have a strong or diverse network of contacts are also thought to have more social capital Social capital accelerates

and improves access to health resources for immigrants (Subedi & Rosenberg, 2014 ;

Hall, Pangan, Chan, & Huang, 2019). Hall et al. (2019) found that social capital also

affects how immigrants access healthcare, their health status, ability to work, connections

to co-workers, suicide rates, attitudes surrounding children, and behaviours. Communities

with strong social capital are very cohesive, which improves the health of individuals in

the community. Immigrants can maintain a healthier community through social capital

(Daoud et al., 2016)

      Amin, Perez, and Nyachhyon (2014) highlighted the role of ACHB and AAHB in

providing dental care to low-income families. Such services are of critical importance

because Alberta provincial health insurance does not cover dental services (Amin et al.,

2014). Residents of Calgary use the services of ACHB and AAHB and it is plausible that

eligible low-income Ghanaian immigrants residing in Canada can also benefit from this

program. A potential obstacle to use of ACHB and AAHB is a lack of awareness of such

services. Amin et al. (2011) observed an increased level of awareness by low-income

immigrants residing in various cities of Alberta due to information from the Canada

Revenue Agency, pamphlets, posters, newspaper articles, and verbal communications.

Another obstacle is a potential lack of understanding of the importance of preventative

dental hygiene and health among the newly arrived African immigrants. Parents often

refrain from seeking dental service for their children unless they are afflicted with a

serious dental problem (Amin et al., 2011). The extent to which these misconceptions

affect Ghanaian immigrants' healthcare choices remains to be examined.

      One of the main challenges faced by immigrants accessing heath care is the

language barrier. Many new immigrants are not fluent in either of the primary Canadian

languages (English and French). In 2005, 36% of the people entering Canada admitted a

lack of knowledge of English and French (Gushulak et al., 2011). Some newly arrived

African immigrants employ community workers to orally communicate their health

concerns (Amin & Perez, 2012). Translators assist patients who cannot communicate with

their doctors; however, there is often a fear of misinterpretation, which can happen either

when the translator attempts to convert colloquialisms from other languages to English, or

when a doctor attempts to explain complex medical concepts. Immigrants from Ghana are

often familiar with the English language prior to arrival and may be less prone to verbal

barriers than other immigrant groups (Chiswick & Miller, 2001).

Members of the Arab community reported a lack of interpreters as a major

obstacle to access of healthcare services in Toronto, Canada (Yuan, Rootman, & Tayeeh,

2000). Communication difficulties between immigrants and healthcare practitioners

significantly influence healthcare choices (Zanchetta & Poureslami, 2006). Surprisingly,

there is a preference for French-speaking doctors over English-speaking doctors by sub-

Saharan African immigrants living in Calgary in the early days of arrival, due to previous

unpleasant personal experiences with English-speaking doctors (Ngwakongnwi,

Hemmelgarn, Musto, Quan, & King-Shier, 2012). Some of these preferences for French-

speaking doctors had to do with individual health concerns that these immigrants prefer to

keep to themselves. This seems to suggest that language may create some level of

inconvenience or influence on health decision-making.

Another factor is the reluctance of members of some communities to employ a

translator, due to a fear of breach of confidentiality by the translator h (Yohani,

Brosinsky, & Kirova, 2019). Immigrants may withhold crucial information regarding

their health status while employing translators or interpreters due to privacy concerns.

One of the greatest adverse effects of language barriers is the translocation of immigrants

to another country to seek better and more accessible healthcare systems (Pollock, Newbold, Lafrenière, & Edge, 2012). Thus, when people change locations due to medical reasons and cannot fluently speak or express themselves in a particular language, effective communication of health concerns may be a casualty.

The likelihood of Ghanaian immigrants in Toronto to prefer Canadian health services to traditional healthcare methods may be affected by their level of education (Barimah & van Teijlingen, 2008). Higher education may improve individuals' comprehension of Canadian medical practices. Such a correlation between level of education and healthcare choices has not been investigated within the Ghanaian immigrant population in Calgary.

The age of immigrants also influences their healthcare choices. Among a cohort of sub-Saharan African immigrants with cardiovascular disease in Calgary, those aged 40 and above had limited health management capabilities (Anokye, 2014). The healthcare choices of older individuals heavily reflected self-assessment. The same individuals above the age of 40 exhibited a preference for herbal supplements over prescription drugs (Anokye, 2014). This suggests that the age of immigrants may influence the decisions they make about health care in their new country.

Differences in healthcare systems. The mistrust of modern medical technologies by immigrants may be due to strong spiritual beliefs, and/or lack of knowledge of Western medicine. Cultural stigma, especially regarding mental illnesses, often prevents immigrants from seeking appropriate healthcare services (George, Thomson, & Guruge, 2015; Thomson et al., 2015). This is likely the case for Canadian Ghanaian immigrants who often harbor strong stigma toward mental illnesses (Tawiah, Adongo, & Aikins, 2015). A potential solution is an increase to immigration of Ghanaian healthcare

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professionals to Canada (Labonte & Crush, 2006). A large influx of Ghanaian nurses to

Canada occurred between 2000 and 2010, which led to greater acceptance of healthcare

practices by Ghanaian immigrants, and more community-based health support systems

(Dovlo, 2007). Such community-based health support systems already exist in Calgary to

treat African immigrants, including Ghanaians, suffering from HIV illness (Este et al.,

2009). A lack of knowledge regarding healthcare practices is determinant of healthcare

choices (Este et al., 2009). Some African immigrants in Calgary still follow the healthcare

practices of Africa; therefore, certain aspects of healthcare (e.g., use of insurance, a

family doctor, frequent checkups) are uncommon. A solution may be to better educate

African newcomers to Alberta (Amin & Perez, 2012).

      Preference for traditional health practices. Immigrants in several Canadian

provinces reported use of traditional approaches to medical care due to communication

barriers, mistrust in Canadian medical practices, and fear of discrimination. Traditional

medicine methods (TMM) of Ghanaians include herbal remedies, divination, prayers,

psychotherapy, solitude, and spiritual healing (Waldron, 2003). These approaches are

believed to treat chronic conditions such as mental illnesses, diabetes, and asthma

(Barimah & Van Teijlingen, 2008). However, the specific TMM practices among

Ghanaian immigrants living in Calgary are unknown. Findings from a study of TMM

practices of Ghanaian immigrants in Toronto suggested that 73% of Ghanaian immigrants

preferred TMM to Canadian health services (Barimah & Van Teijlingen, 2008). However,

Ghanaian immigrants also have concerns regarding TMM (e.g., lack of expiration dates

on pre-prepared traditional medicine mixes, qualifications of traditional healers residing

in Canada, challenges of storage and preparation of traditional medicines) (Barimah &

Van Teijlingen, 2008). Within TMM, many immigrants prefer faith healers who address

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both spiritual and physical wellbeing. Choices of TMM depend on the supposed origin of the disease condition, either natural or supernatural (Barimah & van Teijlingen, 2008). Faith healers address diseases thought to be caused by supernatural sources and are believed to be the highest source of healing. However, some immigrants have adapted to Canadian practices. This adaptation aligns with levels of education, income, and acculturation (Pariah & van Teijlingen, 2008).

   Cultural beliefs and differences. Culture is inclusive of people's way of life and comprises the attitudes, beliefs, values, customs, and speech that a social group shares from one generation to the next (Hoffman, 2019; Bussey-Jones & Genao, 2003). Members of a culture uphold these shared values; an act that is contrary to cultural beliefs is a denigration. Cultural practices and beliefs influence people's attitudes toward diseases and health problems (Ojua et al., 2013), and health beliefs differ from culture to culture (Chin & Noor, 2014). Cultural disparities can affect healthcare assistance given to clients by healthcare providers and affect the tendency to seek healthcare (Knibb-Lamouche, 2012).

   Some authors confirmed that diversity in culture poses numerous challenges for patients and health providers (McKeary & Newbold, 2010). According to Chin and Noor (2014), the cultural impact on health status is noticeable in beliefs about the causes of diseases, appropriate approaches to treatment, healthcare service accessibility and acceptability, and doctor-patient interaction. Different people have different beliefs to explain the cause of ailments and what they deem appropriate modes of treatment. Some perceive diseases as having a natural scientific cause; others believe disease is a result of supernatural punishment. Cultural beliefs are difficult to explain to health professionals with different cultural background and language proficiencies from those of the patient

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(Maneze et al., 2015). Others perceived the cause as punishment from God or family deity. Abubakar et al. (2013) assessed Kenyans' perceptions and attributions of disease causation and found that respondents indicated that malaria, fever, and typhoid had natural causes that could be treated by combating microorganisms. These culturally stereotyped systems of belief influence health practices and behaviors of migrants (Awasthi & Mishra, 2010). When migrants' beliefs about certain diseases conflict with those of members of the host country, they are unlikely to accept treatment (Davies et al., 2006).

As Chin and Noor (2014) explained, doctor-patient interaction also affects health status. This relationship requires trust between patients and healthcare providers so that patients accept and follow medical advice to ameliorate health conditions (Vaughn et al., 2009). Strong relationships with healthcare providers require interpersonal and communication skills. Difficulties arise when personal beliefs do not align with endorsed medical beliefs (Uskul, 2010). Cultural disparities may result in doctors disregarding disease symptoms that patients deem relevant and patients not following prescribed treatments (National Collaborating Centre for Aboriginal Health, 2009). These disparities also leads to potential prejudice against patients (Nobles & Sciarra, 2000). Doctors view contrary patients as unintelligent or disinterested in their health service (Knibb-Lamouche, 2012).

According to Davies et al. (2006), communication problems preclude migrants from seeking medical help due to difficulty expressing their needs and comprehending the bureaucracies of the health system. Healthcare services develop to meet the needs of the local people (Kale & Kumar, 2012). Immigrants experience challenges if they do not

share or are not proficient in the language of the host country (Maneze et al., 2015; Segalowitz & Kehayia, 2011).

Individual cultural perceptions of how to report and react to an illness can be a barrier to healthcare. Health professionals who are not members of patients' communities may be unaware of the cultural background and fail to detect or interpret important information regarding a patient's medical status (Bahl & Hopkins, 1993; Halwani, 2002). Individuals from different communities have unique verbal and non-verbal methods to communicate stress and illness (Halwani, 2002). Cultural beliefs influence various aspects of healthcare (e.g., use of medication and selection of practitioners) (Lai & Chappell, 2007; Wang, Rosenberg, & Lo, 2008). Another cultural aspect is prior knowledge of diseases and screening methods. Abotchie and Shokar (2009) reported that Ghanaian college students avoided Papanicolaou (pap) tests for cervical cancer due to three barriers: (a) physical discomfort; (b) belief that the test would compromise virginity; and (c) lack of knowledge that cervical screening aids in the diagnosis of cancer.

Language, culture, and religious differences are very sensitive topics. The behaviour of immigrants within a host country heavily relies on how others respond to their cultural and religious beliefs; unfortunately, discrimination is very common (Edge & Newbold, 2013; Pollock et al., 2012). Some healthcare professionals discriminate against immigrant patients and fail to attend to their sensitive sociocultural and religious beliefs (Grewal, Bhagat, & Balneaves, 2008; Reitmanova & Gustafson, 2007). For example, an African immigrant living in the United States stated, "I cry a lot when I see the people being settled here. Some are very frustrated, because the culture is so different from what they know" and "they look at you and wonder why you are even here" (Crary, 2013, p. 24). Alienation from Canadian society, in schools or work places, or alienation within the

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immigrant community due to cultural differences are also common. Zaami (2012) found

that being part of a Ghanaian church community in Toronto, Canada reduced

discrimination and alienation for the younger generation of immigrants. Immigrants may

feel alienated due to their own actions and decisions not to follow mainstream societal

beliefs, resulting in social exclusion (Pierson, 2010).

Patriarchal Systems

African and Ghanaian societies are primarily patriarchal (Takyi, 2001). After

immigration to new countries, Ghanaians tend to follow the same societal gender norms

they practiced in their home countries (Boohene, Sheridan, & Kotey, 2008; Carr, 2008).

Males traditionally control behaviours, choices, education, financial details, and health

decisions of African women; men hold superior status and determine the lives of women.

Masculinity concepts of African or Ghanaian immigrants affect their lifestyle and

approaches to maintaining good health (Brako, 2013; Griffith, Gilbert, Bruce, & Thorpe,

2016). Immigration, higher education, improved social interactions, and awareness often

change the traditional belief in male empowerment, resulting in an ascension of

femininity (Harger, Naheed, Costa, & McDonough, 2013). The Canadian government

promotes female empowerment to establish gender equality and increase women's

livelihood by providing them with opportunities in economic and political sectors and

social security (Ghana Web News, 2010). The influence of patriarchy is declining within

Africa and Western countries as women contribute to major decision-making processes,

attain high career levels and authoritative positions, and shift traditional gender role

(McGee, 2015; United Nations, 2011). Re-orientation of men's perceptions of gender

roles and responsibilities through education may enhance the women empowerment

process in sub-Saharan African countries, such as Ghana (Asiyanbola, 2005).

The idea of patriarchy in Africa began after Christian colonizers oppressed or subverted the ancient matriarchal society (Chengu, 2015). The males became the leaders and decision-makers. Despite their constitutional right to equality in Ghana, women faced discrimination, abuse, and oppression. Male dominance exists at all levels of societal, institutional, and political sectors in Ghana (Mohan, 2002). Gender equality for African women is not fully actionable but still changed the perception of women's gender roles in general (Sossou, 2006).

A primary cause of gender disparities in healthcare choices is the power difference between men and women (Turner & Maschi, 2015). Gender differences influence men and women's life choices. As a socially constructed phenomenon, gender identity determines social position, power, and prestige, which in turn assigns different roles and responsibilities to individuals within a society (Eckert & McConnell-Ginet, 1992). In many African societies, men have higher social status than women do. Men are household heads and have power over family resources. They also determine the roles that women perform. Males control their female partners' access to healthcare; some immigrant women must seek permission from their partners (Dyer, Abrahams, Mokoena, & Van der Spuy, 2004). Women are unable to make decisions in the absence of their partners, which has adverse consequences on women's health. Their social status and power within the family and community influence their reluctance to seek healthcare (Courtenay, 2003; Robertson, 2009).

Patriarchy in African society greatly influences the independence of women; however, some women challenge this norm. African women regained some of their strength and power, similar to the matriarchal society that existed thousands of years ago in Africa before oppression by Christian patriarchies (Chengu, 2015). For example, Akan

is a matriarchal Ghanaian society in which females are the founders but males also have

the authority to lead (Garrison, 2017). Ashanti people from Ghana are a subgroup of

Akan (Asante) and represent the principal tribe in Ghana (McGee, 2015). Modern

Ghanaian women adopted ancient matriarchal concepts to develop their status in the

family, society, economy, and politics (McGee, 2015). Atuoye and Odame (2013)

described the effect of queen mothership (women in cultural leader positions of power)

on female empowerment in upper west Ghana. "With increasing women's empowerment,

there is a growing realization that women are co-agents of nation-building resulting in the

expansion of roles of queen mothers as conduit of development" (Atuoye & Odame,

2013, p. 4).

　　　With time, women gained more power and took authoritative positions; they co-

exist and sometimes dominate economic and political sectors. Women changed from a

traditional housewife role to more active agent of the society (Overa, 2007). The role of

men in this society also changed (Asiyanbola, 2005; Overa, 2007), resulting in gender

equality and a crisis of masculinity (Peralta, 2010).The economic crisis in sub-Saharan

African countries resulted in a significant shift in the gender differences as all family

members searched for employment. Women found more job opportunities, and traditional

concepts of gender-appropriate behaviour changed to reflect this need to work in roles

that require masculine behavior (e.g., traders and entrepreneurs) (Langevang & Gough,

2012; Overa, 2007). As Ghanaian women became breadwinners, there was increased

unemployment and underemployment of men who resorted to jobs that were previously

female-oriented (Overa, 2007). Sub-Saharan African and Ghanaian men must redefine

their masculine roles in a rapidly evolving society but often struggle to transition, leading

to a masculinity crisis (Reid & Walker, 2005). Gender role shift could play a significant

part in how both immigrant men and women use health care services and may affect their health care choices. It is important to unveil effect of gender role change on health decision making among Ghanaian immigrants in their new society.

Summary

Many authors indicate that Ghanaians, and other Africans, immigrate to Canada hoping for a better life. While basic health services are provided to immigrants, immigrants make complex health choices that may challenge their ability to attain access equal to that experienced by Canadian-born citizens. Ghanaians' and other sub-Saharan Africans' health care choices in Alberta are influenced by many factors (e.g., health status, social determinants, spiritual aspects, mistrust, and preferences for traditional approaches). Past studies have addressed health choices that contribute to the HIE of Ghanaian and African communities in cities within Alberta, including Calgary. Socioeconomic factors influence the utilization and accessibility of healthcare services. However, many health programs in Alberta reduce the influence of these factors and provide services to support health access for immigrants (Curtin, Loitz, Spencer-Cavaliere & Khalema, 2018; Raphael, 2018). Alberta healthcare services already follow such recommendations by implementing knowledge translation strategies. However, this literature review has identified some of the many knowledge gaps regarding factors that affect Ghanaian healthcare choices in Calgary. More research is needed to determine how these factors intersect to influence Ghanaian adult immigrants' healthcare choices. These findings may provide the basis of future studies to facilitate better health services for these immigrants.

CHAPTER THREE: METHODOLOGY

Introduction

This research study was an investigation of the factors that influence healthcare choices of adult Ghanaian immigrants living in Calgary, Alberta, Canada. In this chapter, I provide a detailed and reflexive description of the methods and strategies I employed for data collection and analysis. I begin the chapter by stating my philosophical stance and its relevance to my research. Subsequently, I describe the method and criteria for recruitment of participants for the study. This is followed by details of the data analysis process using an inductive thematic approach. Finally, I discuss the various strategies employed to ensure rigor, trustworthiness, and compliance with ethical standards.

Philosophical Stance

Ormiston, Spencer, Barnard, and Snape (2014, p. 2) stated the following regarding the foundations of qualitative research and how philosophical stances may impact research practices.

> Views on whether and how quality in qualitative research practice can or shouldbe assessed depend in part on positions that people hold on key areas of philosophical debate. In other words the degree to which a research study is accepted, and by whom, will partly depend on the particular stance(s) that those involved (researchers, funders, participants, etc.) take.

Guba and Lincoln (1994) argued that the ontological assumptions concerning the perception of how things exist and the epistemology of beliefs related to how an event can be studied reflect the researcher's philosophical beliefs and traditions. Therefore, my cultural or religious beliefs, educational background, and environment may influence my perception and understanding of social reality. Those factors may also influence my view of the stories of participants. To maintain the quality of the research, I considered any biases and interests that may influence or shape the results of my study.

I used the information gained from the participants to generate knowledge through exploration of their social environment. This type of research requires the researcher to use both interpretivist and constructionist approaches. For the interpretivist approach, I follow the views of Immanuel Kant in developing my research.

> Perception relates not only to the senses but to human interpretations of what our senses tell us. Our knowledge of the world is based on 'understanding,' which arises from thinking about what happens to us, not just simply from having had particular experiences. Distinctions exist between 'scientific reason' (based strictly on causal determinism) and 'practical reason' (based on moral freedom and decision-making which involve less certainty). (Adapted from Ritchie, Lewis, Nicholls & Ormston, 2013, p. 6-7).

This study is also informed by the social constructivist paradigm. This paradigm suggests that individuals create meaning through experience, interaction, and observation within the environment (Coll & Chapman, 2000). Using this paradigm for my research, I obtained knowledge of healthcare choices of immigrants through in-depth interviews with participants. I emphasized the co-construction of meaning, which was a subjective relationship between the participants' and researcher's understandings and experiences of factors that influenced their healthcare choices (Hayes & Oppenheim, 1997). Moreover, an in-depth exploration of the approaches to these factors as perceived by the study participants enhanced my understanding of the rich experiences of newcomers (Lythcott & Duschl, 1990). The goal of this research was to gain valuable new information regarding the factors affecting the healthcare choices of participants from their point of view via a social constructivist paradigm.

Theoretical Approach

In the constructivist paradigm, knowledge gathered from the participants emerges from their descriptions of their beliefs, confidence, and common sense. I assumed and accepted that the social constructivist paradigm is independent of the relativist

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perspective (Andrews, 2012), which affirms that people use their experiences to understand their environment.

The social constructivist paradigm is a common approach used by health researchers, specifically those who are interested in evidence-based practice and improving treatment outcomes through knowledge translation (Davis et al., 2003; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Thomas, Menon, Boruff, Rodriguez, & Ahmed, 2014). It is also useful for health promotion practice; it increases understanding of the philosophical tensions between patients and healthcare practices (Labonte & Robertson, 1996). Using the social constructivist paradigm in my research facilitated understanding of participants' knowledge and their perspectives on improving their health status, access to available healthcare services, and potential implementation of new recommendations to improve services and attitudes of healthcare professionals.

Study Design

This research involved the study of Ghanaian adult immigrants' healthcare choices in Calgary, Alberta via a qualitative naturalistic approach using in-depth interviews. The qualitative naturalistic approach allows researchers to gain detailed descriptions of the issue through direct face-to-face interviews with participants in their natural setting (Lincoln & Guba, 1985; Patton, 2002). In this study, a qualitative naturalistic approach served as a way to understand individuals' daily activities and health-seeking behaviours in a socially constructed setting (Bromley, 1990; Sargent, 2012). The natural setting includes participants' social, cultural, economic, and health status in their immediate environment.

Qualitative researchers investigate a subject by gathering data about individual experiences, interactions, and social constructs (i.e., how participants understand the

world) (Merriam, 2014). As discussed by Berg (2001), qualitative inquiry is dependent on the subject or phenomenon under study. Berg stated that the method allows investigators to seek realistic answers to research questions by following a well-planned procedure to collect data from participants in a natural state rather than from secondary sources. In so doing, researchers come to know all participants by discussing their experiences in their natural environment.

Exploring Ghanaian adult immigrants' healthcare choices from the qualitative perspective was essential to understand their challenges and to find solutions. My choice of a qualitative inquiry approach stemmed from identifying how immigrants identify factors that affect their healthcare choices. I also explored the barriers and facilitators to choosing healthcare options and ways to improve healthcare experiences in the host country.

Research Setting

The research study was conducted in the Ghanaian communities of Calgary, Alberta, Canada. The city of Calgary has a population of approximately 1.2 million, making it the largest city in Alberta (Statistics Canada, 2015). Calgary is located at the confluence of the Bow River and the Elbow River in the southern part of the province, about 80 km from the eastern ranges of the Canadian Rockies. (Figure 1)

Figure 1. Map of Calgary, Alberta, Canada. (Google, 2017).

Ghanaian Canadian Association of Calgary (GCAC). Ghanaian immigrants living in Calgary, Alberta, Canada created the GCAC about 30 years ago. The GCAC is composed of people from Ghana with different sociocultural backgrounds, diverse cultural and belief systems, and many languages, a range of educational qualifications and economic status and different age groups. Therefore, it was reasonable to expect that they represent a group of Ghanaian immigrants with diverse approaches to healthcare choices.

The GCAC is an incorporated non-profit association that provides a place for Ghanaians to network, communicate, and support each other. The main objective is to create a supportive environment for Ghanaian immigrants living in Calgary by promoting and preserving social, cultural, and religious aspects of Ghanaians. It provides assistance for transitioning into Canadian culture upon arrival to Canada. The GCAC also provides education for Ghanaian youth, family support, and counseling services. The current study was conducted with members of the Association. Interviews took place in a safe, private

setting that was convenient and comfortable for, and selected by the participants. The confidentiality of participants' identity and contribution was maintained.

Participant Recruitment

In this study, I used a purposeful sampling strategy described by Myers and Newman (2007) to identify participants who were easily available to respond and freely contribute to the research study. I met with gatekeepers of the GCAC through personal contacts and a letter of introduction (Appendix A). The gatekeepers introduced me to the members of the GCAC so that I could explain the purpose of my research to potential participants. I provided a letter of information stating the risks and benefits of the study (Appendix B) to all members of the GCAC. In addition, I displayed posters (Appendix C) at community centres, grocery shops, and churches to raise awareness about the study.

The selection of participants reflected their residency in Calgary and their ability to speak English. The ages of participants ranged from 18 to 60 years. All participants recruited to the study were required to read, understand, and sign the consent form in English language (Appendix D). The consent form included detailed explanations of the purpose, risks and benefits of the study, and the ability to withdraw without penalty.

The number of participants is a critical factor in qualitative research, especially for thematic analysis. Current guidelines suggest sample sizes ranging from two to more than 400 participants (Fugard & Potts, 2015). While, there is a lack of general agreement concerning qualitative study sample size. Bryman (2012) suggested that no fewer than six participants should be included. Adler and Adler (2012) recommended sample sizes between 12 and 60. Baker et al. (2012) recommended that a sample size of eight to twelve was ideal for a master's thesis, providing ample time to plan, conduct, and transcribe interviews. Based on these recommendations, my goal was to interview 10 participants.

Data saturation was used as a guideline to identify if adequate data was collected (Ness, 2015). Each interview was transcribed and reviewed before the next interview, which helped me assess if new information was added, or not. Ghanaian experiences and complexities about health care choices were captured.

Data Collection

Data collection for this study involved in-depth interviews with each of the participant Based on studies by Kvåle (2007), in-depth interviews guide conversations between two parties to generate concepts regarding a phenomenon. Therefore, I used an in-depth interview method and observations during the fieldwork stage of the study to understand the experience and opinions of the participants.

The confidentiality and privacy of participants were paramount. Throughout the study, I established rapport and trust between myself and the participants, which ensured the collection of detailed and rich information from them (Bryman & Bell, 2012). All observations that I made during the study were documented in reflective journals (Lincoln & Guba, 1985). The importance of observation is to allow the generation of different kinds of data and to enhance understanding of the context and topic. My field notes gradually became insightful data that aided in the understanding of participants' statements concerning the factors that influence the healthcare choices of newly arrived Ghanaian immigrants.

I used a semi-structured interview guide (Appendix F) to facilitate conversations with participants and guide exploration of areas relevant to my research question. In addition, I used guided probing techniques to access information that was not talked about during the interview. I made sure that my probing questions did not interfere with or

interrupt participants from freely sharing their opinions. Furthermore, I audio recorded all interviews with participants' consent.

Data Analysis

An inductive thematic analysis approach was appropriate for this study. Firstly, it provided a correspondence of the study objectives and results of data collection (Thomas, 2006). Second, an inductive thematic approach involves carefully reading through the participants' transcripts to get a better understanding of the information collected (Braun & Clarke, 2006). Thirdly, thematic analysis leads to reasonable conclusions and prevents researchers from manipulating the data via personal interests and opinions (Liamputtong, 2009). Thus, it allows researchers to organize and interpret data solely from the participants' actions and words. By choosing an inductive thematic analysis approach, I ensured that the findings and conclusions from this study were strictly based on the data collected from the participants. There are six major phases/steps of thematic analysis proposed by Braun and Clarke (2006; 2013). I completed these steps as a recursive process. An outline of the basic steps involved and a short description of each step appear in Figure 2.
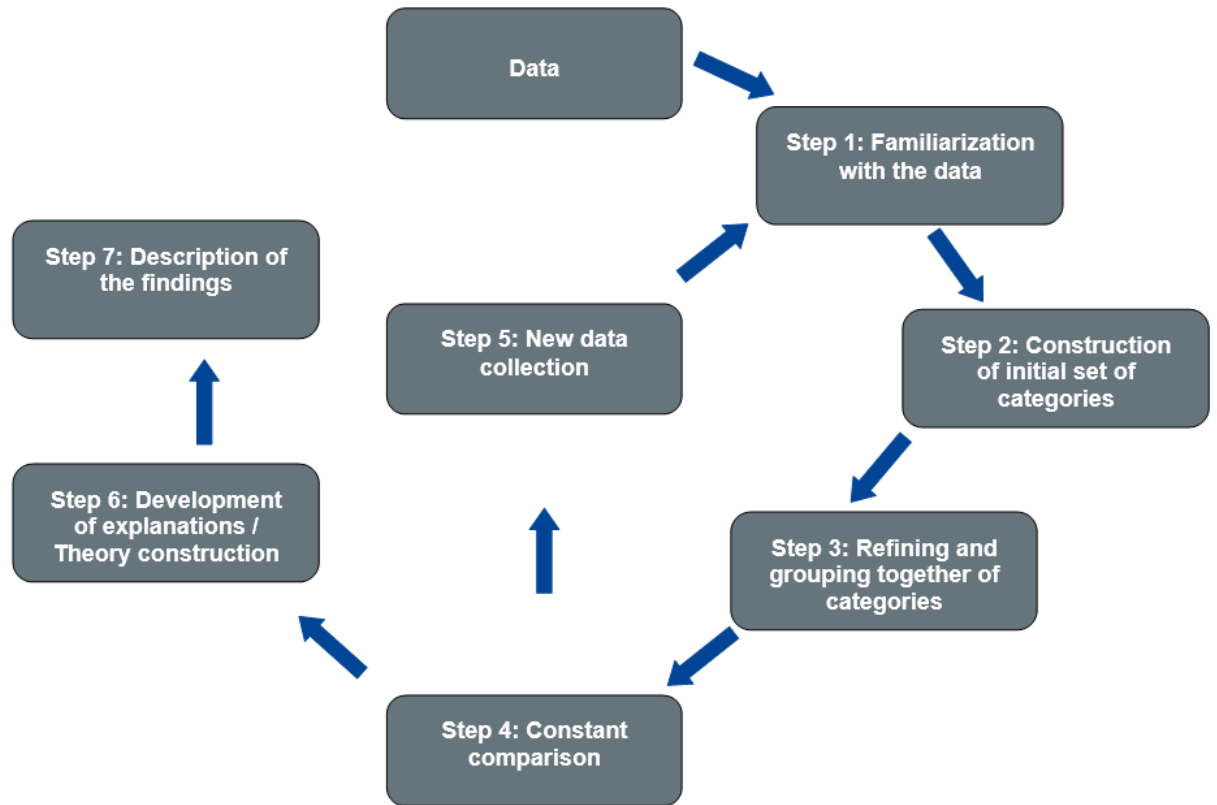
Figure 2. Phases of thematic analysis (Kohn & Christiaens, 2013, p. 44).

I transcribed the audio recordings from the participants' interview verbatim and began data analysis immediately after collection. The immediate analysis of the participants' transcripts provided an additional opportunity to review the transcript with respondents for more clarification, if necessary. I used the previously collected interview data as a reference for later interviews. As such, important issues raised by previous participants were taken into consideration to improve subsequent interviews.

I read the participants' transcripts multiple times to become acquainted with the generated data. Simultaneously, I looked for codes, themes, and statements that would provide critical insights into the research topic.

> In qualitative data analysis, a code is a researcher-generated construct that symbolizes and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorization, theory building, and other analytic processes. (Saldaña, 2015, p. 21)

As recommended by Braun and Clarke (2006), I referred back to the field notes I composed during the interviews to check for necessary quotes or sentence that contributed to coding and theme formation. I developed several directories of codes, attaching deeper meanings to phrases, words, and sentences from participants' transcripts. This stage of code and theme generation occurred under the direct supervision of my thesis co-supervisors.

I completed coding using NVivo software (Welsh, 2002). Coding in NVivo involved multiple steps, as outlined by Hai-Jew (2014), including precoding, defining terminology, coining new terms, and linking to memos. I summarized codes and themes into categories with brief and clear interpretations. Following the creation of codes and themes, I examined the relationships among these themes. Subsequently, I further analyzed the codes with the initial definitions affixed to individual codes. The codes classified outside the already created themes were put into a different group with another name for use in results and/or discussion sections (Braun & Clarke, 2006).

Scientific Rigor and Trustworthiness

The evaluative criteria for trustworthiness ensured that the data and analysis were robust (Guba & Lincoln, 1994; Lincoln & Guba, 1986). The criteria include credibility, confirmability, dependability, and transferability (Bryman, 2012; Lincoln & Guba, 1986). The following sections explain how each of the criteria was used in reference to this current study.

Credibility. Credibility refers to how appropriately the researcher represents participants' views during all phases of the study (Chilisa, 2012; Schwandt, 1997). To comply with this criterion, I presented all data gathered to my co supervisors for appropriate guidance. I also ensured accuracy of transcription by transcribing exact

phrases, comments, and perspectives of the interviews verbatim. Furthermore, I conducted checks with participants through e-mails and phone calls to ensure that the reports accurately reflected their comments and statements.

Confirmability. Confirmability refers to the degree to which findings from the research are not influenced by the researcher's beliefs and biases and the extent to which the results could be confirmed by readers (Braun & Clarke, 2006). I adopted confirmability during the research process by consistently keeping an active, updated, and well-detailed document with my knowledge and experiences along with my beliefs and biases about the research topic. I articulated my beliefs and biases about the topic to prevent any interference at any stage of the study (Lincoln & Guba, 1985). I held frequent discussions with my supervisors to ensure that my personal views exerted minimal influence on the study (Cherry, Ellis, & DeSoucey, 2010; Creswell, Shope, Plano Clark, & Green, 2006).

Dependability. I ensured dependability by including detailed descriptions of the research methods used (Lincoln & Guba, 1985). I made sure that accurate details of the general procedures such as problem formulation, participant selection, field notes, transcription, and data analysis were maintained. These records will be easily accessible to peers, audience, and other independent bodies who may serve as reviewers of my research work (Bryman & Bell, 2012).

Transferability. Transferability is the hope of researchers that their findings may be generalized to a greater portion of the population (Van de Ven, 2007). I focused on providing detailed descriptions of the participants' views on the phenomenon of interest (Bryman & Bell, 2012; Creswell, 2013; Geertz, 1973). I obtained rich and detailed qualitative data during interviews to generate useful concepts in other settings. The

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observations in my field journal also provided detailed description of the factors that influences Ghanaian adult immigrants' healthcare choices.

Ethical Considerations

Ethics help researchers define what is expected of them before and after social science research. Ethics also define what is morally right and acceptable in research (Neuman, 2011). This study was approved by the University of Lethbridge Human Subject Research Committee to ensure that it complies with the principles of the Tri-Council Policy Statement (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2014). I employed the ethical standpoints of Nuremberg Code in my research, which provide protection to human subjects/participants including their right to withdraw from the study at any time and the conducting of research by a qualified and trained individual (Speziale, Streubert, & Carpenter, 2011). Additionally, I adhered to the three main principles of the Tri-Council Policy Statement: (a) respect for persons; (b) concern for welfare; and (c) justice (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2014).

Respect for persons. I maintained respect by disclosing details of the study in my letter of information to potential participants (Bryman & Bell, 2012). Participants understood their right to freely participate in the research study based on their informed consent. I informed the participants that their identities will remain confidential even if they decide to withdraw from the study. Further, I ensured that the participants' views were carefully noted and used in the research study.

Concern for welfare. I attempted to establish rapport and to build trust with participants during data generation. I ensured that the confidentiality and privacy of participants were secure during and after the study. I protected the participants' welfare by notifying them of their right to withdraw at any time without penalty in the consent form. Moreover, I explained the risks and potential benefits associated with their involvement in the research study. I also provided refreshments to participants during the interview process. The participants understood that they were not required to reimburse me for the food even if they wished to stop at any time during the interview.

Justice. The topic of justice reminds researchers that participants must not feel exploited as a result of their participation in a study. I treated my participants with equity and fairness and justified the relevance of my study to help improve immigrants' healthcare choices (Bryman & Bell, 2012). I ensured that participants were on the same level of understanding with me during the interviews.

Summary

In this chapter, I provided my philosopical stance and rationale for using social constructivism and a qualitative naturalistic approach. These methods improved my interview process and allowed participants to extensively discuss their rich experiences. I explained full accounts of participant recruitment, description, and data generation processes including interview questions. This chapter also included the stages of interviews, data management and organization, and all ethical concerns. The next chapter includes the study findings and interpretation of data.

CHAPTER FOUR: STUDY FINDINGS

Introduction

The healthcare choices of Ghanaian adult immigrants influence their pathways to care. In this chapter, I discuss some factors that influenced these choices during decade after immigrants' arrival in Calgary, Alberta, Canada. The decisions of immigrants often related to their pre-migration, migration, and/or post-migration experiences. The chapter includes details about the challenges and decision dynamics of immigrants' healthcare choices and a brief description of participants' backgrounds (e.g., age, gender, educational level, employment, citizenship, and marital status). I also discuss the healthcare decision-making process of Ghanaian adult immigrants, their reasons for migrating to Calgary, common health conditions, and their experiences.

The results of this study reflect data from in-depth interviews with 10 Ghanaian adult immigrants. They include observations, field notes, and interpretations of participants' experiences. During interviews, participants answered an extensive range of questions that helped to illustrate the intersecting factors that influenced their healthcare choices. The overarching theme of these data is *not the land of milk and honey*, which explains Ghanaian adult immigrants' expectations as shaped by experiences of healthcare choices while living in Calgary. Using the thematic analysis approach described by Braun and Clarke (2006), I identified four major sub-themes: (a) looking for a lifeline; (b) how do I fit in here; (c) navigating a new healthcare system; and (d) intersecting pathways to healthcare choices.

Demographics of Participants

   Ten Ghanaian adult immigrants (five men, five women) participated in this study.

Participants' circumstances and experiences varied widely, but most were married,

employed, and educated. I assigned each participant a pseudonym to protect identities.

Table 1
Demographics of Participants

Name	Gender	Age	Education	Employment	Citizenship	Marital status	Number of years in Canada
Aunty-G	F	36	University	Employed (PT)	Temporary resident	Married	2
Cecile	F	44	High school	Employed (FT)	Citizen	CL	5
Juana	F	52	College	Employed (FT)	PR	Married	2
Elder	M	38	College	Employed (FT)	PR	Married	10
Dorcas	F	29	Primary school	Employed (PT)	Citizen	Single	4
Joe	M	54	High school	Under the table	Temporary resident	Married	5
Jerry	M	60	University	Employed (FT)	PR	Married	18
Peace	F	39	High school	Employed (PT)	PR	Married	**7**
Menu	M	56	High school	Unemployed	Temporary resident	Single	3
Juvenal	M	31	College	Unemployed	PR	Married	3

Note. CL = Common law, S = Single, PR = Permanent resident, FT= Full time, PT = Part time.
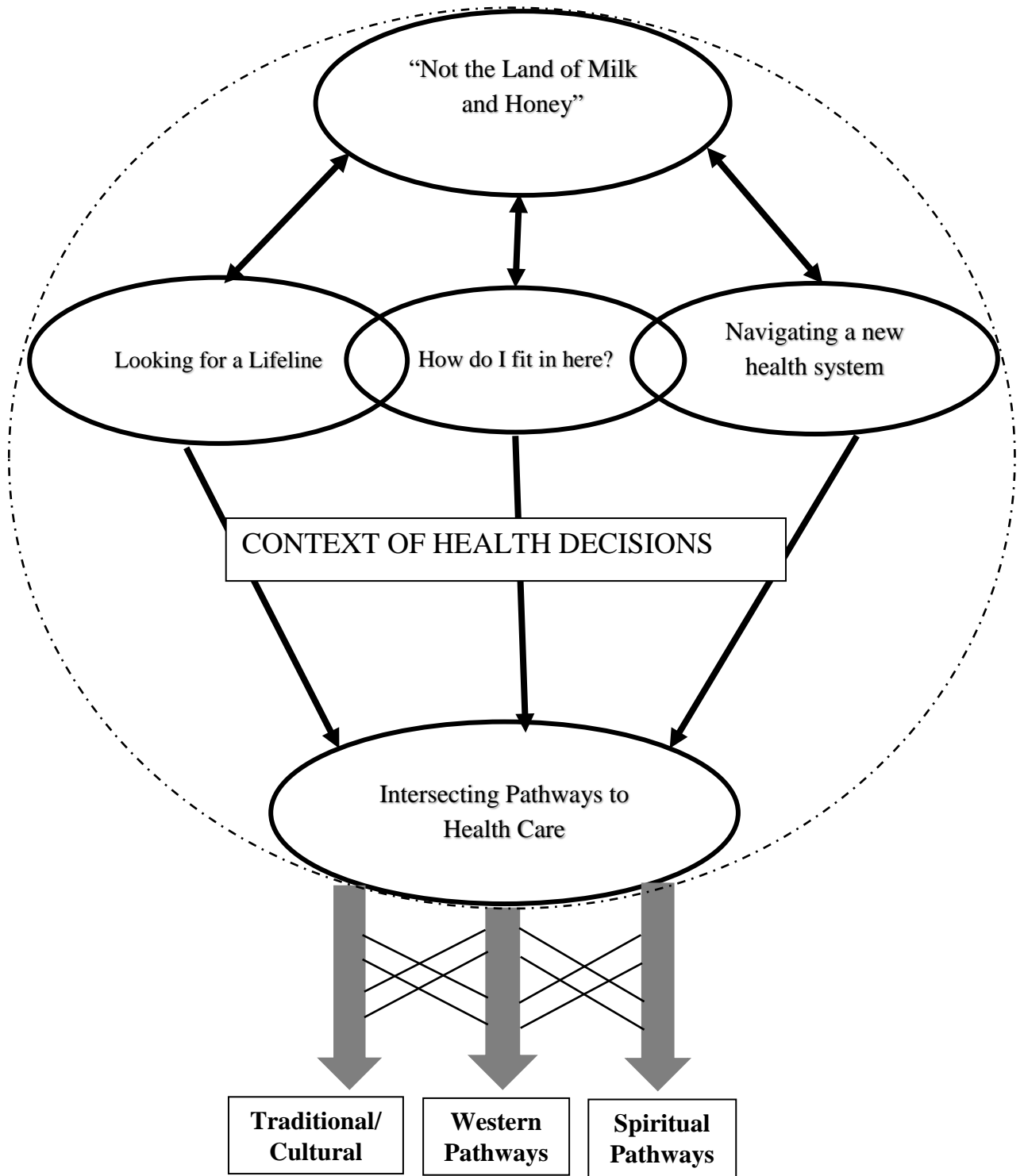
Figure 3. Intersecting factors that influenced health care choices.

Central Theme: Not the Land of Milk and Honey

The central theme of *not the land of milk and honey* speaks to the common

disappointment and disillusion that many Ghanaian immigrants experienced following

migration to Canada, and its effect on the health care decisions they make. The pre-

migration period was challenging in its own way, but participants characterized it as

hopeful due to the promise of a better life for themselves and their families in terms of

economic success, opportunity, and overall wellbeing. For instance, Cecil stated,

> …before coming to Canada, I thought the place was like safe haven, everything
> you need are easily available, there is happiness, I was told. But once I got here, I
> found out that nothing is easy to get, especially for the social and economic aspect
> I did not expect this.

Participants noted many intersecting factors (e.g., social and economic

marginalization, difficulty navigating a new healthcare system) that shaped their decision-

making pertaining to healthcare. They frequently felt disappointed by the quality and

accessibility of their healthcare experiences and the difficult process of navigating

between traditional/cultural, western medicine, and spiritual pathways. Most participants'

expectations of the host country being a land flowing with milk and honey did not align

with what they experienced when they arrived. For example, Juvenal stated, "in two years

of my stay in Canada, I started realizing that the place is not as green as we thought. You

have to go through a lot here to be able to get something for a living." Other

disappointments included barriers related to racism, discrimination, and language

(English proficiency) that participants had to overcome to communicate and interact in

the new environment. Factors such as perceived severity of the illness or ailment and

familiarity with healthcare providers informed their choices, which still reflected the

influence of the pre-migration experiences.

Sub-Theme 1: Looking for a Lifeline

Looking for a lifeline was an important aspect of the participants' experiences before and after migrating to the host society. After struggling to migrate to the land perceived to have no suffering, participants shared their mixed experiences looking for support. More than half reported many challenges when attempting to immigrate to Canada, some of which affected their physical and mental health. Participants reported feeling pressure and stress when preparing to migrate. Juana said, "After getting the visa, I had to do all kinds of jobs to save something for my ticket to be able to travel here, and that was really a hectic time for me, very tedious. The stress gave me headaches."

Most participants shared that their residential locations at the time of their immigration to Canada significantly influenced their experiences and health outcomes. Those living in rural areas had more difficulty accessing immigration documents than their urban counterparts, and some experienced mental health problems. Most of the rural dwellers recalled feeling extremely anxious and stressed when they traveled to the capital city to process their immigration applications. Joe stated, "It was a long journey back and forth from my place to the capital city. I did not have any choice because it was the only place to process your documents, which require a long-distance travel." Some reported that there was not a single day that they were not depressed by problems with their passport application. Fatigue and sleeplessness were the most common physical health problems for participants. The following sections include details of pre-migration strategies that immigrants often used to cope with these stressful situations. These strategies included leaning on family and friends, self-soothing and self-medicating with alcohol, and turning to God. There was great anticipation about how life was going to be

in Canada but the process of migration was anxiety-inducing. All participants felt that it would be worth it in the end.

Leaning on family, friends, and community. Support from family and friends emerged as an important method of coping and managing immigration application-related stress. Close connections with children, parents, and extended family members provided participants with outlets to share their immigration struggles and gain positive encouragement, reassurance, and hope. In this regard, Menu stated, "I gained emotional support from my children and wife, and sometimes friends during my immigration struggles in Ghana." Menu shared challenges through everyday conversations with his wife and brother and benefited from their words of encouragement and support. This support provided him with the strength to overcome the stress.

When support from family members and close friends dissipated or waned, participants turned to members of the larger community or workplace. For example, Menu started talking to his coworkers about his immigration dilemmas when his wife and children were no longer able to cope with his stress. He said, "At that point I felt the need to start talking to other people at work, and sometimes at public places, to seek hope and optimism for what lies ahead for me and my family in general." For participants, whose family members were unable to provide adequate support during immigration struggles, relationships with co-workers played an important role in their ability to cope with and manage psychological problems. Participants, who lacked emotional support from immediate family, felt distanced from them, which complicated their emotional struggles. Elder voiced his disappointment by stating,

[My] wife and children became fed up of listening to my worries and concerns about the potential outcome of my visa application. At that time, I was feeling very tense and anxious always, and I had no choice but to look elsewhere for emotional support. It was my friends at work who provided me the platform to voice my concerns and seek strength and hope. They were my lifesavers.

Significant others (e.g., spouses and close friends) sometimes provided counseling to the participants. Elder repeatedly talked about his wife as his only source of hope when he had not heard from the visa application office. He stated, "I borrowed money from the bank and did not know how to pay back if things did not go well. My wife counselled me many times to be patient while waiting for the outcome of my visa application." Similarly, Joe talked about the importance of counsel from significant others in relieving immigration stress, anxiety, and depression.

Receiving emotional support was essential to participants' psychological well-being. Overall, participants viewed strong relationships with family and friends as effective coping mechanisms for stress.

Some participants sought spiritual counseling in Ghana for immigration-related concerns and associated health problems. When participants worried about the potential outcome of an immigration application, they contacted religious and spiritual leaders for encouragement and advice. These leaders helped the participants make sense of what was going on in their lives and find solutions to their concerns. Dorcas talked to her pastor about her stressful immigration situation and sought guidance to overcome it. Cecile emphasized the importance of sharing her concerns with her church pastor and other leaders. Such consultations helped her stay calm and not feel overwhelmed by what was going on in her life. Juvenal believed that religious and spiritual counselors provided

insights into future possibilities regarding successful immigration applications. She stated, "My spiritual pastor was able to tell me beforehand that my visa application would be successful, and that assurance helped to alleviate my concerns and stress for several weeks while waiting for a response from the Canadian immigration office."

Participants believed that the counseling they received from religious and spiritual leaders or other non-professionals was much more effective than that provided by professional counselors in addressing their concerns and fears. Aunty-G said her "church pastor was always talking, and encouraging me that there is hope, and that things will be fine." Aunty-G tried to engage a professional counselor to alleviate her concerns but did not feel supported. When she received advice and words of encouragement from her pastor, she tended to feel more relaxed.

Turning to God. Participants had diverse responses to managing psychological problems when processing their immigration documents and dealing with pre-migration and post-migration stress. Many participants used non-medical methods to treat and manage psychological problems, the most common of which was prayer. Prayer is vital to the life of many Ghanaians; so, it was not surprising that participants depended on words of encouragement from the Bible and God for emotional healing. When participants experienced psychological disturbances and physical fatigue from the immigration processes, they turned to their faith for strength and hope. Juana said she would not have successfully coped with the stress of immigration without God's help. Participants with strong religious and spiritual connections expressed greater interest in seeking counsel from people who shared similar beliefs than from a trained health professional. In this study, participants' expressions of their perspectives on counselling services did not refer

to formal counselling from a professional; they referred to untrained caregivers, such as community elders or religious leaders.

Many participants believed that it was through prayer that their psychological health problems resolved. Dorcas prayed whenever she felt anxious and depressed, and was able to cope with the immigration-related stress. Overcoming psychological problems with prayer was more common among female participants than males. Male participants (four out of five) hardly used prayer to treat depression. However, Elder prayed at most once a day to cope with immigration-related stress and other mental disturbances. He stated,

> I remember praying one or two times maybe in three days or sometimes a week, but I prayed more than twice when I felt severely depressed and too empty to do anything. It was in those moments that I was forced to pray a little more and seek strength from my faith. I rarely prayed more than once when feeling less psychologically disturbed by the immigration processes.

All female participants identified prayer as central to their psychological well-being; they prayed many times each day to redirect their thoughts and attention away from immigration issues. Juana used prayer to "manage stress from a visa refusal shock." Two years prior to her migration, Juana failed to attain a visa to Canada, which caused her to develop major depression and anxiety. She used prayer to deal with these problems, and relied on the "encouraging words from the Bible to build hope and optimism for positive future immigration outcomes."

Self-medicating stress. A few of the male participants adopted behaviours such as drinking as a stress management strategy. Although they knew of its adverse impact on their physical health, some consumed alcohol throughout the week to distract themselves from thinking about the uncertain outcomes of their immigration applications. Jerry would drink "three to five bottles of the local or traditional alcoholic beverages," such as

high-alcohol content palm wine, to take his mind off things that made him feel depressed. The best outcome for participants who used alcohol to cope with stress was for others to remain unaware of their behaviour. Jerry expressed regret for using alcohol to cope with stress when his wife and children became aware of it. He thought he could hide it from them, and felt ashamed and guilty when they found out. This made his psychological problem worse. His approach to dealing with stress during the immigration process was not helpful according to him and but he failed to recognize this mistake at the time. Jerry stated,

> I still feel ashamed of what I did to myself with my drinking. I thought the drinking was going to help me to gather strength to face any unexpected outcome of my immigration application. When things happened in ways I had anticipated, I felt very bad for my behaviour. To date, I still feel that the shame it brought upon me and the family has not yet been dealt with completely.

Many Ghanaian adult immigrants and their families hoped migration to a new land would lead to a better life including: improved economic and social success, and general wellbeing. However, most participants experienced disappointment in their host country. Male and female participants used different approaches to deal with the stressful migration process. Some leaned on family, friends, and the community for social and economic support. Other participants depended solely on God (through prayers) to manage their psychological problems, while others self-soothed with alcoholic beverages to mange their stress despite knowing the consequences of such drinking behaviours on their health.

Sub-Theme 2: How Do I Fit in Here?

The theme *how do I fit in here* describes social and economic challenges experienced by participants in a number of categories. Each category represented an area

of social tension. Social tensions are stressors that participants reported carrying along with them to their new place of residence. Immigration exposed participants to a new environment that required leaving old cultural practices behind. Participants felt uncomfortable giving up their traditional ways and avoided adopting new ways of life. The primary social tensions articulated included: technological connection and disconnection, shifting gender expectations and norms, and experiences of racism.

Shifting gender expectations and norms. In Ghana, men often play the role of decision-making breadwinner, family head, and provider. Women manage and clean the house and perform other duties to support the men. Male participants complained that there was a shift in their roles as men after leaving Ghana. Tension between men and women in this study resulted when they experienced different gender roles in Canada, which affected both men and women's perceived social and psychological wellbeing. Three of the male participants stated that they were unable to take care of their children's educational needs or pay for their family's medical issues. A common view of male participants was a feeling of helplessness. For instance, Jerry commented,

> In fact, sometimes I don't feel that I am the man in the house. As culture demands, as a man I must work to support the family and…it is hard for me now. I feel like I have fail on my duties as a man. It leaves me thinking every day and night…It is more difficult than I thought.

Most men in this study felt subordinated; they reported less control over their health due to changes in their gender roles. They feared this change would make women more powerful. The shift in power caused some men to experience low self-esteem and distress due to loss of identity in losing their role. For example, Elder stated,

> My wife does everything in the house and even takes every decision. It's a shame on my side as a man but I'm the woman now in terms of responsibilities and leadership, because she earns more than I do, she pays greater part of the bills and

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has taken control in the house, my self-esteem is down…sometimes, I feel helpless.

In contrast, female immigrants felt empowered and safer in Canada than in Ghana. Aunty-G added,

> I saw coming to Canada was the better choice ever to have opportunity to be myself, not any more restrictions from my husband, and to create better life for myself …fortunately, Canada has equal opportunities for us. So when my husband first came, I told him that here in Canada, he should leave "that thing" [exercising too much power]. Now, I have my college diploma, and no more housewife. Canada has really enlightened me a lot especially to be independent.

Some male participants complained that their wives denied them sex. Others blamed their wives for adopting a bad attitude and the Canadian culture, which made them feel superior to their husbands. Joe said, "She refuses me different times [sex], and I can't do anything to her here. I cannot complain to anyone. It's a shame to let someone know this."

Experiencing feelings of subordination, many men sought other ways to emphasize their masculinity. When asked about how often they seek healthcare/medical care, four male participants reported they do not often seek medical attention because they want to prove their masculinity. These men only seek medical care in case of emergency. Joe said,

> As a man, you do not have to be going to the hospital or the clinic like the women do. It is okay to endure it. Men are to swallow pain and drink the bitter medicine. We need to show that we are men.

Most of the women in this study held higher paying jobs than the men, which was quite different from the situation in Ghana. This increased women's sense of choice and power and allowed them take roles previously associated with the male head of the family. They made most of the decisions about their healthcare choices and did not have to rely on their husbands. Aunty-G stated,

> Now, I go to see the doctor at any time on my own, I do not have to wait till he [the husband] decide for me before I work and earn good money for myself and I can buy whatever I want. I feel free to use any medication of my choice without any influence from my partner.

She explained that in Ghana, all family healthcare decisions were under the control of her husband. She added,

> Being a woman in Canada empowers and make me feel like a real woman and I feel great to be in control of my own self. I make my own health decision in Canada which wasn't so in Ghana. I don't ask my husband for money to buy pills or anything, I do search for them myself.

Elder stated that sometimes violence erupts due to challenges of adapting to changing roles. For example,

> A man stabbed his wife all because there is competition and tension in some families because the women think they are now men, our women have grown "horns" we are nothing to them now. About two years ago one ex-wife in Toronto killed her husband on the same issue. Attitudes and behaviours of our women. It is sad and we never expected this in marriage are going down. Talk to more Ghanaian men and listen their worries.

Women found it easier to adjust to changes in the new environment. Cecile commented that coming to Canada was the best decision she ever made because she feels in control of personal issues in life and marriage. She added that things gradually started working out "and I know that I will be there." Most male participants said migration affected their physical and mental health. Many of the men abandoned daily activities, including self-care, which sometimes devolved into trauma and/or abusive behaviours. However, most women felt more independent and in greater control of their lives. Despite the fact that female participants reported greater independence and control in relation to their health care decisions and lives in general, this did not eliminate their general feeling that Canada was *not the land of milk and honey* that they had expected, or fully compensate for the challenges that had arisen for them.

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Technological connection and disconnection. Technology is an important

determinant of healthcare choices. Technology can connect people to their home country,

facilitate sources of traditional medicine usage, and connect individuals to information on

healthcare services and products. Technology significantly influenced participants' health

decision-making. Aunty-G shared,

> I do go online and look for homemade medication, and you know it will tell you
> to do this and do that and it works for me, so most times you don't have to see a
> doctor for any prescription.

Participants who lacked technological skills consulted their family and friends to

help them search for health information and services available to them. Participants who

struggled to use technology before and after migrating to Canadian society experienced

difficulty navigating the Canadian health system. They frequently sought technological

assistance from reliable individuals in the GCAC. A low level of technological

knowledge affected participants' ability to navigate the Canadian healthcare system and

engage in health decision-making; they were unable to make choices due to a lack of

knowledge. Dorcas explained,

> Some of us really need help here and everybody seems to be too busy, nobody has
> time to explain things to you. Everything about this place is Internet, this place is
> [more] complex than Ghana, so I ask my grandson to help me when I need
> something and when he is not around then I have to go by self-care.

Peace added,

> Well, with time, I have gained a little control and it is not easy for me as well. But
> yeah, I do not have to do these entire Internet things in Ghana, I just send or walk
> to that shop or place for whatever service I need. I think the more you get familiar
> with the system the more you catch up with the technology. It is not easy for me.

Some participants stated that technology replaced their traditional socialization

system. It (e.g., Internet, mobile phones, WhatsApp, Twitter, and Facebook) often

replaced face-to-face communication among friends and families. Some participants

complained about feeling lonely and isolated because their medium of communication

was mostly through technology. Participants felt worried and sometimes depressed

because they were unable to contribute to decisions for their children or even spouses.

Juana, a parent, talked about how technology changed her family relationships:

> There was this unity/togetherness in our families back in Ghana. In Canada,
> sometimes I can call my children several times and they will not answer. They
> insist I send a text message. It is sad how technology is destroying my family.
> Here in Canada, it is more about the nuclear family but we focus on extended
> family back in our home country so there is this conflict with immigrant parents'
> upbringing their children.

Experiencing racism and discrimination in their new home. Racial

discrimination occurs when an individual treats another person less favorably due to skin

color, nationality, race, descent, ethnicity, or immigration status (Scott, 2014).

Participants talked about such discrimination based on their appearance and inability to

speak like Canadians. Joe shared an experience during a visit to a doctor at a clinic. "Yes,

when the lady who speaks English sees me, she tells me, oh no, an African. She does not

know what to do to be able to communicate effectively with me." Juvenal talked about

health workers' overall attitudes towards immigrants from poor countries:

> Since I come from a poor country in Africa, they treated me as if I don't know
> anything. People discriminate against me perhaps because I am not able to speak
> like a Canadian…It is something that happens to most African immigrants in
> Canada.

The fear of racial discrimination led to avoidance of healthcare services; some

participants' friends and family members discouraged them from using clinics and

hospitals. This was most common among the male participants in the study. Juvenal

stated,

> I wish to always go to the clinic or the hospital but my wife told me that she had a
> painful experience at the hospital when she had her finger chop off, she was using
> the garage sliding door. She was not treated early at the emergency room for more

than two hours before treating her. She said that they treated her like she was just trying to get pain medicine from them and her finger couldn't be fixed again until she threw the piece off. All because she is black. So you see because of this, I prefer to treat myself than to be a victim.

Cecil, a female participant who was in her mid-40s and a recent arrival to Canada stated,

So, the first time I arrived here, and I got sick I was going around my neighborhood to see if I could find what I used back home but unfortunately, I could not find them, so I rushed to the clinic for a diagnosis and the doctor gave me some medicine, but you know because as a black woman they will look at me "some way."

Some participants felt racially discriminated against when applying for jobs. Some mentioned individuals who considered suicide because of the stress they experienced.

Juvenal shared,

I have a friend who committed suicide because he was turned down every time he applies to a job. I am just an immigrant here; what am I looking for, where I am going, nobody cares. I don't think I deserve to be here, so the next simple thing is to just commit suicide.

Participants described health services for immigrants as being of poor quality. Cecil talked about her experience with a nurse at a clinic when she first arrived in Canada. "When the nurse found out that I knew how to read and write proficiently in English, she started to change. She started to treat me with respect. Before that, she would humiliate me for not understanding her." Participants perceived that they were treated badly due to an assumption they had a lack of education.

Economic marginalization. The theme of economic marginalization includes the financial conditions that created tension and negatively influenced participants' healthcare. Most participants took low-paying or under the table jobs. Others faced challenges such as low-income, transportation issues, and unemployment. Most were unable to afford personal vehicles, making it difficult to access some medical services if they lived far from hospitals and clinics. Due to financial challenges, those without health

benefits or insurance coverage struggled to pay their medical bills. They had to start with low-paying jobs to catch up to their previous economic and social status in Ghana. Many participants' income problems contributed to their decision to avoid hospital bills for themselves and their dependents. Elder commented that,

> If you don't have family to support you when you here [Canada], you feel beaten up by the demand imposed on you which is a big blow. Also, the kind of job that we get is usually comes with very low income, the labour is difficult and the pay is not good, that alone put stress on you thinking how to pay for this and that and take care of yourself. Sometimes, no employment at all.

Most only sought care when they deemed it an emergency. Most of the male participants complained that they were professionals back in Ghana. Upon migrating to Canada, they did not feel valued and lost status because of the nature of jobs they were able to find. Joe explained,

> In Ghana, I wear better suit and put on good tie to work, I am very free and respected, but hmm here in Canada is not like that. I thought it was going to be same or even better than my previous work in Ghana but…hmm. I know you know all this.

Another participant, Menu added,

> I cannot tell my wife the job I do to survive here, she will ask me to come back to Ghana. I don't want to have any quarrel with her again. She is difficult sometimes I have been thinking of hiding it from her always. I just want to get it done.

Some participants complained about pressure to send money to their family and friends in Ghana because of the perception of their new country as *rich soil*. Others believed it was their responsibility to send remittances. However, participants earned a low income and had to take care of their own needs before supporting their families and friends back home.

> You could hardly explain to these people back home that it is not as we all thought it would be. They think I swim in money and have better-paid job and good living so yes I have to send money to them. But sometime it is even difficult to save something for your personal needs like going for checkups. I have two kids, they

are all in school and all their expenses are on me. The people back home are always calling, you can imagine. (Juana)

Another major issue that the participants discussed was educational credentials. Most stated that their previous educational qualifications from their country of origin were unrecognized, making it impossible for them to earn a higher income. Participants had to prove themselves, extend their education, or accept low-paying jobs. This affected their health-seeking behaviours and healthcare practices.

> It is very difficult in this country [Canada] when you come fresh because you do not have good jobs and have to start from scratch to earn high income and afford better healthcare. No doubt because, myself when I came here in Canada, I came with first degree in psychology and it was very difficult to get a job. And I was told that I have to pass their exam before I can get a job. I have to take the low paying jobs available like that or I could not survive. I could not afford a personal car for my own errands. I used to rely on friends and it was hell for me. (Jerry)

In addition, most participants faced a lack of Canadian work experience, even though they possessed advanced education qualifications and other training in their field. Menu complained about his situation after arrival in Calgary and stated,

> Life was not easy at the beginning when I came, because everywhere I went for job interview they keep asking Canadian working experience. Where do I get that? Because I was new. I had a lot of working experience back in Ghana but I am not getting a job in this field here in Canada with it because of precious Canada experience. It was very frustrating, you have to keep trying, and trying. It was hard to come by money or get something for other expenses that you needed to attend to, like going for medical check up and others.

Age was another factor that limited employment options. Participants in their mid-50s and above found it to be more challenging to find a suitable job when they had low or no educational qualifications.

> When I applied to work in the factory at the north Calgary, I struggled getting the job because they thought I was old and inactive. I was later given a menial job after several months of the application. I kept thinking about how I was going to take care of my bills and health. (Juvenal)

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Participants also discussed difficulties taking time off work to attend to health concerns. Participants had to work enough hours to earn enough money to take care of themselves and their family. Some participants noted their dissatisfaction with the operating hours of clinics, which were less favorable for people who worked long hours. Most participants worked in low-paying jobs and had little control over their work schedule. As a result, they were unable to take time off to meet their healthcare needs. Juvenal stated, "due to the tight working schedule I am not able to make a time for my doctor's prescription at the pharmacist just to spend a little or some time for my own self to buy medications is a problem for me." Other participants stated that they were afraid they might lose their jobs if they took time off for medical appointments.

Transportation. Transportation made it difficult for newly arrived immigrants to navigate the healthcare system in Canada. Living far from a clinic or hospital made access to services challenging. Some participants found public transit less helpful for accessing clinics because of long travel times. Travelling by public transit delayed access compared to the use of a private car. Participants felt less able to control their daily routine, activities, and schedule (e.g., keeping doctor's appointments, going to the pharmacy) without dependable transportation.

Peace, a high school graduate, complained, "The services that I need are unavailable or far away from where I stay." Accessibility is a crucial issue. Lack of sufficient income to take care of their needs affected access to healthcare. Jerry stated,

> During the summer time, I try to walk to wherever I want to go because I cannot afford to take the bus always. Sometimes, I give up to some of the places because it is far like the big hospitals and the pharmacy shops. I try to get everything close by so that I do not have to take the bus. During the wintertime, if I don't have the money to take the bus, I stay home.

Similarly, Juana added,

Many times, I miss the location when I use the public transport. Sometimes, I missed my appointments. I mostly go talk to some of the new friends to drive me and guide me the first few visits to the clinic or hospital. But it is difficult to get them every day to escort me to these places because they are all busy. I am alone here as well.

Dorcas, a primary school graduate, shared her frustration:

It is very painful to walk to the bus terminal and to return home because you missed it. It is so annoying here [Canada]…Because you cannot afford to take the taxi and you have a very short time.

Dorcas further explained,

For me whenever I missed the bus unfortunately, I missed my appointment as well because it will take me almost an hour to get to my appointment. During the winter, I do not book any appointment at all unless a friend or someone will assist me.

Other participants sought financial assistance from friends and families to arrange for private transportation to healthcare settings. The cost of private transportation was a burden for participants. Some participants spent between $40 and $60 every time they went to the clinic or hospital. Most participants experienced these challenges during the early days after arrival in Canada due to their inability to afford private vehicles or pay for a taxi and the long process of getting a driving permit.

In summary, participants stressed that economic marginalization created unfavourable conditions for them to survive in their new country after arrival. Some of the barriers negatively influenced participants' healthcare choices. One contributing factor to economic marginalization was the lack of recognition of previously earned qualification, which led to underemployment or unemployment and low income. Low income or financial difficulties made it hard for most participants to pay their medical bills. Transportation was a major challenge for most participants upon arrival. The cost of

getting to appointments became difficult due to financial barriers, which delayed seeking healthcare and resulted in reliance on family and friends for support.

Sub-Theme 3: Navigating a New Health System

This theme, *navigating a new health system*, captures the process by which immigrants learned to navigate new healthcare spaces, the challenges of communicating in English, and difficulties making healthcare appointments. Ghanaian immigrants' expectations of the type of care they received affected their healthcare decisions. They often avoided medical doctors and looked elsewhere for care. For instance, Elder stated, "I thought my diabetes problem was going to end once I get here, but they just put me on medication to stabilize it. Now, I look for several leaves of plants from herbal shops and take care of things myself." Participants revealed issues and challenges regarding where and how they sought healthcare. Male participants expected a male doctor rather than female and did not feel comfortable with female doctors. Jerry explained, "I was uncomfortable about some of the questions that the doctor [female] asked me the first time I visited the hospital." This challenge hindered immigrants from accessing healthcare and raised doubts regarding their immediate healthcare options.

Learning new spaces. Participants reported that they managed to navigate the healthcare system thanks to their family and friends who had been in Canada longer. Juana stated,

> When I first came to Canada, I met someone who later became my friend, he assisted with a lot of things, and I call him anytime I need help. He even helped me with how to make doctor appointments and helped me get to the clinic or hospital anytime I called on him.

Friends and relations, rather than health practitioners, became trusted advisors for participants. Some participants also relied on members of the GCAC for advice and

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health directives. Juana reported that she was comfortable taking advice from fellow Ghanaian immigrants because of their experiences with traditional medications and their personal experiences with the Canadian system.

Most participants did not know how to find information about healthcare when they first arrived in Canada. Some participants found their way to the hospital but complained that they had difficulty accessing a doctor and healthcare service due to their unfamiliarity with the Canadian health system. Health-related information from friends sometimes failed to help them properly access care. Cecile, who is now a Canadian citizen, stated,

> I had tough time to get to the hospital, and even after getting there, it was not easy for me to get access to a specialist for my health problem. I can tell you that I was frustrated at the hospital. I did not know where to go I was roaming like a bee at the hospital for help.

Participants also accessed information regarding the Canadian health system through Canadian public libraries in various cities. Elder reported that free learning centres (English classes) were good sources of information about the Canadian system for immigrants. By attending free English classes in the city centre, he gathered enough information to get help for most things, including his health issues. He used information from health literacy classes and traditional home care remedies to treat health problems. Other participants had similar experiences upon their arrival.

Some participants stated that alternative or non-medical health practices are more affordable and convenient. Elder stated, "There are no high charges associated with traditional medications or self-care, and no need for complex instructions in English. So why do I have to worry myself. If one door closes, another opens." Some newcomer participants used technology or books as navigation tools to access and make decisions

regarding healthcare. Some participants used search engines like Google to find available clinics or hospitals and ways to get there. Others felt more comfortable asking people from Ghana for help because they spoke their language. Many received help from Canadian volunteers or hosts. Those who attended English proficiency classes also consulted their literacy teachers. Many participants, whose spouse or older child privately sponsored them, received assistance from family. Settlement centres organized orientations and connected immigrants with doctors or health personnel.

Lost in translation. Most participants mentioned that a lack of English proficiency was a major barrier to easy use of healthcare services in Canada. Joe explained that he felt uncomfortable going to the doctor because it took a long time for him and the staff to understand each other due to the language difference. Many participants suggested that discussing health problems in their local language would be a better option than presenting them in a different language they barely understood. For instance, Peace stated,

> Well, I think it would be great if the system will consider having one of our own [health professional] in the clinic or hospital who will understand us easily to avoid this language problem we face when we visit the doctor. When you speak I feel they don't understand because there are some things better explained in our local language. I would rather prefer to take care of myself at home.

Menu added,

> Yeah, the problem is language and it is a difficult thing. If you don't understand what they say, sorry for you, but if you do, it makes it easier. What I used to do when I go to the clinic or the hospital and I don't understand them, I just nod my head and say "okay" to make them believe I understand, but I have no idea if they understood my side of explanation to them. Me, when I go home then I do my own thing.

Peace commented that doctors and health practitioners either speak too fast or have difficulties understanding them because of their unfamiliarity with participants'

accents. Participants felt that doctors did not pay adequate attention to their health

concerns and were not listening to them, which caused frustration. This led many

participants to avoid the Canadian healthcare system. Aunty-G explained,

> They have problem with how we speak. As you can notice they have problem
> with my accent, whenever I speak they find it difficult to understand me, my
> English is not clear. I am not able to express myself very well and it gets difficult
> to tell them what I want. I feel like not going there [hospital or clinic] again. If I
> can put together garlic, lemon, and some foreign herbs, I'm ok.

You could die waiting. The processes involved in making an appointment with

healthcare professionals were unfamiliar to participants when they arrived in Canada.

Some thought that it took too long to arrange even basic healthcare appointments. Juvenal

stated, "In Ghana, I just walk in to see a doctor at the hospital without any appointment

but here in Canada, you have to go through long process and wait for a long period till

you can see a doctor." Long waiting times for appointments made services feel less

available. As a result, participants sought alternative or non-medical healthcare that was

easily accessible. Some participants used self-medication practices rather than medical

healthcare practices to avoid long waits for appointments. These participants did not have

people to support them or to explain how the new system worked and why they needed to

book an appointment to see a doctor. Peace, a permanent resident and part-time worker,

argued,

> I do not know why they [doctors] do that. I suffered to get an appointment when I
> first came here [Canada] and it will take you the whole year to see the doctor or
> specialist to actually take care of you.

Peace, also, described her experience with the Canadian healthcare system compared to

the Ghanaian healthcare system.

> In Ghana, you just walk in any day, you get checked and given the medication
> needed. Me, I almost gave up my appointment because it was not forthcoming. To

some point, I treated myself because it was too much long waiting for one appointment.

Participants who needed urgent care experienced problems because their health situation worsened each time they failed to see a doctor. Similarly, participants whose conditions were initially manageable developed chronic health problems over time due to lack of assistance. Aunty-G emphasized,

> I am asthmatic patient living alone, my inhaler was getting finished and I was afraid that I could die at some point. Because I did not know how to get to the hospital and did not know anyone at the time I had booked an appointment, it was very sad.

Family, friends, and the GCAC were among the most important people in participants' lives when trying to navigate the new healthcare system. Specifically, participants noted the role of their families and friends in supporting their transition and adjustment to the new country. Participants expressed challenges navigating the complexity of their new healthcare system due to its complex nature. Most struggled to communicate and express their health conditions to healthcare providers, and some participants felt uncomfortable using interpreters in the care system because their privacy would be breached. However, some participants were fluent in English and did not have to use interpreters. Participants reported difficulty booking appointments with doctors or specialists, which was not a practice in their country of origin. Another major issue that influenced participants' decision-making processes was waiting time. Participants repeatedly complained that they could die waiting a long time for care, and this fear influenced healthcare choices.

Sub-Theme 4: Intersecting Pathways to Healthcare Choices

The theme of *intersecting pathways to healthcare choices* describes the decision dynamics of the study participants. Participants discussed their pathways to healthcare

that reflected their cultural, traditional, and religious beliefs. When the time came for participants to make decisions about healthcare, they considered many things. The perceived severity of illness influenced which pathways participants chose. Participants explained that if they perceived their health condition to be a minor issue, their first choice of healthcare was a traditional/cultural pathway. When participants felt that their health condition was more serious, they opted for Western medicine. Psychological distress and mental health issues often led participants to choose spiritual pathways. Participants were often uncertain of the benefits of using Western pathways and seeking help for psychological issues from professionals, whom they considered strangers. Therefore, most participants went to members of their community rather than a specialist for mental health problems. Some participants preferred prayers from their pastors and congregation to medical treatments. Some participants did not choose traditional medicine because they believed that the process of medication preparation involves a traditionalist performing evil magic, which contradicted their Christian values and practices.

Social and economic marginalization also created the context that informed participants' choices. The worst situation was the possibility that they avoided seeking healthcare services, resulting in the severity of illness progressing from acute to chronic conditions over time. Such situations could contribute to emergency care needs.

Traditional/cultural pathways. Jerry and Juana stated that they used traditional medicine when Western medicine seemed ineffective in treating their illness. Joe and Cecil also chose non-medical approaches if the Western medical approach seemed potentially harmful. Joe expressed,

I consider traditional medicine to be very powerful and effective than the white man's medicine which has side effect in the treatment of diseases and I would avoid taking any medicine which have side effect to get me sick again. You don't know what other health problems this medicine would leave in your system with time.

Juana added,

I go to the health centre to see the doctor sometimes but the medicines they give does not work for me. I was given quinine the last time and it makes my illness more serious because it has a lot of side effect, which makes me feel weird, and my body gets weak. There is something in it, I think the chemical content has side effect.

Some participants acquiesced to Western medicine when battling severe illness.

Elder, who is in his tenth year in Canada, stated,

I use home remedies for sometime when I have any health problem. If the sickness does not go then I go to see the doctor. I do that between first two to three days. Again, if I see how serious the sickness is I go to the doctor or I call the doctor to book an appointment and I go to the doctor to prescribe some medicine for me and give advice and maybe go for lab work.

Jerry explained,

All that I do if I have headache I drink more water or try to have enough sleep. But the symptoms or it become very severe I quickly run to the clinic or to see a doctor. The same happen to every other health problem I think I can do something to it myself if the problem is not big enough for me.

Belief in and adherence to traditional health practices increased participants' use of traditional/cultural pathways because they were more familiar with such practices after a life in their country of origin. Participants who were aged 50 and above often felt more connected to their home country and were hesitant to seek Western medication. Some participants stated that their family members in Ghana reminded them of the importance of traditions and the potential implications if they stop practicing them in their new home. For those who were constantly encouraged to hold strongly to tradition, the number of years they spent in Canada did not affect their health practices. Some participants

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engaging in traditional health practices had been in Canada more than 10 years. The data revealed that health choices and care practices of immigrants reflect the society to which they feel most connected.

Most participants talked about the lack of available traditional medicine in Canada. Many reported a history of traditional health practices and rare use of Western medical treatments. With time, some participants began using the Canadian medical system more frequently because they did not have access to traditional treatments. Some participants complained about immigration regulations regarding transporting traditional medication to Canada. Others revealed that international shops (e.g., Asian or African shops) carried traditional herbal treatments that might remedy minor health problems.

Western pathways. Some participants considered Western pathways of health as addressing mainly the physical aspect of health. If the traditional or religious approach did not work or if a situation became more serious (e.g., life or death), participants opted for Western healthcare. Among the reasons for delaying the use of Western medicine was fear of side effects. Participants sometimes had positive feelings about Western health approaches and later regretted using them. Elder argued, "My only problem is the side effect, I'm scared about getting another disease after my problem. So, my problem is the side effect so I worry about it a lot." Most participants who used Western healthcare services were highly educated, or had bad experiences with traditional healthcare. Past experiences influenced participants' decisions and attitudes concerning traditional and Western health practices. One participant had a stress-related illness and the doctor referred her to a stress management support group. Her previous experience in Ghana with Western treatment kept her from trying a stress management support group in her new country.

Feeling connected to Canadian society motivated participants to believe in Canadian customs and adopt Western health practices. These participants sought cures at clinics or hospitals when feeling sick, and were more cautious about their use of medications. Some stated that they checked the content and expiration dates of medications before they take them. These participants took their health seriously and avoided drugs or medications that they deemed unsafe or those that were not medically prescribed. They considered Ghanaian health practices to be non-medical and unsafe after to their exposure to Canadian practices. When participants attended Canadian events and made Canadian friends, their way of life changed, including how they approached healthcare. This was most common in immigrants who had lived in Canada for more than five years. The interviews revealed that the longer participants stayed in Canada, the more they felt connected to Canadian culture and health practices. However, most of these individuals recalled memories of feeling that they were not in the land off milk and honey.

Spiritual pathways. Some participants felt prayer was enough to meet their healthcare needs. They preferred to pray to God as the only healer, rather than choosing between traditional medicines with unknown content from perceived evil sources and Western medicine with side effects. These participants believed both traditional and Western pathways were against God. Some participants chose to believe that God is the only healer; any other source of healing contradicts this faith. Dorcas stated,

> When I go to church, I feel happy and okay even when I'm sick. When I was around with the church people, I do not feel depressed anymore, God talk to me there and I get well, I feel God's presence and like I don't have any problem. When I'm around God's people, we're never talking about problems…I feel bad if I go for any traditional medicine because God himself can heal me through the pastor and directly from him.

Other participants explained that feeling useful to others or having a connection with nature and spirituality would naturally heal them without depending on traditional or Western medicine. Participants' preferences depended on their personal attitudes and beliefs as well as their interactions with people in the Ghanaian community in Calgary.

When Juana first arrived in Calgary, a family advised her to always hold fast to God even in times of illness and not to listen to people. Her religious beliefs led her to be strict and only turn to God for healthcare needs. Four female, and three male, participants stated that their healthcare choices were based on their mindset about God. Through prayers and concentration on God, they received revelations about what to use for their healthcare. Dorcas explained how belief influenced health decisions.

> My options between traditional and western medicine as I told you is the mindset on God. If your whole mind is on God, He will show you the herbs to use. Since I became Catholic for about 15 years now, it has been part of me. God helps me with every decision I make because he alone knows healing and he is a healer. When I pray, he answers me.

Aunty-G stated,

> The religion that I serve teaches temperance and the bible confirms it. The bible also teaches how herbs works for our general wellbeing, I serve God and I believe in it, so I can't change it, I have used it ever since I came here and is very effective and it's the primary source I use every day although it's not common here. What my religion teaches matters most.

Faith in God played a major role in the lives of many Ghanaian immigrants' healthcare decisions. Several participants believed that traditional medicine is good to use but that it also conflicts with their Christian faith and belief in God. Some participants believed the conflict resulted from the preparation of traditional medicines. These participants believed that the traditionalist uses charms or magic during the preparation of traditional medicine. This contradicts their faith as Christians and believers in the

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supreme God. These concerns created tension for some participants; they did not trust and accept the source and use of local traditional medicine.

The advice and information that participants received from church members, church leaders, and pastors greatly affected how they made decisions about their healthcare. Such community members shared common bonds and identities with immigrants; therefore, their views carried weight and motivated participants' healthcare choices. If religious figures believed in and practiced Western medicine, their advice for the participants reflected this belief in Western health practices. As Juana put it, "it was one woman in my church I consulted who told me that she will take me to her doctor since I do not have one." On the other hand, if participants' choice of healthcare practice was to pursue traditional practices, it may have been in opposition to the social ties among these religious groups.

Summary

This chapter presented evidence of the study findings conducted with 10 Ghanaian adult immigrant who lived in Calgary. Participants described several factors that intersected to influence their healthcare choices. The central theme of *not the land of milk and honey* was the core-overarching theme that described how participants were optimistic about what life was going to be like in their destination country. Four main subthemes emerged; looking for a lifeline, how do I fit in here?, navigating a new health system, and intersecting pathways to healthcare. These sub-themes helped to further explained common patterns of healthcare choices among Ghanaian adult immigrants. There were many complexities that underlay participants' views, experiences, and decision dynamics. Social and economic barriers influenced participants' decisions about

healthcare. Their high expectations turned to disappointment when met with the realities in Canada, which also affected their decision making regarding healthcare.

Participants often chose religious counsel for stress and mental health concerns. Most participants turned to the community or the church because they trusted the Ghanaian community more than they trusted people they did not know in the medical profession. Most participants ignored formal counselling and Western pathways. Instead, they depended on pastors and church members. A common theme was that in the process of seeking healthcare, participants had difficulty deciding which form of healthcare to use. When participants felt stressed and had problems with Western healthcare, they avoided health professionals or specialists. Most participants did not choose traditional medicine because they believed the cultural process for preparation of such medicines contradicted their Christian values and practices. Other participants preferred prayers from their pastors and congregation. Western medicine was the most common choice for physical health issues when all other options failed or health problems became severe. Social and economic tension caused difficulties for participants deciding whether to use traditional or Western medicine or to integrate both options. The worst situation occurred when participants did not seek healthcare services or waited a long time before opting to use traditional or Western medicine. Illness can progress from acute to chronic if participants continue to be indecisive for too long. This could lead to more health problems due to delays in seeking medical attention.

CHAPTER FIVE: DISCUSSION OF FINDINGS

In this thesis, I explore factors that influence the healthcare choices of Ghanaian adult immigrants after their arrival in Calgary, Alberta, Canada. To find answers, I explored two primary research questions. 1)., "what factors influence newly arrived Ghanaian adult immigrants' healthcare choices in Calgary, Alberta?; and 2). how do these factors intersect to influence Ghanaian adult immigrants' healthcare choices within the first 5 to 10 years after arrival in Calgary? In this chapter, I situate the major findings of this study in the context of existing literature and discuss their significance in terms of strategies to improve healthcare among Ghanaian immigrants. I also analyze Ghanaian adult immigrants' challenges accessing and maintaining healthcare and make recommendations for further research, practice, and policymaking.

Data from participant interviews underwent rigorous qualitative thematic analysis. Each of the ten personal interviews highlighted participant knowledge, experiences, perceptions, beliefs, and attitudes. I organized the resulting themes into a detailed thematic map (Figure 3) to illustrate how participants' pre- and post-migration experiences created the context for healthcare decisions. The central theme of these results was *not the land of milk and honey.* Four main sub-themes emerged from the analysis: (a) looking for a lifeline; (b) how do I fit in here; (c) navigation of a new health system; and (d) intersecting pathways to healthcare. The thematic map helped me answer the research questions by identifying factors that, according to participants, influenced their decisions about healthcare choices. The following sections include discussion of these factors in the context of existing literature to provide an in-depth understanding of the findings of this study.

Not the Land of Milk and Honey

Immigrants and refugees of African descent, including Ghanaians, are a significant portion of the Canadian population due to the pro-immigration initiatives of the Canadian government. Many African-born Canadian residents immigrated between 1981 and 2001 from countries including: Ghana, Ethiopia, and Nigeria (Konadu-Agyemang et al., 2006; Statistics Canada, 2001). This trend continues. As of 2016, 27.3% of all Canadian immigrants were of African descent (Statistics Canada, 2016).

The central theme of *not the land of milk and honey* reflected participants' expectations when they arrived in Canada and the disappointment they experienced regarding healthcare access. For most participants, their dream was to achieve personal goals in a new country. The concept of a *dream country* is what Bell et al. (2017) described as a mythologized "promised land endowed with endless opportunities and abundance" (p. 2). The Ghanaian immigrants in this study had different financial, educational, religious, and cultural backgrounds, but shared a common goal of a better future, and the dream of being in *a land of milk and honey*. The realities of finding and maintaining the basic necessities of life (e.g., adequate healthcare) in Canada were vastly different from their expectations. Friends and family members portrayed their lives abroad as exciting and new, which may have influenced immigrants' perspectives. Unfortunately, most participants had mixed experiences and were shocked by the realities of life in Canada. Others were hopeful and were not bothered by their new experience.

In 1928, a Danish newspaper advertised that Canada was *the land of milk honey* (Canadian Museum of Immigration at Pier 21, 2019). Even now, Canada is still advertised that way to immigrants (i.e., a dream world for individuals searching for a place to call home, study, work, and have better healthcare and protection for their

family) (Spitzer, 2013). Sub-Saharan Africans, such as Ghanaians left the country of their birth to migrate to Canada and other countries around the world. Their reasons included lack of healthcare, safety, and work prospects. However, Ghanaian immigrants to Canada realized their *land of milk and honey* has yet to become a reality due to social integration issues, economic challenges, marginalization, and difficulty accessing the Canadian healthcare system (Spitzer, 2013).

Similar to the findings of previous studies of Ghanaian, Ethiopian, and Somali immigrants living in the United States and Canada (Asuo-Mante, 2010; Danso, 2002), the majority of participants in the present study felt let down when their experiences did not align with their expectations of life in a new country. In the American context, Auso-Mante (2010) described that immigrants often felt that "the image of a heavenly, graceful America got shattered after residing in this country" (p. 12). The idea of "Ghanaian immigrants' utopian American dream" appeared in an article describing the history of Ghanaian immigrants in the United States (Agbemabiese, 2012, p. 9).

Despite the dream of high-paying employment, many Ghanaian immigrants report receiving low income in their host countries (Agbemabiese, 2012; Nkrumah, 2016). The current participants had low paying or tax evasive (under-the-table) jobs that were inconsistent with their dreams. They experienced the unexpected reality that countless job applications were necessary to find any job at all (Asuo-Mante, 2010; Danso, 2002).

Participants' employment status affected their healthcare choices (e.g., health-seeking behaviours and healthcare access). Their low income influenced them to avoid or delay seeking professional healthcare or to use traditional health practices. The lack of health seeking behaviour, use of self-care, delayed access, and reliance on traditional

medical practices observed in the present study support past findings regarding Ghanaian and other sub-Saharan African immigrants in Canada (Barimah et al., 2008; Woodgate et al., 2017). In contrast to what was reported by Barimah et al. (2008), it is possible some Ghanaian immigrants may find traditional medicine unattractive, and unwholesome, due to its method of preparation, and this could be the reason that some participants modified their attitudes and opinions about its use. However, the current study demonstrated that the nature of employment status affected participants' decisions about health due in part to their low earnings, which is consistent with the findings of Woodgate et al. (2017). It is extremely important that immigrants have realistic expectations about how their host country's health system works and regular education regarding possible challenges in their host countries before they choose to migrate.

Under-employment and unemployment were compounded by personal and cultural challenges that hindered participants' successful access of health services. Under-employment and unemployment affect immigrant health-seeking behaviours, especially access to, and use of, healthcare services (Dunlavy et al., 2018; Karanikolos et al., 2013; Wilkinson et al., 2003). In the current study, I investigated how these factors influence immigrants' choice of healthcare. The research findings revealed that poor employment conditions contributed to financial difficulties and stress. For example, some participants experienced financial stress regarding out-of-pocket healthcare and transportation costs. Racism and discrimination, paired with limited English proficiency, further limited socioeconomic success and served as additional factors that contributed to a lack of healthcare access. These disappointing elements of migration experiences created barriers that influenced participants' ability to achieve a good health status and to efficiently access healthcare services.

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The overall narrative regarding the post-migration healthcare choices of Ghanaian immigrants in Calgary revealed that most participants found that the perceived *land of milk and honey* did not exist. Several elements contributed to this perception and appear in the sub-themes *looking for a lifeline*, *how do I fit in here*, *navigating Canadian healthcare*, and *intersecting pathways of healthcare choices*. The following sections discuss how each of these themes influenced the healthcare choices of participants.

Looking for a Lifeline

Looking for a lifeline describes how participants experienced many struggles and challenges in their new host country causing them to reach for a lifeline to get them through their experience. For some, this involved leaning on friends, family, social ties, or associates. Others self-medicated their stress with alcohol and tobacco. However, this strategy ultimately worsened their psychological wellbeing. Research exploring he physical and mental health of recent and long-term immigrants includes observations such as the Healthy Immigrant Effect [HIE}(Ichou et al., 2019) and the healthy immigrant mental health effect [HIMHE] (Agic, 2015). Ichou (2019) explained, "the [HIE] posits that recent migrants are in better health than the host population and other migrants who have lived in the host country for a long time" (p. 77). The HIE often diminishes with the length of residence and parallels Canadian averages over time, leading to the increased need for healthcare (The Aboriginal Multi-Media Society of Alberta, 2016). In a Canadian nation-wide survey conducted in 2000-2001 on health status and healthcare utilization (Ali, 2002), recent immigrants from Africa and Asia reported depression and alcohol dependence at a lower rate than the Canadian-born population. However, long-term immigrants had rates of depression similar to the Canadian-born population. Mental health (e.g., reflected in rates of depression and alcohol use) were not dependant on the

socioeconomic status of the immigrants. Lou et al. (2005) found that mental health in male immigrants diminished over time; and poor health was self-reported by recent immigrants (2.39%) andlong-term immigrants (5.17%), compared to higher rates in the Canadian-born population (6.38%). In contrast, the trend for women reflected poor mental health in recent immigrants (6.65%), compared to the Canadian-born population (7.71%), and long-term immigrants (8.36%). These findings suggest that the mental health of male and female immigrants diminishes over time, and that the stress that immigrants encounter and their subsequent coping strategies may be contributing factors to diminishing mental health status (Agic, 2015; Lou et al., 2005).

Immigrants often experience a range of mental health issues (e.g., anxiety, depression, PTSD and psychotic disorders), depending on their immigration or refugee status and country of origin (Agic, 2015). The Public Health Agency of Canada (2010) reported 12 contributing factors to mental health: gender, culture, social environment, social support networks, physical environment, health practices and coping skills, income and social status, employment and working conditions, education and literacy, biology and genetic endowment, healthy child development, family relations, and health services. All these social determinants of health except biological and genetic endowment may contribute to the diminished psychological well-being Ghanaian participants reported in the present study.

Examples of diminished mental well-being exist among African immigrants from many countries. For example, Afro-Caribbean immigrants living in Sweden reported an increased rate of psychosis during stressful experiences, before and after migration (Zolkowska et al., 2001). The findings of the current study suggest that the traumatic experiences (e.g,. moving to a new country) of Ghanaian participants informed their need

for access to healthcare services, and the pathways they chose to address these needs in Canada. Seeking healthcare was reported as a challenge for many immigrants due to the complicated structure of the Canadian healthcare system. Taylor et al. (2014) reported that "Ontario's healthcare system can feel like a maze. The system has become so complex that even people who work in it every day often struggle to navigate it" (p. 17).

Ghanaian participants in this study had abstract perceptions of life in Canada before arrival, and experienced stress when this perception was proven false. Carling (2014) proposed an aspirations-centreed model of migration to discuss the desires, attitudes, and process of migration to other countries. For example, Cape Verde immigrants indicated that life without migration is meaningless (i.e., they will only be successful if they travel outside their home country). Carling's (2014) participants stated that unless they migrated to countries that they perceived to be greener pastures, it would be impossible to live the way they wanted. Van Heelsum (2017) confirmed this ideology among recent refugee immigrants; many migrants in the Netherlands thought migration would lead to a better life and had high expectations of their new home. Immigrants either adopt a *life aspirations* perspective that does not always materialize, or an *integration theory* of immigration that incorporates the destination-country's perspectives (Li, 2018; Van Mol, Snel, Hemmerechts, & Timmerman, 2018). If an immigrant expects success, frustrations and disappointments fail to satisfy their desires (Van Heelsum, 2017). The problem is the inconsistency between imagined expectations and the realities of migration. In the current study, unexpected challenges increased Ghanaian participants' anticipatory anxieties in their new Canadian home.

More than half of the participants also experienced significant anticipatory anxiety while preparing to migrate. Most challenges involved obtaining travel documentation;

however, participants experienced varying levels of anticipatory anxiety or stress during the stages of migration: pre-migration, during the process of immigration, and post-migration. Some immigrant's precarious legal status related to obtaining work permits in Canada, also creates long-term effects on their health (Goldring et al., 2013).

Anticipatory anxiety occurs when "a person experiences increased levels of anxiety by thinking about an event or situation in the future" (Anxiety UK, 2018, p. 10). This phenomenon is similar to experiences Ghanaian participants described in the present study. Brown and Holloway (2008) discussed the possibility of immigrants experiencing excitement or culture shock during the initial stages of migration. Berardo (2007) discussed that, immigrants often felt overwhelmed by culture shock (e.g., sadness, loneliness, and feeling homesick despite feelings of excitement) (Brown & Holloway, 2008).

In their quest to acquire documents to travel, participants in the present study invested all their resources into completing the necessary paperwork. Some participants lived in rural areas of Ghana, and felt highly stressed due to challenges accessing travel documentation and resources, which affected their mental health and caused fatigue-associated health issues. Participants may have had overly optimistic expectations of the income they would gain upon arrival to Canada. These findings deviate from those of McKenzie(2013) regarding immigrants to New Zealand, who under-estimated their earning potential based on stories of negative employment experiences.

Other reasons for anticipatory anxiety included communication difficulties, discrimination due to language, religion, race, or cultural beliefs, and difficulty accessing healthcare (Esquivel et al., 2010; Little et al., 2016). The type of anxiety experienced by the participants in the current study changed over time as they settled. This increased the

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physical and mental health issues they experienced. Participants' expectations started to fade as they experienced the realities of their new country. With time, they began to experience additional forms of psychological distress, including stress and depression. This observation aligns with the results of a mixed methods study by Warfa et al. (2012), who stressed that when aspirations and dreams of migrants meet hostile situations in their new homes, individuals experience frustration, anger, doubt, and disappointment. Similar experiences of unexpected realities greatly increased the stress levels and overall health reported by participants in the present study. It is important for immigrants to understand and consider possible consequences of their migration.

The results suggest that trauma associated with migration and disappointment contributed to mental distress, which affects physical health and immigrants' health-seeking behaviours. However, most participants presented a good face to family and friends back in their home country, to hide feelings of regret, while struggling to address challenges and disappointments. The health implications of immigrants portraying false realities include feelings of: low self-esteem, anxiety, depression, and emotional trauma (Ortiz et al., 2018). Therefore, it is important for migrants to accept their new realities and adapt to their new situation.

Financial stress also contributed to the mental distress of participants. Several authors have indicated that immigrants struggle to thrive in their destination countries due to a lack of economic opportunities (Constant, García-Muñoz, Neuman & Neuman, 2018; Stein, Gonzales, Coll & Prandoni, 2016). Ku (2000) suggested that upon arrival to the host country, Korean immigrants had difficulty finding employment in job fields of their choice. Many Ghanaian immigrants in the present study had similar experiences. Several factors contribute to the unemployment/underemployment of recent immigrants,

including: limited job experiences, lack of recognition of their educational credentials from their home country by the host country, and lack of qualifications for the positions sought (Guo, 2018). Therefore, it is not surprising that Ghanaian immigrant participants experienced poor economic performance within the Canadian system due these factors.

Newly arrived Ghanaian immigrants often benefited from the social capital associated with their immediate social networks in many ways. For instance, receiving some basic needs such as food and clothing from family members as well as obtaining general information and services including health (Zhao et al., 2010). Newcomers relied on the support provided by both old and new friends, colleagues, and families probably due to the aforementioned factors affecting their resettlement. Linking social capital with family and friends in Ghana, Canada, and beyond was facilitated by technology and linking social capital was accessed through new friendships post-migration, and frequently through their churches (Zellweger et al., 2019). In particular, the shared values, ties, and understanding facilitate cooperation and bonding social capital within the GCAC and among the Ghanaian immigrant community at large (Hyman et al., 2011; Zellweger et al., 2019). In all cases, accessing these various forms of social capital played a large role in facilitating resilience, integration, positive health outcomes, and healthcare decision-making (Daoud et al., 2016; Hall et al., 2019; Subedi & Rosenberg, 2014;Zhao et al. 2010).

Furthermore, the present study revealed that most participants had no choice but to accept low-paying jobs. This trend of immigrant underemployment, despite possessing qualifications and education from their home countries, was similar to the experiences reported by Korean immigrants (Kim, Hocking, McKenzie-Green, & Nayar, 2016). In the current study, most Ghanaian immigrants were college and high school

certificate/diploma holders, with white-collar jobs in their home country; yet, they found

themselves in cleaning and other low-profile jobs that they never expected to do in

Canada. Finding ways to provide knowledge of economic challenges to Ghanaian

immigrants prior to migration or upon arrival may help them cope with these challenges.

Ghanaian immigrant organizations in Canada could provide guidance and industry-

targeted training for their members.

Other factors that fell under the subtheme *looking for a lifeline* included the

unexpected high costs of living, the cost of healthcare, and limited health insurance.

These factors were major barriers to healthcare access for Ghanaian immigrants. A

significant cause of anticipatory anxiety for immigrants is access to healthcare in a new

country (Delara, 2016). Similar to the findings of Newbold (2009) regarding short-term

health of newcomers to Canada, some participants in the present study struggled due to

lack of insurance. The Alberta Healthcare Insurance Plan (AHCIP) is available for

Calgary immigrants three months after arrival in Calgary (Campbell, O'Neill, Gibson, &

Thurston, 2015). Until they are eligible for AHCIP, immigrants must pay for all Canadian

healthcare services. Many employers provide employee health insurance benefits.

However, the extent of the benefits depends on the agreement between employees and

employers; most part-time jobs do not provide health insurance.

Newbold (2009) explained that immigrants hesitate to seek healthcare because of

long waiting times at health centres, especially when visiting a specialist. Participants in

the current study reported similar experiences. The difference is that some also reported

an inability to afford medical bills because they did not have any insurance coverage,

which was not reported as a major challenge by Newbold (2009). Immigrants to Canada

often feel surprised by long wait times when seeking medical treatment at primary care

facilities (Woodgate et al., 2017). Some immigrants wait for years to find a suitable doctor who meets their expectations. One Ontario immigrant stated, "I spent nine years looking for a doctor" (Asanin et al., 2008, p. 24). Immigrants may look to emergency care delivery to meet their needs, depending on their health condition.

Lack of transportation represented another stress factor. Similar to the findings in the current study, Hedberg and Tammaru (2012) suggested that transportation difficulties contribute to the inability of immigrants to appear for appointments and may cause immigrants to delay seeking healthcare in the first place. Unfamiliarity with public transportation in a new city is a problem for many immigrants. These difficulties were particularly prominent among Ghanaian participants with children and among those who did not know anyone before coming to Canada. Hedberg and Tammaru (2012) identified that after arrival, most immigrants relied on public transportation systems due to their inability to afford private transportation, or for fear of getting lost. A further evaluation of the effects of socioeconomic factors on the lifestyle choices of Ghanaian immigrant is necessary for a detailed understanding of their effect on transportation related healthcare choices, which was beyond the scope of the current study. However, the current findings suggest that more greater knowledge of transportation options, and easier access to transportation may increase the healthcare options of new Ghanaian immigrants in Calgary.

How Do I Fit in Here?

The data revealed several intersecting factors that influenced Ghanaian adult immigrants' healthcare-seeking behaviours. These factors reflected shifting gender roles, expectations, and norms, technology connection/disconnection, and racism/discrimination. Participants expressed several opinions about shifting gender roles

that influenced their health-seeking behaviours. Gender roles and expectations of Ghanaian adult immigrants also influenced participants' social and psychological health and their sense of agency regarding healthcare decisions. Ghanaian society is primarily patriarchal and has strong gender-based roles for men and women (Takyi, 2001). Following migration to Canada, Ghanaian adult immigrants initially tend to follow the same societal gender norms that they practiced in their home country. Males frequently control decisions, behaviours, education, and finances; they play a significant role in directing the lives of women. The present study revealed the emergence of new gender roles of Ghanaian adult immigrants after migration to Canada. Lack of employment and unrecognized educational certificates of Ghanaian immigrant men contradicted their traditional beliefs about their status and social role. However, this erosion of patriarchal power also contributed to Ghanaian immigrant women becoming more involved in making health-care decisions, fulfilling their dreams, and taking influential positions on their community.

This gender shift contradicted typical Ghanaian cultural views that women are unlikely to provide for the family, or take social roles previously assigned to men (McGrath et al., 2009). Most Ghanaian immigrant men held higher-status jobs and were professionals in their respective fields in Ghana. However, in Canada, it was the opposite. Immigrant women often possessed higher status, contributing to the development of anxiety and aggrieved entitlement among men due to a loss, or denial, of rights supposedly enjoyed over women (Kimmel, 2010). This significant shift in gender roles created a massive power shift in the home. Many women pursued further education in Canada, while men relied on their previous education. They hoped to get good jobs only to realize that their previous education was less valuable in Canada. Consequently,

immigrant men frequently felt despair and confusion due to their changing status. Shifts in gender roles created conflicts; and many male participants perceived that Canadian culture negatively influenced women.

Several Ghanaian men discussed their perceived loss of status as men relative to that of their spouse. They stated that changes in gender roles increased women's financial independence and fueled marital conflict, domestic violence, and divorce among some Ghanaian families. Many Ghanaian immigrant men struggled with stress due to these new changing social roles. Others expressed feelings of frustration over their inability to support their family, which further contributed to their state of anxiety. These observations are consistent with Pyong's (2001) study of Korean immigrants' gender roles, social status, and marital conflicts. Most Korean immigrant men developed negative behaviours such as gambling, smoking, and excessive drinking due to status anxiety and changes in their roles, which contributed to conflict. Immigrants may benefit from better understandings of cultural norms when they migrate due to inevitable clashes with the new norms of their host country. This is an essential part of acculturation into Canada. Immigrants must integrate into the new culture and have a sense of belonging in their new home (Berry et al., 2006). This may help immigrants understand and feel part of their new society.

Challenges of acculturation contribute to continued anxiety and stress (Berry et al., 2006). The anxiety some participants experienced due to shifting gender norms could be considered a form of acculturative stress (Arbona et al., 2010). Culture is a significant social determinant of health that can impede access and utilization of healthcare in a new country, particularly by immigrants. For example, "culture can influence immigrant's access to the healthcare system by influencing their perceptions and interpretations of

symptoms, help-seeking behaviour, decision-making, expectations of the sick role, and coping style and communication with health providers" (Delara, 2016, p. 3). Most participants in the current study demonstrated these factors, which influenced their health-seeking behaviours in the host country.

Shifts in gender roles dramatically affect men and women in their everyday lives. Mental and psychological stress for men may cause depression, anxiety, and low self-esteem when they feel disconnected and lack social support (Piccinelli et al., 2000). Women experienced psychological trauma and emotional stress when they reflected on previous experiences of oppression in Ghana and fear that their families may learn of their empowerment. This could result in conflict and divorce within Ghanaian immigrant families. Gender role conflicts and power struggles between men and women occasionally led to suicidal thoughts or other self-harming habits. These conflicts also affected healthcare practices. Most male participants in the current study engaged in negative physical health practices. Men abandoned daily activities, including self-care, which could be dangerous to their health. Women became independent and gained control over their health needs. Men with depression and emotional trauma often refused healthcare and turned to smoking, alcohol, drugs, or traditional medicines to numb their emotional pain (Faria, 2015).

Technology also influences the health-seeking behaviours of Ghanaian adult immigrants (O'Neil & Crapser, 2011; Wester, Vogel, O'Neil, & Danforth, 2012). Technology was used by immigrants in an attempt to self-diagnose and/or to determine whether to visit a hospital. The use of technology also played a significant role in negatively affecting some participants because of their low level of technological expertise, since the Canadian environment challenges them to read and use the Internet.

To make better healthcare decisions, immigrants should be well informed about the use of technology to access information including health and general services in their host country. This finding reveals a potential need for computer literacy/healthcare literacy classes for newly arrived immigrants.

Most participants felt socially disconnected from their traditional ways of communicating with friends and families. This finding aligned with those of Burrell and Anderson (2008), who reported that in the United Kingdom, Ghanaian immigrants needed more knowledge of technology to help maintain connections with family and friends. In the present study, the need for technological adaptation was especially common in parents and the elderly, who had less experience with technology. These individuals had limited daily personal interaction with their children, who communicated with their parents through text messages or the WhatsApp application, which some parents found difficult to use.

Another reason participants felt they did not *fit in* was their fear of unpleasant experiences attending the hospital. Some participants noted the reason for their fear was their belief that they might not be treated the same as Canadian-born patients, due to racial discrimination. One participant, Juana, related the experience of a co-worker who made her feel different and bitter. This mindset influenced most of the participants' health-seeking behaviours. Other participants' perceived discrimination related to their skin colour, which was a deterrent to seeking healthcare. Immigrants' experiences of racial discrimination greatly affect their health due to continued psychological trauma (Lee, Kellett, Seghal, & Van den Berg, 2018) and influence their health behaviours (Lauderdale, Wen, Jacobs, & Kandula, 2006) because they may hold on to experiences of racial discrimination which can affect their psychological health (Sanmartin & Ross,

2006). This finding in the current study aligns with that of Vang et al. (2015) who

suggested that when immigrants begin to feel racialized upon their arrival to the host

country, their health weakens.

Navigating Canadian Healthcare

Most participants encountered challenges when navigating the healthcare system

in Calgary, despite their high expectations. A study of Somali immigrants in America

showed that not only did immigrants' previous experiences and knowledge influence their

expectations, but they also felt valued if service providers took their health concerns

seriously (Pavlish, Noor, & Brandt, 2010). The findings of the current study also

demonstrated that participants' high expectations reflected preconceived notions of how

easy life would be, and that access to all services including healthcare in their new home

could be the solution to their health issues.

In the current study, Ghanaian immigrants believed that when they received

injections from health service providers, they would get better faster due to a more

advanced approach to treatment and diagnosis in the Canadian healthcare system,

compared to the process that would occur in Ghana. Consistent with previous research,

some participants were disappointed that they often received no medication and were

instead referred to undergo further testing (O'Donnell, Higgins, Chauhan, & Mullen,

2007). Participants expected to receive prescribed medication after their first visit to a

health centre (Asanin & Wilson, 2008; Bustamante et al., 2012). In Canada, doctors only

provide medication if the health condition of patients warrants it; however, participants

expected to receive treatment in the form of prescribed medication or injections from

their health providers. This suggests that participants' beliefs about healthcare were quite

different from the realities of the host country. Health providers should be aware of the

different health beliefs of immigrant, so that they may be able to manage the expectations of their immigrant clients, and explain why pharmacological intervention is not necessary.

Consistent with the current findings, Vaughn, Jacquez, and Bakar (2009) and Sarpel et al. (2018) found that Ghanaian and other immigrants experienced long wait times due to the number of tests they must undergo to determine a diagnosis and relevant treatment. The current and previous studies indicated that Ghanaian immigrants often wait weeks to see their family doctor (Carrière & Sanmartin, 2010; Lee et al., 2010); thus, some participants used the emergency room, which also required long waits for service. Participants did not expect to encounter these kinds of challenges in the country they perceived to be the *land of milk and honey*. According to Nguyen-Truong (2018), such disappointment leads to frustration, which participants in the current study expressed as fear that they might die if they did not receive care. As in the current study, Nguyen-Truong's participants reported long wait times at clinics. Due to frustration, they lost hope of receiving healthcare. Immigrant health-seeking behaviours and perceptions or preconceptions of the healthcare experience in Canada changed following new experiences (e.g., delays in receiving care).

Participants in the current study noted that one of the most challenging and highly noticeable factors that affected their choice and access to healthcare was the communication barrier. Most immigrants often cannot fluently speak the language of their destination countries, which can limit their healthcare options and access (Genoff et al., 2016; Laroche, 2000; McKeary & Newbold, 2010). In the current study, most Ghanaian adult immigrants were able to speak and understand English, but few were fluent. This language barrier limited their ability to express medical concerns and understand

information from healthcare providers. A study of Chinese immigrants suggested there was a need to intensify efforts to address immigrants' English proficiency to improve their interactions within the American healthcare system (Li, Matthews, & Dong, 2018). This is a valuable suggestion for the GCAC and immigrant settlement agencies in Calgary. Some participants said they found it intimidating when they could not understand medical instructions or prescriptions, which affected their healthcare-seeking abilities. Communication difficulties created anxiety regarding healthcare services and decreased participants' willingness to use these services. Therefore, the GCAC can support adult immigrants by working together with literacy institutions in Calgary to assist with language problems, and to create educational programs and workshops to improve language skills.

Interpreters may help explain health concerns but may be unable to correctly or fully translate in all cases, which could lead to incorrect diagnoses or prescriptions. Participants argued that their privacy might also be exposed by using a translator. This is a common issue for immigrants. Meyer, Pawlack, and Kliche (2013) indicated that friends or family members who understood more English than newly arrived immigrants or refugees might wrongly represent health problems, leading to incorrect diagnoses.

Intersecting Pathways to Healthcare Choices

The second research question asked how the previously discussed experiential factors intersected to influence Ghanaian adult immigrants' healthcare choices in Calgary within the first decade after arrival. The study findings indicated that Ghanaian adult immigrants' choice of pathways to seek healthcare often reflected some combination of the preceding factors (e.g., looking for a lifeline, how do I fit in here, navigating Canadian healthcare). Davidson et al. (2008) and Victoor et al. (2012) found that people of different

places of origin and status made healthcare decisions based on how healthcare providers treated them and how health systems functioned. However, in the present study, the healthcare choices of Ghanaian adult immigrants also depended on the perceptions of which pathway (medical Western healthcare versus non-medical pathways such as traditional and religious approaches to care) worked best for their health concerns. Healthcare choices also depended on what *health* (mostly related to physical) meant to participants and were influenced by their length of stay in Canada.

Barimah and Van Teijlingen (2008) reported that Ghanaian immigrants in Toronto often continued to use traditional plant medicine in Canada and did not necessarily shift away from traditional medicine usage after migration. Similar to these authors, I found that when participants had problems that threatened their life, they sought help at a clinic or a hospital rather than seeking traditional medical practices (Donkor, 2005; Knipscheer, De Jong, Kleber, & Lamptey, 2000; Lassetter & Callister, 2009). This indicates that most participants are not certain about what healthcare might work best for them. More health education may be necessary to help address this challenge in the GCAC and among Ghanaian immigrants in general.

Participants often treated minor health conditions with traditional medicine, as found in several previous studies of immigrant healthcare choices (Ransford, Carrillo, & Rivera, 2010; Rao, 2006; Sandhu & Heinrich, 2005). A novel finding in the current study was that Ghanaian immigrants often changed pathways depending on the changing nature of their healthcare needs. This is similar to the findings of Rao (2006), who reported that choices of medications depended on the belief of what medication they perceived was best for an illness. In the current study, the Ghanaian participants depended on knowledge of the effectiveness of medications. This behaviour was a norm, even though their belief

about the effectiveness of the medication may have no clear evidence; however, most participants arrived in Canada with inherent knowledge of traditional healthcare practice, which may influence their choice of the traditional pathways at times. To avoid deteriorating health, immigrants may need to regularly visit a clinic or hospital if they have health problems. Health providers also need to be aware of the characteristics or decision dynamics of Ghanaian immigrants to better assist them.

Participants who viewed health only in terms of the physical were less likely to choose traditional remedies over the Western approach. These findings were similar to earlier findings in the literature (Kim, Han, Kim, & Duong, 2002; Liang, Yuan, Mandelblatt, & Pasick, 2004). The pattern of healthcare utilization of both Korean elderly immigrants and Chinese American women were shaped by how they understood health, and most were reluctant to seek healthcare when they thought their health problem could be self-managed (Kim et al., 2002; Liang et al., 2004). Most participants chose religious pathways when they experienced mental or emotional distress. The religious pathway intersected with both Western and traditional pathways. In unexpected situations, some participants crossed over to the Western pathway or sought God's intervention.

Most participants were less familiar with new pathways to healthcare in Canada and struggled to adapt due to the change in context. This finding helps to explain why most Ghanaian adult participants placed religion first in their lives, which influenced their health choices. Participants' exposure to traditional beliefs began in childhood. Ghanaians are highly influenced by the colonial impact of Christianity and its associated ontology (Chattopadhyay, White & Debpuur, 2006; Osafo, Knizek, Akotia, & Hjelmeland, 2013). Therefore, most participants' views included their biblical belief that God knows best, which influenced their choice of the spiritual pathway and an emphasis on prayers. Lee et

al. (2010) reported similar findings among Chinese immigrants to Canada regarding a reliance on God and prayer for healing. Other studies reported similar findings of immigrants using prayers and relying on words of encouragement from the Bible and God to make health decisions (Koenig & McConnell, 2001; Lagman, Yoo, Levine, Donnell & Lim, 2014).

Another discovery in this study was that participants chose to manage mental health issues in different ways. They relied mostly on the bridging social capital of their church or the bonding social capital of the GCAC for support related to social and emotional issues because they represent their new social and extended family networks following migration (Zellweger et al., 2019).. Traditionally, Ghanaians are society-centred. Their attitudes, beliefs, behaviours and sociocultural practices are collective in nature, which lead to a strong social bond with others. They would have turned to their social network to deal with these issues in their home country. In Canada, these institutions represented their social support network and extended family. Many Africans, especially those in the sub-Saharan countries, define mental health as absence of sickness because they believe that is natural and does not require healthcare (McCann, Renzaho, Mugavin & Lubman, 2018). Some Ghanaian immigrants do not choose the Western pathway because they do not feel a sense of belonging to their host society. Jalali (2005) and Yeh et al. (2006) reported that participants preferred to rely on family and friends instead of a doctor for stress and psychological issues because they believe these are situations that do not require a doctor.

According to McDonald and Kennedy (2004) and Newbold (2005), after immigrants settle for approximately 10 years in a new country, they become familiar with

their new environment, which influences their healthcare seeking behaviours. The findings of the present study support this statement. Most participants, who migrated to Canada more than five years ago, chose the Western pathways with time, as they settled. Waters (2003) reported similar findings for immigrants in Vancouver, Canada; longer-term residents felt more connected to Canada than new immigrants did. When the participants felt connected, they participated in the country's activities including the use of Western medical practices. The nature of their new environment shaped their decisions about healthcare and the best pathway to take (Davidson et al., 2008; Macintyre et al., 2002; Popay et al., 2003). Other participants felt aligned to neither Canadian culture nor their home country. The health choices of these participants reflected both Canadian and Ghanaian traditions.

It is also possible that participants' views changed over time due to exposure to a new environment (e.g., education or new programs). Routine health education or intervention programs for newcomers are necessary for Ghanaian immigrants in Calgary to create awareness of the possible dangers involved in choices between healthcare options. These interventions could be achieved through partnership with the GCAC and resources from the general community, such as lessons for new immigrants about making health decisions. In addition, healthcare providers could refer individuals with such challenges to available resources to help achieve their health goals.

Limitations of the Study

A major challenge of this study was financial challenges that led to time constraint. An extended longitudinal study would have brought about more diverse data regarding factors that intersect to influence Ghanaian adult immigrants' healthcare choices in Calgary. The settings and participants of this research were confined to the

Calgary Ghanaian population. African populations in other cities could have provided more diverse views on this topic. However, this issue does not necessarily undermine the findings of this study because sub-Saharan African immigrants living in southern Alberta may have similar views on healthcare choices due to their collective socially conservative nature (Adams, 2014). Furthermore, the small sample size of this study limited transferability of these findings.

Suggestions/Recommendations for Future Research

Several researchers have explored immigrants' healthcare access and utilization in their host countries (DiCicco-Bloom & Crabtree, 2006; Patton, 2005). Existing literature suggests that the longer the length of stay of immigrants in their host countries, the greater the positive or negative effects on their health (Jass & Massey, 2004; Lebrun, 2012). Based on the present study, researchers and healthcare providers may wish to explore how healthcare choices of immigrants change with time as they adapt to new cultural health norms. There are also differences between Ghanaian men and women in perceptions of healthcare decisions, which require further exploration. Furthermore, there is a need to explore how Ghanaian adult immigrants integrate traditional and Western medicine and how they incorporate the spiritual and social aspects of their lives when managing health challenges. Further research using a different theoretical framework (e.g., health belief model) and a different qualitative method (e.g., focus group interviews) may inform other interventions for immigrants at different stages of acclimation into society in Calgary.

It is critical to understand the kind of trauma and stressors and their consequences for immigrants to properly address these issues. This is especially true if immigrants' health status declines post-migration. Clinicians and other healthcare professionals should

follow proper evidence-based guidelines established by Canadian health authorities and

consider immigrants' potentially fragile mental health status, linguistic barriers, stigma,

and fears (Foster, 2001; Pottie et al., 2011).

Implications for Practice

Immigrant men and women may benefit from regularly talking among themselves

about the strengths they share to minimize conflicts and tension due to shifting gender

norms. As these types of conversations are difficult to engage in given the emotionally

charged nature of the topic, counsellors and mental health practitioners may wish to

explore development of programs or resources to facilitate these necessary conversations.

Immigrants may also find it beneficial to learn about technology and Internet usage,

including telephone and mobile phone use, to schedule appointments to see a doctor. This

may decrease their apprehension of engaging with the health care system and encourage

their utilization of healthcare services in Canada. Most participants shared similar needs

and possible solutions to their health problems while adapting to their new environment.

Most also suggested that immigrant awareness programs should educate them to avoid

self-medication or consulting friends and family members, who are not medical

professionals.

The findings also indicated that mental health was a significant issue for Ghanaian

adult immigrants. More education surrounding mental health and a strong mental health

supportive system may assist immigrants in making better choices regarding visiting a

medical doctor and avoiding emotional pain, addictions, self-harm, or suicide.

Knowledge Mobilization

Dissemination of these findings may provide the GCAC, government immigration

agencies, and immigrant support services with new ways to establish effective policies

that could assist immigrants. Leaders at the GCAC may find feedback from study

participants useful for improving current practices to benefit Ghanaian immigrants in

Calgary. I plan to communicate the study findings to immigrant communities in Calgary,

via presentations or seminars, and present a summary document of the findings to health

service providers who work with immigration offices. Furthermore, I plan to publish the

findings of this study in scholarly journals that address immigrant health scholarship. To

date, I have already presented these findings at one local and one international conference

(First World Congress on Migration, Ethnicity and Health in Edinburgh, Scotland, UK,

and at the University of Lethbridge's Meeting of the Minds conference). Preliminary

findings (abstract) from this study have also been published in European Journal of Public

Health (EUPHA). A copy of this thesis will also be available at the University of

Lethbridge Thesis Portal.

Significance of the Study

Based on research, the province of Alberta has implemented many healthcare

programs that reduce barriers to immigrants' healthcare (Anokye, 2014; Belding &

McRae, 2009; Este, Worthington, & Leech, 2009). The findings of the present study

expand this knowledge and may help improve immigrant healthcare programs. Moreover,

this research on facilitators and barriers that influence Ghanaian immigrants' healthcare

choices may inform the creation of better services to maintain a healthy life style for these

immigrants.

This study is also significant in that the findings may help policy makers and

healthcare officials appropriately engage Ghanaian immigrant communities in Calgary to

increase their awareness of the Canadian healthcare system, improve educational

programs for both the immigrants and the healthcare providers, and possibly implement

cultural competency training services specifically for Ghanaian immigrants living in Calgary. Ghanaians and other Africans belong to immigrant, refugee, ethno cultural, and racialized (IRER) groups that require non-discriminatory healthcare (Edge & Newbold, 2013; McKenzie, 2009). The present research revealed knowledge gaps regarding Ghanaian immigrants' healthcare choices in Calgary, which may serve as a foundation for future research to facilitate better health services for these immigrants.

Reflection

As a novice researcher, I learned a lot about conducting qualitative research in the natural setting of participants. Compared to my usual interaction with Ghanaian immigrants, this qualitative research provided an opportunity to obtain more insight via interviews regarding their views and experiences of healthcare as they settled in Calgary. The research was interactive and exposed me to the social worldview of participants in their own words, which gave me a better understanding of their experiences. I learned what to say, when to say it, and how to go about interacting with participants to construct meaning from the information they shared. As a new researcher, I discovered developing questions for interviews significantly contributed to the results of the study.

The data collection approach of using a digital audio recorder, phone, and laptop during interviews and note-taking helped me gain skills and knowledge about the research process. Working closely with my supervisors, I learned that this research study was not only academic, but also social. I learned about effective communication via relationships with my supervisors. Through the close guidance of my co-supervisor, I effectively used NVivo software for coding and creating themes the data. Using the software was challenging and it shaped my understanding of qualitative research, data collection, analysis, and reporting of findings. Transcribing occurred immediately after each

interview to help develop different strategies and probing questions for subsequent interviews. I transcribed all the interviews, which took about three hours for each interview. The analysis of each interview helped me explore responses from participants with different cultural and ethnic backgrounds within the Ghanaian immigrant population in Calgary, Alberta, Canada.

I encountered some challenges while working with participants as they shared emotions and real-life experiences. It was often difficult to suggest participants move on to the next interview question. This research was time-consuming and intensive with long procedures including transcribing, developing themes and codes, and constructing meaningful results. This qualitative research developed my knowledge and writing skills. The study enhanced my interviewing and interpersonal skills. I gained insight into the healthcare choices of Ghanaian immigrants and learned something about myself as well. I developed an interest in qualitative research and look forward to continuing in this research area.

Conclusion

The purpose of this study was to explore Ghanaian adult immigrants' healthcare choices in Calgary, Alberta, Canada. The findings from this study provide a better understanding of how Ghanaian adult immigrants make healthcare choices, the barriers and facilitators they encounter, and their decision-making dynamics. The findings also provide insights about tensions in making healthcare choices as immigrants resettle in a new environment. Participants emphasized the challenges that Ghanaian immigrants faced and intervention programs that community leaders and institutions should provide to help address the needs of immigrants. Generally, immigrants who recently arrived in a host society made decisions based on beliefs from their country of origin. With time, they

adapted to their new environment. Some participants, irrespective of their length of stay in Canada, continued to value traditional medical practices.

Education and support are necessary to assist immigrants in navigating the Canadian healthcare system. Participants identified that faster social integration may help solve most of their physiological health issues in Calgary. This study revealed that perceptions of racism, and selective treatment of immigrants in hospitals, kept some participants away from formal healthcare services. Another important finding from this study is the identification of challenges associated with reading and writing English, which affected participants' abilities to adjust to the public transportation system and understand healthcare providers. Most participants contended that lack of proper work-related compensation kept them at their jobs even if they were ill. It is recommended that newcomers to Calgary receive support or assistance from people with relevant skills and interest to help address medical issues.

Participants stressed the importance of healthcare professionals, policy makers, and immigration authorities, and suggested they create programs or policies to support the healthcare needs of Ghanaian adult immigrants. These intervention programs may influence immigrants' behaviours and attitudes towards the Canadian healthcare system, migration tension/stress, and shifting gender expectations/norms. Social tension, technological connections and disconnections, and intersecting pathways to healthcare choices greatly influence immigrants' health. Exploring how immigrants integrate traditional and Western medicine in Calgary may lead to more effective ways to improve immigrant healthcare choices. The results of the study provide a collective understanding of the diverse Ghanaian immigrant population and potential strategies to improve their healthcare choices and utilization of the Canadian healthcare system.

<div align="center">**REFERENCES**</div>

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APPENDICES

APPENDIX A: LETTER OF INTRODUCTION

To the Ghanaian Canadian Association of Calgary Executive,

First, I would like to thank you for giving me this opportunity to do my research study with your members. I am a student at the University of Lethbridge, Alberta, Canada. I am trying to find out how Ghanaian immigrants living in Calgary make decisions about their health. I kindly seek your help and support to invite willing members of the Association to participate in my study. Certain things in life might serve as barriers for Ghanaian immigrants in choosing health care in Canada, and I believe that this study will reveal these things and help find possible solutions to help Ghanaian immigrants living in Calgary.

I will ask questions and participants will tell me their views. The discussion will be done in English, at a place where the participant feels comfortable. The discussion will last for about forty-five minutes. I will offer people who take part in this study a drink and snack during the interview. Participants can decide not to continue at any point without penalty or consequence.

If you have any questions, feel free to contact me or my school supervisor Dr. Jean Harrowing, Faculty of Health Sciences, the University of Lethbridge (phone: 403-394-3944 or email: harrjn@uleth.ca) or the Office of Research Services, the University of Lethbridge (phone: 403-329-2747 or email: research.services@uleth.ca). Attached to the letter is the copy of the poster for my research study.

Thank you for your time and support in allowing me interview members of the association.

Yours sincerely,

Evans Oppong.
evans.oppong@uleth.ca
Phone number: 403-894-1821

APPENDIX B: INFORMATION LETTER

Dear Association Members,

My name is Evans Oppong, I am doing my master's degree in Health Sciences at the University of Lethbridge, Canada. I'm trying to find out what things, in everyday life, influence Ghanaian immigrants' health choices. I will be happy if you accept to tell me your experiences on what you think controls the health choices you make for yourself and maybe your family. I am grateful for any information and time you wish to spend with me sharing your thoughts on this subject. We will talk for about forty-five minutes.

The interview will take place where you feel comfortable. If you feel uncomfortable or not able to answer any of the questions, please feel free to stop me. It is okay if you don't want me to continue asking questions or do not want to talk about it anymore. I hope you are okay to any follow-up meetings if required. I would also like to record what you say, with your permission, on a tape recorder so that I can listen to it later, and write down what you say. Only my teacher and I will know all that you discuss with me. If you feel disturbed after the interview and want to talk more about it, please let me know so that I can give the help needed. If you would like to talk to someone other than me, I will do my best to help you find someone else who will be helpful.

The interview is secret and your name will not be shown for others to know what you discussed with me. The ideas you share with me will help give important information to get ideas of how health care can be improved for Ghanaian immigrants. All information will be destroyed, 5 years after the study.

The study is based on your readiness to participate. You are free to get out of the study at any point, if you do not wish to continue with the interview what you say will be deleted as soon as you leave.

Please feel free to contact me, Evans Oppong (M.Sc. student and principal investigator) or Dr. Jean Harrowing (teacher), Faculty of Health Sciences, the University of Lethbridge at 403-394-3944 or harrjn@uleth.ca if you have any questions. Any questions regarding your rights in this study can be directed to the Office of the Research Services, University of Lethbridge phone: 403-329-2747 or Email: research.services@uleth.ca).

Yours sincerely

Evans Oppong
MSc Student
evans.oppong@uleth.ca
Phone number: 4038941821

APPENDIX C: POSTER

HEALTH CARE CHOICES FOR GHANAIAN NEWCOMERS

.....would you be willing to participate in a research

interview?

I' m trying to find out what things, in everyday life, influence Ghanaian

immigrant's (newcomers) health choices

To take part you must be between 18 and 60, residing in Calgary, Alberta for 5 to 10 years

after your arrival from Ghana. This interview will be conducted in English and will take

about 45 minutes.

Feel free to contact Evans Oppong @ 4038941821 or email: evans.oppong@uleth.ca

APPENDIX D: CONSENT FORM

Please tick your answer(s) to the following questions

A. I agree to participate in this study

Yes   [ ]

No   [ ]

B. I agree to be recorded during the interview

Yes   [ ]

No   [ ]

C. I wish to receive a copy of the findings

Yes   [ ]

No   [ ]

Mr. Evans Oppong, has told me that he is trying to find out what things, in everyday life, control's Ghanaian newcomer's immigrant's health choices. I am ready to help him with my views about what he want to find out. I have signed this paper to show my readiness and willingness to be among the people in this study.

_____   _____
Signature of Participant   Signature of Researcher

_____   _____
Date   Date

** Contact information for transcribed interview and/ or summary of the findings:

Phone number or mailing address: _____

_____

A copy of this form has been given to you for your records.

APPENDIX E: DEMOGRAPHIC INFORMATION SHEET

1) Age……………years
2) Gender
   a) Male
   b) Female
   c) Other (specify)………………
3) Marital status
   a) Married
   b) Common Law
   c) Single
   d) Divorced
   e) Widowed
4) Highest level of formal education that you have attained
   a) Primary school
   b) High school
   c) College
   d) Polytechnic
   e) University
   f) Other (specify)…………….
5) Employment status …………………………………
a) Employed full-time
b) Employed part-time
c) Not employed
6) Type of employment
   A) Permanent
   B) Contract
   C) Seasonal
   D) Other, (please specify) ……………………….
7) Citizenship status
   A) Permanent resident
   B) Non-permanent resident
   C) Canadian citizen
   D) Student

APPENDIX F: INTERVIEW GUIDE

Below are the questions that will serve as a guide during the interview period with participants. Follow-up questions may be used that will help participants provide deeper explanations of their views.

Tentative guiding questions.

1) What does it mean to be healthy?

2) What do you do to stay healthy in Canada?

3) What makes it easier for you to look after your health and well-being as an immigrant?

4) What factors have influenced your choices of which health care providers (traditional or Western) you access since you have been in Calgary? How did these factors influence your decision? What do you think are the contributing factors to your decision making? What is easy and what is hard about making these choices?

5) How do your cultural beliefs affect your choices of health care in Canada as an immigrant?

6) How might your economic status influence choices of health care in Canada as immigrant?

7) How did you choose between western and traditional medicine before arrival in Calgary? How do you now choose between the two?

8) What are your suggestions on how health care systems can be improved in Calgary for immigrants?