Exploring the experiences of mental health among internal migrants in Nigeria

Temitope. O. Labinjo

A thesis submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Doctor of Philosophy

February 2022

Candidate Declaration

I hereby declare that:

I have not been enrolled for another award of the University or other academic or professional organisation while undertaking my research degree.

1. None of the material contained in the thesis has been used in any other submission for an academic award.
2. I am aware of and understand the University's policy on plagiarism and certify that this thesis is my own work. The use of all published or other sources of material consulted has been properly and fully acknowledged. The work undertaken towards the thesis has been conducted in accordance with the SHU Principles of Integrity in Research and the SHU Research Ethics Policy.
3. The word count of the thesis is 78,729.

Name	*Temitope Olufunke Labinjo*
Date	*February 2022*
Award	*PhD*
Faculty	*Health, Wellbeing and Life Sciences*
Director(s) of Studies	*Dr Russell Ashmore*

Abstract

Internal migration has been a long tradition in Nigeria. Culture is a significant aspect of internal migration in Nigeria as internal migrants move from one state to another. They, therefore, must adapt to a new culture, language, beliefs, and social identity. In addition, existing evidence showed that social, cultural, and economic factors were linked to a migrant's status thereby impacting their mental health. Studies conducted in Nigeria identified the causation of mental disorders to supernatural causes and drug misuse with stigma towards people with mental disorders.

This study identified and explored factors impacting the mental health of voluntary internal migrants in Nigeria. In addition, the study examined the perceptions, knowledge, and attitudes of Nigerian participants towards mental disorders.

After a thorough search of existing literature on mental health in Nigeria, there were no studies exploring experiences of mental health among voluntary internal migrants in Nigeria. Therefore, a qualitative phenomenological study was conducted with nineteen voluntary internal migrant participants from Kaduna state, Federal Capital Territory (Abuja), and Lagos states in Nigeria. Semi-structured interviews were undertaken using the video conferencing platform Zoom©. The 'silences' theoretical framework was used as a guide in this study which explored the experiences of a marginalised and under-researched group of voluntary internal migrants in Nigeria.

Five themes emerged from this study: 'purpose of migration,' 'experience of migration,' 'coping strategies,' 'knowledge of mental health,' and 'impact of internal migration on mental health.' The participants described the reasons for migrating as work, marriage, and wanting a better life. They described having accommodation issues, difficulties finding a job, language and cultural barriers, transportation problems, infrastructural challenges, and experienced challenges of lack of social support. In addition, they explained that insecurity challenges in the nation negatively affected them. These challenges resulted in significant stress, ultimately leading to poor mental health. Religion and perseverance helped them cope after relocating. Finally, there was an improvement in knowledge of mental health, but there were still high levels of stigma towards persons with mental disorders.

This study contributes to existing knowledge by exploring the gaps in the body of knowledge regarding the experiences of voluntary internal migrants concerning mental health in Nigeria. In the long-term, this study will assist in creating further research to assist relevant stakeholders in providing more access and delivery of mental health services in Nigeria.

Table of Contents

List of Figures

List of Tables

Acknowledgments

This thesis is dedicated to my loving husband (Adams Labinjo) for his constant encouragement and emotional and financial support.

I am sincerely grateful to everyone who helped and supported me on this lifelong project, and I offer my sincere thanks to:

The study participants who shared their lived experiences as internal migrants and the impact on their mental health.

My supervisors Professor Laura Serrant, Dr Russell Ashmore, and Dr James Turner, for their guidance and support.

Nigeran Institute of Medical Research (NIMR), T& T Schools Kaduna, and Living Life Church Abuja, who gave access to recruit study participants in their institution and as a research venue.

Staff and tutors of the Health, Wellbeing, and Life sciences department at Sheffield Hallam University for their support, guidance, and assistance.

My parents and Brother for their constant support and prayers.

My friends, colleagues, and acquaintances for their encouragement, support, and prayers .

Operational Definitions

Adults: aged 18 years and above.

Immigrant: a person who moves to live permanently in a foreign country outside the country of origin.

Indigenes or natives: people who can place their heritage or ancestry to the community they were born.

Internal migrant: a person who moves within the border of a country

Mental disorders: consist of a combination of abnormal thoughts, perceptions, emotions, behaviour, and relationships with others (World Health Organisation, 2019).

Mental health: will be explained in detail below.

Migrant: a person who moves from one place to another for work or a better life. However, some scholarly articles describe migrants as within-country migrants. There is no standard definition of a migrant or immigrant in law. For this study, the focus would be on internal migrants.

Migration: will be explained in detail below.

Migrant status: is a position when an individual changes their place or location of usual residence.

Introduction to the Thesis

This chapter sets the context and overview of the thesis, including the background to the study. This chapter also presents the theoretical framework that guided the research process in alignment with the aims and objectives of the study. Finally, this chapter described the structure of the chapters in this thesis.

I. Background

I.I Migration

Migration is a change in the location of residence of a person for some time. According to a United Nations estimate, one-third of the world's population is a migrant, i.e., they live or work away from their place of birth. The total number of international migrants in 2019 was 272 million, which comprised of 3.5% of the world population. Fifty-two percent were male, while 48% were female and were between 20-64 years (International Organisation for Migration, 2020).

More than half of international migrants are residents in Europe and North America (International Organization for Migration, 2020). One in every thirty-five people in the world is a migrant (International Organization for Migration, 2020). Migration can be internal (within a nation) or international (outside the country).

Migration can also be classified as involuntary (forced) or voluntary. Forced migration, also known as involuntary migration, can be caused by either conflict or disasters. Conflict-induced migration can be due to ethnic conflicts, wars, insecurities, etc (Migration Data Portal, 2021). In contrast, disaster-induced migration is caused by natural disasters such as floods, earthquakes, etc. (Migration Data Portal, 2021).

The International Organisation for Migration (2019, p77) defined forced migration as ‘a migration movement which although the drivers can be diverse, involves force, compulsion or coercion’. According to United Nations High Commission for Refugees (UNHCR), the total number of people displaced at the end of 2020 both within countries and across borders was 82.4 million, of which 48 million people were internally displaced, 4.1 million were asylum seekers, and 26.4 million were refugees (UNHCR, 2021a).

Voluntary migration is when people willingly leave their place of origin to reside in other areas. For this study, the focus is on the voluntary type of migration.

Two factors that influence migration are ‘Pull’ and ‘Push’ factors. The pull factors draw or attract the individual for economic benefit or educational and/or career upgrade, while push factors are political factors that extract individuals from one culture to another (Bhugra and Gupta 2011).

The process of migration is divided into pre-migration, migration, and post-migration. Pre-migration describes a decision by the individual to move and prepare for migration (Bhugra and Gupta, 2011). Migration is the actual relocation from one place of residence to another. Post-migration is the adaptation of the migrant to the social, political, economic, and cultural framework of the new environment. Cultural and social values related to adaptation have to be learnt at this stage. The individual's changes in this phase can result in isolation (Bhugra and Gupta, 2011).

In the pre-migration phase, the individual identifies the reasons for migration with an expectation of safety. Preparation is essential in this phase, and it also involves identifying

resources such as travel costs, contacts in the new place, etc. Migration is the actual movement to a new environment.

In the post-migration phase, sometimes, the individual's expectations or desires may not be met on arrival due to socioeconomic and sociocultural factors. This may lead to isolation and low self-esteem. Also, factors such as language skills, including an understanding of accents, financial position, and support, play a significant role. In addition, the character of the host culture and people can affect this experience for the migrant. Therefore, the amount of cultural adaptation and acculturation of the migrant will be determined by personal and external factors (Bhugra and Gupta, 2011).

I.II Internal migration

Internal migration is a change in residence by an individual within a country (Rees, 2020; 2001; Adepoju, 1981). Internal migration is also a process where individuals move within the boundaries of their own country (Skeldon, 2018). For example, in Nigeria, internal migration is the movement from the country's local government area to a new residence either temporarily or permanently (International Organisation for Migration, 2011 as cited in ACP Observatory research guide, 2011). There are a lot of arguments in the existing literature on the length of stay between a state of origin and a state of relocation in Nigeria (Oyeniyi, 2013). Therefore, the National Population Commission (2012) suggested that to be classed as internal migration, these movements must have occurred within six months and moved from one local government to another.

Thus, internal migration in Nigeria is the movement of Nigerians from their local government area to another to reside temporarily or permanently (National Population Commission, 2012). For this study, study participants must have moved from their state

of origin or residence to live in another state. The migration pattern is rural-urban or urban-urban as most participants must have moved from their local communities or states of origin to reside in Kaduna, FCT, and Lagos states.

According to the United Nations Development Programme (UNDP), internal migrants are three times more than international migrants (United Nations Development Programme, 2009). As a result, movements within countries in the previous 40 years have been mostly internal with about 740 million internal migrants globally (IOM, 2020; Oyeniyi, 2013).

Most studies on internal migration have focused on the structure and pattern of net migration due to population change (Rees, 2020; 2001). North America and Australia have higher rates of internal migrants than in Europe. However, within Europe, the North and Northwest regions have higher rates of internal migrants (Rees, 2020). Most data in developed countries on the social, economic, cultural, and ecological drivers, including the impact of internal migration, are derived from high-quality data (Lucas,1997).

In many developed countries, internal migration had shifted from large cities to smaller towns and rural settlements. This term is called counter urbanisation. The pattern is variable across various age groups. The movement is most prominent among older age groups. Retired individuals moved more to smaller towns and rural settlements while the younger ones moved to larger cities to seek higher education or obtain job opportunities. Education is positively related to the probability of migrating between regions and moving from one’s birthplace (Schultz, 1982; 2003; Schwartz, 2007). Therefore, a family’s investment in their children's education increases the possibility of that child migrating (Rees, 2020).

The characteristics of internal migration are different in several areas of the world in terms of gender. For example, in North America, men usually migrate towards the western frontier territories, and the women accompany them later. On the other hand, in the 20th century, women were more likely to move from rural to urban areas to find employment outside the agricultural sector (Rees, 2020).

There are similar patterns in Latin America, except indigenous populations where lack of education, insufficient knowledge of Spanish, and other cultural constraints affected these women's migration experiences. Women and men moved to urban cities and towns after completing their education and moved after their weddings to join their spouses (Rees, 2020).

In Southeast and East Asia, women migrated to work in industries that aligned towards export. For example, in Taiwan, old married women in rural areas who worked in rural sectors contributed to their family income without moving to urban cities. This led to a reduction incurred in considerable expenses in urban cities (Brinton, Lee & Parish, 1995). However, in Southeast Asia, for example, in Malaysia, circular migration occurred where men in rural areas moved to find temporary urban jobs and returned to their families in the rural areas to help on their farms during agricultural seasons (Rees, 2020).

Many countries, especially developing countries, identified economic reasons for migration (Rees, 2020; Quang, 2008; Adepoju, 1998; 1981). For example, a study in Vietnam identified the primary reason for internal migration as economic. Due to unemployment and low income, people moved from rural to urban areas to seek better job opportunities (Quang, 2008). According to Quang (2008), 80% of participants reported finding better income after migrating, even though they earned 20% less than

their local counterparts (Quang, 2008). Thus, in the long run, internal migration relieved the pressure of unemployment and underemployment in the rural areas, thereby improving the living conditions of the rural population. However, like many industrialised countries, internal migrants tend to experience employment pressures and challenges due to restrictive employment contracts, wage negotiation, expensive social insurance, and other social services in the urban cities (Quang, 2008).

Another aspect of internal migration is the forced migration of ethnic, racial, and other groups from their origin areas. Forced internal migration has resulted in the displacement of people from their places of origin. These individuals were displaced due to several reasons such as insecurity, environmental disasters, etc (International Organisation for Migration, 2020). Forced migration can happen within a country and internationally. People displaced outside their countries of origin are called refugees, while people displaced within their countries of origin are called internally displaced persons (IDPs) (UNHCR, 2021b).

In Nigeria, there is a growing number of internally displaced persons (IDPs). These are people who were forced to flee from their homes or communities due to armed conflict, violence, or natural and human-made disasters (United Nations, 1998). For example, according to the International Organisation for Migration (IOM) displacement tracking report (2021), 2,191,193 people were displaced in May 2021 alone.

I.III Mental health

According to the World Health Organisation Report (2001, p1), mental health is defined ‘as a state of well-being where individuals can adapt to the condition of daily living. They

can achieve their goals or aspirations, work productively, and contribute to their communities'.

Even though this definition moves from the concept of mental health as the absence of mental disorders, this definition has raised concerns among researchers. This is due to the potential misconception when identifying positive feelings and positive functionality as main concepts of mental health (Diener et al., 1999; Waterman, 1993). People with a good mental health can sometimes be sad, unhappy, or unwell and it is part of being a human being. However, mental health is often regarded as a positive event with feelings of happiness and control (Galderisi et al., 2017).

Keyes (2006; 2014) identified three components of mental health which are emotional wellbeing which involves feelings of happiness, life interest and satisfaction. Psychological wellbeing involves appreciating own personality, managing life responsibilities, relationship with other and daily living. Finally, social wellbeing is ability to function positively and contribute to society (social contribution), being part of a community (social integration), belief that society is a better place (social actualisation) and accepting the ways society works (social coherence). However, there may be situations where individuals may have difficulties experiencing such positive attributes due to their circumstances. For example, adolescents who are socially isolated or migrants/ minorities who experience discrimination or perceived injustice and inequality. However, there was a consensus among researchers that mental health is not just the absence of mental disorders (Galderisi et al., 2017; Deci and Ryan, 2008).

Therefore, a proposed definition as agreed was that: 'mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with

universal values of society. Basic cognitive and social skills, ability to recognise, express and modulate one's own emotions, as well as empathise with others. Flexibility and ability to cope with adverse life events and function in social roles. Harmonising relationship between body and mind represents important components of mental health which contributes to varying degrees to the state of internal equilibrium' (Galderisi et al., 2017, p231). This definition was drafted to eliminate unrealistic norms to encourage a more inclusive approach. It also encourages a human life experience which is sometimes good or sad. Finally, this definition also encourages the principle of recovery from an illness which is a process to achieve a fulfilled life (Slade et al., 2014).

I.IV Global burden of mental disorders

Mental disorders constitute a significant global burden of disease, which is vastly underestimated. About one in four people are affected with mental disorders worldwide, with an estimate of about 450 million people experiencing a mental disorder (WHO, 2015; 2006). The World Health Organisation estimates that about 10% of adults are currently experiencing mental disorders, and 25% have developed mental disorders at a particular time in their lives. It is found in all countries, gender, class, and all settings. It accounts for 13% of the global burden of disease and will rise to 15% by 2030, with depression the second highest contributor.

There are also high costs to the treatment of mental disorders. WHO estimates that about 44-70% of patients in developing countries with an effective healthcare system do not receive treatment, while about 90% of patients in developing countries without an effective healthcare system do not receive treatment (WHO,2015; 2001).

I.V Mental disorders

Mental disorders are a group of conditions that influence an individual's mood, thought, and behaviour. Examples of mental disorders include depression, anxiety, eating disorders, and addictive behaviour. Mental disorders occur when an individual experiences continuous symptoms resulting in stress and an inability to function (Hooten, 2016).

Mental disorders are not specific to any group. Mental disorders are found in all social classes, geographical locations, gender, and life-course stages, i.e., infancy to adulthood. About 450 million people experience mental disorders such as unipolar depressive disorders, bipolar affective disorder, schizophrenia, epilepsy, alcohol, and selected drug use disorder. Others are Alzheimer’s and different dementias, post-traumatic stress disorder, obsessive and compulsive disorder, panic disorder, and primary insomnia (WHO, 2015; 2001).

The prevalence rate changes if an individual has the disorder at a particular point in time (point prevalence), during a specific time (period prevalence), or in their lifetime (lifetime prevalence). The one-year or period prevalence determines the level of service provision required in a year (WHO, 2015).

There are biological, psychological, and social factors responsible for mental disorders. Studies have shown that specific natural components affect individuals' mental health and stability (WHO, 2016; 2014). Some genetic components can contribute to the risk of developing a mental disorder affecting the brain. In addition, mental disorders are sometimes linked to abnormal function of the nerve cell pathway that connects to the brain (WHO, 2006).

Exposure to a particular environment can present a potential risk to developing mental disorders, ranging from vulnerability to psychotropic substances as a foetus, malnutrition, developing infections, disorganised family environment/ settings, dilapidation, isolation, or trauma (WHO, 2014; 2001). In addition, personal relationships across the life course, i.e., from childhood to adulthood, affect mental and behavioural disorders.

Family settings, level of care, and relationships at the childhood stage can affect children's mental state and make them more likely to develop mental disorders. For example, evidence showed that children living in institutions lacked adequate social interactions; even though these children received good care, they were shown to exhibit poor interactions and an inability to cope in stressful life events in their later life (WHO, 2014).

Also, evidence showed that some mental disorders such as depression and anxiety occurred due to an individual's lack of resilience in a stressful life occurrence. It is believed that people who avoided dealing with stressors tend to develop depression, while people who shared their problems and tried to find solutions tend to function better and more effectively (WHO, 2016; 2014).

Half of the population in urban settlements in low- and middle-income countries lived in poverty, with many homeless, forcing many to migrate to urban areas for a better livelihood (WHO, 2014). However, sometimes, migration does not enhance social well-being; instead, this sometimes results in unemployment and poor living conditions (Bhugra and Gupta, 2011). Therefore, exposing these migrants to social pressure and lack of adequate social support puts these migrants at risk of contracting mental disorders (WHO, 2014).

Poverty is associated with factors such as unemployment, low education, and deprivation. Developing countries tend to have limited funds for mental care, and these provisions are not available to low-income individuals. Even rich countries tend to have these problems due to lack of insurance accessibility, unemployment, race, ethnicity, and language barriers, creating hindrances to medical care for migrants (WHO, 2014; 2001).

II. Study Aims and Objectives

This study aims to identify and explore factors that impact the mental health of voluntary internal migrants in Nigeria.

The objective of this study is to:

1. Explore the experiences of selected voluntary internal migrants and the impact their internal migration experiences had on their mental health using a new theoretical framework (Serrant-Green, 2011).
2. Improve knowledge level and awareness about mental health issues in Nigeria.
3. Assist in creating further research to assist stakeholders in providing more access and delivery of mental health services in Nigeria.
4. Test the application of the 'silences' framework (Serrant-Green, 2011) for researching an under-researched group about a sensitive issue in a new context.

The research questions guiding the study are:

1. What are the views, knowledge, and experiences of voluntary internal migrants in Nigeria concerning mental health issues?

2. What are the influencing factors concerning mental health among voluntary internal migrants in Nigeria?

3. What is the impact of voluntary internal migration on mental health in Nigeria?

III. Justification for study

The decision to undertake this study at this time was out of a personal experience of being a voluntary internal migrant in Nigeria. Further explanation will be made in chapter two of this thesis. There were three main reasons for investigating this study.

The first reason was that voluntary internal migrants in Nigeria had been excluded from academic literature, especially regarding health outcomes such as mental health (Labinjo et al., 2020; Oyeniyi, 2013). Internal migrants account for 40% of the total population of the country (National Bureau of Statistics- Nigeria Living Standards Survey, 2020; National Bureau of Statistics- Annual Abstract, 2017; Oyeniyi, 2013). Historically, the increasing pattern of rural-urban migration began in the colonial era due to economic reasons and recently due to civil wars and ethnic conflicts (Oyeniyi, 2013). Also, voluntary internal migration significantly affected the internal migrant's socio-cultural adaptation, such as family structure, language, etc. (Sibiri et al., 2014). Therefore, it would be necessary to explore Nigerians' voluntary internal migration experiences and the impact these experiences have on their mental health.

Secondly, there is little knowledge about mental health issues in Nigeria. Also, there are low mental health service deliveries with no recent implemented legislation on mental health in Nigeria (WHO, 2014; Gureje and Saxena, 2006). Therefore, it is essential to understand the knowledge and perceptions of Nigerians towards mental health issues to

help provide interventions and strategies to improve awareness about mental disorders in Nigeria (Labinjo et al., 2020).

Finally, research in Africa on both internal and international migration reached a consensus that the primary purpose of migration was for economic wellbeing (Adepoju, 2008; 1998; Oyeniyi, 2013). Adepoju (1998) confirmed that international and internal migration complement each other. Both are derived from a complex mix of economic or social factors, which are primarily associated with the migrant's search for better wellbeing. This excludes migrants displaced by natural disasters and conflict.

Therefore, the complex link between internal migration and mental health among Nigerians needs to be investigated (Sibiri et al., 2014; Owoaje et al., 2016).

IV. Introduction to the 'silences' framework

Over time, topics or subjects have been challenging to research both for the researcher and participants due to ethical, moral, and sometimes personal or sensitive issues (Serrant-Green, 2011). Therefore, using a theoretical framework is vital as it designs how research is created, planned, and executed (Anfara & Mertz, 2006). Thus, the 'silences' framework gives a structural guide for the methodology and methods used in a research study (Crotty, 1998). Even though there is no specific rule as to how a theoretical framework should be selected, Crotty (1998) explains that a significant criterion is answering the 'what' question, i.e., what exactly is the study trying to achieve? Thus, a considerable benefit of a theoretical framework is that it guides the entire research process. Also, the theoretical framework must identify the philosophical basis through which the research is constructed, thereby linking the theoretical with the methodological aspects of a research study (Anfara & Mertz, 2006).

Serrant-Green (2011) developed the ‘silences’ framework to focus on research and experiences which are little researched and reflect the unshared aspects of beliefs, values, and experiences of some groups that affect their health and well-being, identified as ‘silences’ (Serrant-Green, 2011). The framework was designed based on research focused on black Caribbean men's sexual decisions and risk-taking (Serrant-Green, 2004).

‘Silences’ refers to views and information not discussed openly or reported in the existing literature on a specific subject. For example, in the case of this study, internal migrants are silenced due to a lack of existing evidence about this group concerning a sensitive topic such as mental health which is hardly discussed (Labinjo et al., 2020; Oyeniyi, 2013; Gureje et al., 2006).

The individual-centred lived experience of this study is based on the ‘silences’ framework. This is because it recognises the importance of the Silences of their experiences during the data generation process that is relevant to internal migration and mental health in Nigeria. Furthermore, this is because this study focused on the lived experiences of internal migrants in Nigeria by allowing them to take control of the data generation process as much as possible.

The ‘silences’ Framework (TSF) is positioned as an anti-essentialist framework designed to explore individuals’ experiences by appreciating individual interpretations of issues (Serrant-Green,2011). The anti-essentialist view states that reality is not impartial or firm. Still, our social world is viewed or experienced by people in a particular society at a point in time (Williams and May 1996). Therefore, the framework aims to attribute meanings to events by individual participants (Denzin,1998). Thus, in this study, the ‘silences’

framework will focus on research participants to provide answers based on their lived experiences applicable to Nigeria regarding internal migration and mental health.

This approach also aligns with the critical paradigm, which authorises an action-oriented methodology. Critical paradigm is a framework and way of viewing the world in social science research that focuses on power, inequality, and social change (Denzin and Lincoln, 2011). In addition, the 'silences' framework seeks to explore areas of research that are under-researched historically or politically, unnoticed, absent, or silent (Serrant-Green, 2011). Generally, the issue of mental health in Nigeria is very 'silent, 'especially among internal migrants who are under-researched (Labinjo et al., 2020; Gureje et al., 2015; Oyeniyi, 2013; Gureje et al., 2005).

As a result of adopting an anti-essentialist perspective and a critical paradigm, the 'silences' framework aims at exploring the marginalised nature of internal migrants to discover hidden views of mental health and internal migration experiences to help the delivery of mental health interventions in Nigeria. The underpinning critical philosophy of the 'silences' framework fitted well with the study aims and objectives by allowing the individuals share their lived experiences as internal migrants and the impact these experiences had on their mental health.

'Screaming silences' value individual or group interpretations of events and human experiences as a crucial part of what people believe to be the truth (Serrant-Green, 2011). Therefore, 'screaming silences' seek to give voice to the experiences, topics, and issues which are hidden or silenced. I located the silences identified in this study as a researcher based on my lived experience as a first- and second-generation internal migrant in Nigeria (please see chapter two for details). The choice of mental health as a subject study was

due to its sensitive nature among Nigerians. The topic of mental health was hardly talked about (Pederson et al., 2020; Labinjo et al., 2020). As a result, more ‘silences’ were revealed by study participants during data generation.

The ‘silences framework’ (TSF) is associated with the concept of marginal discourses. Marginal discourses are used in identifying bodies of knowledge, beliefs, or assumptions about the world we live in and as human beings (Sawicki, 1991). Marginal discourses have discovered the central role played by the internal migration experiences of selected participants and the impact these experiences had on their mental health. In this study, marginal discourses were located through the significant role of internal migration experiences and perceptions of mental health among internal migrants in Nigeria.

‘Screaming silences’ allowed active positioning of the marginal nature of these views in the study, which provided a basis for the framework. The concept of ‘screaming silences’ recognises that all aspects of human life are influenced by various factors such as beliefs, social change, etc. (Hollis, 1994). Therefore, maintaining personal experiences is critical to a ‘silences’-based study. This study explored the individual lived experiences of internal migrants to ascertain if their migration experiences impacted their mental health. In addition, the study also understood their knowledge and perceptions about mental health issues.

The framework, therefore, provided the theoretical underpinning from designing to exploring and learning from the lived experiences of internal migrants in Nigeria and its impact on their mental health. The theoretical framework was also used in this study because it explored the experiences of marginalised and under-researched groups of internal migrants about a sensitive issue like mental health.

There was a lack of published and unpublished studies on internal migration, especially on sensitive topics like Nigeria's mental health (Labinjo et al., 2020). The ‘silences’ framework was chosen because it provided a clear guide to structure the research process. The ‘silences’ framework was also adopted to explore internal migrants’ mental health meanings and experiences to discover hidden perspectives to improve mental health awareness and delivery in Nigeria.

The framework has been successfully used in several doctoral research and journal articles. For example:

- Janes (2016) Silent slips, Trips, and broken hips: The recovery experiences of young adults following an isolated fracture of the proximal femur.
- Janes, G., Serrant, L., & Sque, M. (2018). Fragility hip fracture in the under the 60s: a qualitative study of recovery experiences and the implications for nursing.
- Eshareturi (2016) Mapping the Offender Health Pathway: Challenges and Opportunities for Support through Community Nursing.
- Eshareturi, C and Serrant, L. (2018). Challenges and opportunities for ex-offender support through community nursing.
- Eshareturi, C., Serrant-Green, L., Bayliss-Pratt, L., & Galbraith, V. (2014). The case for nurses as central providers of health and social care services for ex-offenders: a discussion paper.
- Eshareturi, C., Serrant, L., Galbraith, V., and Glynn, M. (2015). Silence of a scream: application of the Silences Framework to the provision of nurse-led interventions for ex-offenders.

- Janes, G., Serrant, L., & Sque, M. (2019). Screaming silences: lessons from the application of a new research framework.
- Rossetto, M., Brand, É. M., Teixeira, L. B., Oliveira, D. L. L. C. D., & Serrant, L. (2018). The Silences Framework: A Method for researching sensitive themes and marginalized health perspectives (English version).

The ‘silences’ framework consists of five main stages that guide the research process.

- Stage 1: Working in ‘silences’
- Stage 2: Hearing ‘silences’
- Stage 3: Voicing ‘silences’
- Stage 4: Working in ‘silences’

The ‘silence’ framework has a fifth stage which is useful where the research requires an action plan for service delivery (Serrant-Green, 2011). The fifth stage includes recommendations for policy and service delivery.

Stage 1: (Working in ‘silences’) This stage provides the contextual setting of the study by exploring the contextual and historical background on which the study occurs. The objective is to show the ‘real’ world where the study occurs. This begins with accepting that ‘silences’ exist and are prevalent in an ‘imperfect’ world.

This stage also sets the context for the research using a critical literature review. The step is to identify the range and scope of existing knowledge and evidence concerning this subject. This may include the cultural, psychological, and moral aspects of the research. Through the literature review, the reader is presented with ‘silences’ inherent within the

research. The literature review aims not just to show a perfect practice of these issues but also to show the reader how things are and what is not evident or reported using the available evidence and information resource available in the public domain.

This stage concludes with evidence of the benefits for participants, health care professionals, and their relevant stakeholders expected from the planned research. The research should endeavour to answer the crucial question ‘why this research at this particular time’? (Serrant-Green, 2011, p 352) by exposing what is known and what is still to be said. This stage is presented in chapter one.

Stage 2: (Hearing silences) This stage reflects the ‘silences’ arising from the relationship between the researcher, research subject, and participants. The ‘silences’ framework insists that an individual's description of truth is constructed by their social environment and informed by the lived experiences of the individual (Serrant-Green, 2011).

The researcher identity: The researcher identifies and critically reflects on personal experiences concerning the study. The researcher is recognised as the primary listener in the study. The reader is required to enter the study from the researcher's perspective and is assisted through the research process to understand the experiences underpinning the research study and the practical or professional choices that result in the researcher seeking to complete this study.

Research subject: This aspect is essential where the focus is on a topic that may appear 'sensitive' or sometimes where evidence is unknown in a society at a point in time. The researcher identifies the main aspects of the subject in a society that make it 'sensitive' or 'under researched' at a point in time. Sometimes, a researcher's exploration of a subject makes the subject sensitive or difficult to talk about or may allow the 'silence' to be heard.

Research participants: The final element of this stage (hearing silences) involves accurate identification of missing evidence by identifying the 'silences' from participants in the study (Serrant-Green, 2011). The researcher identifies the 'silences' from the 'missing voices or marginalised perspectives of participants in the study (Serrant-Green, 2011). The central aspect of this stage is that the ‘listener’ (study participants) experiences the uncovered silences and interprets this silence which is considered the truth. Therefore, this stage examines the researcher, the research participant, and the subject of interest as an interdependent relationship within the context of this research. This will subsequently inform the overall study design and methods adopted in generating data. This stage is presented in chapter two.

Stage 3: (Voicing silences) This stage comprises the study's data generation and analysis phase. This stage involves the choice of methodology, recruitment of participants, and approach to data generation and analysis, as explained below.

Methods and data generation: This section explores the data generation method and justification for selecting the context of the ‘silences’ explored. The researcher will seek to understand the effects of contextual features and influences on participants' experiences such as social, political, economic, etc. These contexts will allow the researcher to understand how events, actions, and meanings are shaped by unique circumstances in which they occur (Creswell & Poth, 2016).

Participants: TSF aims to identify the 'silent voices' within a particular issue. Serrant-Green (2011, p 355) explained that 'it is the direct exploration of participant experiences that the ‘silences’ framework contributes to knowledge.' This section shows the research participants whose silences are explored and eligibility criteria for inclusion in the study.

Analysis: The data analysis in TSF is derived from the need to address the study's aims and objectives (Serrant-Green, 2011). Data analysis follows the cyclical approach identified within the ‘silences’ framework (Serrant-Green, 2011). There are four phases involved in the analytical process as follows.

Phase one starts with the analysis of data generated by the researcher regarding the research questions using thematic analysis, which will result in themes created from the data. The research process will include preparing and organizing the recorded data transcripts into digital files using an appropriate naming system. Themes will emerge from the process of coding through reading and documenting critical issues highlighted by participants.

Phase two involves the review of the initial results by a selected group of study participants called ‘silence dialogue’. The aim is to ensure the researcher does not further 'silence' the voices of the marginalised participants (study participants) or limit the discussion of sensitive subjects such as mental health during research activities.

Phase three involves the inclusion of a reference group called ‘collective voices.’ These individuals are key and critical stakeholders in the study. These are individuals in the social, cultural, or professional networks of the study participants. The objective is to sample the opinion of individuals in the social network of study participants (internal migrants) whose social, cultural, or family situation impacts the lived experiences of internal migrants. This adds, agrees, or disagrees with issues undisclosed during the proposed silence interview. The purpose is to get from mutual voices the extent of broader similarities or differences of the evidence collated through the experiences of the research

participants. This will determine the transferability of the research results and explore the 'silences' that still exist (Serrant-Green, 2011).

Finally, Phase four involves critical reflection of the findings by the researcher from previous phases and presents a final study outcome. This stage outlines and discusses how the ‘silences’ framework's four-phase cyclical data analysis process was integrated with Braun and Clarke’s (2006) thematic analysis to arrive at the study findings. This stage is presented in chapter three (methodology), chapter four (data generation and analysis), and chapter five (findings).

Stage 4: (Working with silences) This stage critically reflects any practical benefits arising from the study towards internal migration and mental health in Nigeria. This stage also explores how the researcher, ‘silence dialogue’ (selected participants) and ‘collective voices’ (key stakeholders) have impacted the study. It also outlines how the original ‘silences’ identified may have changed because of the study. The ‘silences’ that remain unchanged and new ‘silences’ identified from the study are also addressed. This stage also considers the contextual issues identified in stage one. Limitations are also recognised, and recommendations for future research and policy are also examined. This stage is presented in chapter six.

Stage 5: (Planning for silences) This stage is not applied to all studies. It is only relevant in applied research where the outputs require action planning for service delivery or community action (Serrant-Green, 2011). This study aims to explore the findings for future research and policy improvement at this particular time. Therefore, this final stage will not be applied in this study.

The ‘silences’ framework (stage one to four) was synonymous with the philosophical framework as explained by Denzin and Lincoln (2011) and Creswell (2007), which described the research process in five phases. Phase one explained the researcher's background (reflexivity), phase two discussed the theoretical paradigms and perspectives, phase three addresses the research approaches. Phase four explained data generation and analysis methods, and phase five discussed the interpretation and evaluation of data. Therefore, the ‘silences’ framework was suitable for the research process and overall study.

V. Overview of chapters

This thesis is structured under the ‘silences’ framework (Serrant-Green, 2011). The following are brief descriptions of the chapters in this thesis:

Chapter one provided a contextual setting of the reality of internal migrants in Nigeria by presenting an overview and historical background of Nigeria. This was to identify studies and historical events that answer why the research question exists at this present time. In addition, this chapter presented a scoping literature review of the relationship between migration and mental health in Nigeria, Africa and globally.

Chapter two presents my reflection on the ‘silences’ arising from my relationship with the study, the research subject, and the participants. This subsequently informed the overall study design and the methods used in generating data.

Chapter three explains the methods adopted in the study and their justification for use. It also described how participants were recruited and the data generation instruments used in the study.

Chapter four discusses the process of data generation and analysis and issues relating to trustworthiness and credibility in the study.

Chapter five presents the findings of the study

Chapter six discusses the findings, scoping literature review, and methodological issues relating to the study, including the silences uncovered. This chapter also provided recommendations for future research and policy.

Chapter seven summarises the study and explained the unique contribution of the study to knowledge. The chapter also discussed my reflection while undertaking the study.

VI. Summary

This chapter introduced the study aim and objectives, including the theoretical framework underpinning the study and the overall structure of the thesis. The justification for the study was discussed, and key concepts relating to the study were outlined. Chapter one is a detailed critical analysis of the broader context of the study including a detailed scoping review of existing literature.

Chapter One: Stage 1- Working in ‘silences’ (Setting the Context)

1.1 Introduction to the chapter

This chapter seeks to explore and understand the silences around the mental health of internal migrants in Nigeria. It was vital to explore their lives in a social and political context (Freshwater and Cahill, 2013; Eshareturi, 2016). This chapter began with setting the context by providing an historical background, including the social, cultural, socioeconomic, and socio-cultural context of Nigeria and how these impacted the experiences of voluntary internal migrants in Nigeria.

This chapter also presented a scoping review of literature on internal migrants' experiences and its impact on mental health across different continents globally with a special focus on Nigeria. This scoping review also addressed the knowledge and perceptions of mental health issues in Nigeria across different population groups in the country.

Figure 1: Map of Nigeria.

1.2 Historical Background of Nigeria

1.2.1 Colonialism in Nigeria

The history of Nigeria goes back to early 1100BC where several African cultures settled in a region called Nigeria. These included the Kingdom of Nri, Benin Empire, and Oyo Empire. Islamic religion got into Nigeria through the Borno Empire, while Christianity entered the country in the 15th century through Augustinian and Capuchin monks from Portugal (Falola and Heaton, 2008).

British colonialism started under the disguise of removing the slave trade. Slave trade from West Africa began before 1650, with about 3,000 slaves taken every year and rising to 20,000 per year in the century's final quarter. About 76,000 slaves were extracted each year from Africa from 1783-1792. In 1740, the British were the primary 'slave traffickers' from West Africa (Richardson, 2004). In 1767, British traders encouraged the vicious killings of hundreds of people in Calabar (Nigeria) after inviting them to their ships to resolve a local argument (Sparks, 2004).

A significant argument among African and European historians was whether the British conquest of Nigeria resulted from a generous agenda to stop slavery or an active motive of empowerment and power (Asieghu, 1984). Britain abolished slavery in 1807 and advocated for sales of lawful commodities such as palm oil and cotton by creating an in-house establishment to enforce these markets (Ojo, 2008).

Major missionary activities did not develop until the 1840s. Nigeria's first missions were called the Church of England's Missionary Society (CMS). Other protestant missions from Britain, Canada, and the USA also opened missions. In the 1860s, the Roman Catholic religious orders created missions.

The catholic missionaries were active among the Igbos in the eastern region, and CMS was popular with the Yoruba in the western region. Christianity spread rapidly at the community level from 1860, mainly due to the mission's education system.

Colonial administration encouraged Christianity in the south as part of the requirement to 'civilise' Africa. However, due to Hausa-Fulani leaders insisting on remaining in the north, the British banned Christian missionaries from converting the northerners. This made Western education focus more on the southern part of Nigeria. In addition, the British favour towards Muslims and the Hausa-Fulani ethnic group led to massive movement into the middle belt and widespread conversion to Islam in the north (Hains, 2013).

The British Prime minister in 1851, Lord Palmerston, hated slavery. However, he used local politics, missionaries, and the plot of British consul John Beecroft to ensure the regime's fall. In 1851, King Akintoye, who was removed from power, sought help from the British to return to the throne. Beecroft consented on the condition that the slave trade was eliminated, and in return, British traders had the autonomy of the export commodities. Therefore, the Royal Navy attacked Lagos in November 1851, removed Oba Kosoko, who supported slavery, and created a treaty with the newly crowned Oba Akintoye.

Lagos was conquered as a 'crown colony' in 1861 via the Lagos treaty expansion (Giles, 1977). The growth of the British increased in sales in the last decades of the 19th century. Captain John Glover (the colony's administrator) created a 'militia of Hausa troops' in 1861. The troops became the Lagos Constabulary and later the Niger police force (Asiegbu, 1984).

Lugard implemented a policy of ‘indirect rule’ through the traditional government. These authorities collected taxes and undertook local management tasks. In the North, Lugard worked with the Fulani ruling class, and they used the British to withhold their powers and accumulated wealth. Because these rulers were no longer responsible, corruption and poverty increased (Adiele, 1991).

However, Lugard’s successor from 1919-1925, Sir Hugh Clifford, argued that the colonial government's responsibility was to urgently introduce Western experiences. Clifford opposed the degree of authority imposed on traditional rulers under indirect rule. He concluded that the extension of judicial power to Northern emirs was not logical as their background and culture would not warrant success (Chapin, 1991).

After the Second World War, the British started to consider that colonialism was not feasible in Nigeria. The Lyttleton constitution connected a federal system with three states governed indirectly under a central control system and major ethnic groups. The borders were not meant to divide ethnicity. However, as the British never emphasised promoting unity, colonialism left the people disunited (Adiele, 1991).

Also, lack of access to colonial resources, which was dependent on the strength of ethnic groups, led to competition. For example, there was education, economic growth, urbanisation, and increased skill. There was also a rise in Christianity in the south through missionaries. Although there were few Muslims and indigenous religions’ resident. On the other hand, there was extensive agricultural production in the north with less access to Western education and increased poverty (Adiele, 1991).

Nigeria became an independent country within the Commonwealth on October 1, 1960. The first republic president, the Nnamdi Azikiwe regime ended after the military took

over by coup. One of the major events in the 1960s was the proclamation of independence in the Eastern region (Biafran war) in 1967, resulting in a 30-month civil war (see below for details).

1.2.2 The Nigerian civil war

Nigeria surrendered to military rule after the first military coup on 15 January 1966, which led to the end of civil rule. The coup was organised by Major C.K. Nzeogwu, who accused the civil rule under Balewa of corruption, poor guidance, ethnic rivalry, and favouritism. The coup took the lives of many military and civilian leaders such as Alhaji Tafawa Balewa, Alhaji Ahmadu Bello, Brigadier Zak Maimalari, and Lt. Col. Abogo Largema, and many others (Aremu and Buhari, 2017).

Major general Aguiyi Ironsi was declared the military ruler after the military coup on 15 January 1966. He misjudged the stabilisation policy, which led to the change from federalism with a unitary system of government. He created Decree No 34 of 24 May 1966, which was to abolish the regional structure of the civil service to create a unified national public service. This created anger from the north and great opposition because they feared marginalisation.

There was increasing tension among northern officers who felt they wanted revenge for an Igbo coup (Achebe, 2012), and that their ethnicity was not being fully represented. The northern press did not help matters as they continued to cite grievances against Ironsi's government. The media in the north continued to campaign against the unitary system of government and continued to be verbally aggressive to the south (Olukotun, 2002).

The northern leaders and the press finally agreed to public sentiment by agreeing to the unitary system of government. However, by the end of May 1966, the north became convinced that the Jan 1966 coup was motivated by Igbo tribes trying to dominate the country (Elaigwu, 2005; Abubakar, 2002; Ikime, 2002). These allegations resulted in violent demonstrations, crises, violence, and killings of Igbo people in the north.

The north continued to challenge the Ironsi government by cancelling Decree 34 of 1966 and asking for a unitary system of government, the punishment of the masterminds of the 15 January 1966 coup, and adjournment of the investigation into the massacre of easterners in the north (Achebe, 2012). The failure of General Ironsi to fulfil the stated requests led to a countercoup on 29 July 1966 initiated by the northern military officers. This was a vengeance coup against the Igbos. Over thirty thousand civilian Igbo men, women, and children were killed in the north, and their properties were looted and burned (Abubakar, 2002). The inability of the government to address the attacks against the Igbos made the Igbo elite regard it as a planned attempt to eradicate their ethnic group. This led to mass movement of Igbo residents in the north back to their regions for safety (Aremu and Buhari, 2017).

After the coup attempt on 29 July 1966 and the murder of general Ironsi, Lt Col Yakubu Gowon was appointed the leader, and Chukwuemeka Odumegwu Ojukwu was denied rule even though Ojukwu claimed that General Gowon was his junior (Aremu and Buhari, 2017). The succession of Gen Gowon above his superiors created control problems and challenged the military succession in the Nigerian Armed forces (Onyeoziri, 2002; Onumonu and Anutanwa, 2017). General Ojokwu declined all association and meetings under Gowon's leadership and said his security could not be guaranteed anywhere but in the eastern region (Ojukwu, 1969).

Attempts were made to mediate peace between the two generals in December 1966 with an agreement document called the 'Aburi Accord.' The terms of the agreement were that the army should be ruled by the Supreme Military Council (SMC) under the head of state. Also, military headquarters were to be established in each region headed by the chief of staff, creating an area command in each region to be led by an area commander. Furthermore, the SMC was to deal with all appointments and promotion of executive officers in the armed forces, and police and military governors were to be given command of their regions for the purpose of internal security (Elaigwu, 2005; Oluleye, 1985; Obasanjo, 1980; Aremu, 2014).

It was seen as progress for Gen Ojukwu. However, the federal government did not implement the agreement, which subsequently resulted in the crash of the accord (Aremu, 2014). As a result, lieutenant Col Yakubu Gowon declared the creation of twelve states, thereby repealing the proposed regional political structure. The northern region was divided into six states, the eastern region into three states, and the western region into two states, while the mid-western region became the mid-western state (Elaigwu, 2005).

Lt Col Ojukwu rejected the proposed new states stating that the states were created without his consent. Ojukwu saw that as an act of war against the Igbo tribe. Ojukwu summoned an Eastern Region Consultative Assembly on 27 May 1967. The assembly authorised him 'to declare at the earliest practicable date, eastern Nigeria a free, sovereign and independent state by the name and title of the Republic of Biafra' (Achebe, 2012, p10). On 30, May 1967, Ojukwu cited many malicious acts targeted at the Igbos, he declared independence from Nigeria to be called the 'Republic of Biafra.' (Achebe, 2012). The attempted withdrawal of the eastern region from Nigeria, and the insistence of Gowon to stop the endeavour, led to a full-blown war on 6 July 1967 (Aremu and

Buhari, 2017). Thus, the Nigerian civil war happened from 6 July 1967 to 15 January 1970.

1.2.3 The losses of the civil war

The Nigerian civil war was one of the cruellest wars in sub-Saharan Africa (Akresh et al., 2012; Okafor, 2012). It was described as the 'first black-on-black genocide in postcolonial Africa' (Aremu and Buhari, 2017, p 68) because many casualties were easterners. At the end of the civil war in 1970, it was estimated that about one to three million Nigerians died of hostilities, starvation, and disease, and over three million became refugees and internally displaced persons. These numbers include children, women, pregnant women, and nursing mothers who did not die from bullets but starvation and disease. This also includes soldiers who died in battle (Uzokwe, 2003). The war also led to the destruction of properties and disruption of livelihood of countless individuals, making them insolvent for the rest of their lives. The total estimated loss as a result of the war was about three hundred million naira (Aremu and Buhari, 2017).

In January 1970, the Biafran resistance was dismantled, and the federal government of Nigeria took back control. On 12 January 1970, the then military ruler General Yakubu Gowon made his famous announcement of 'no victor, no vanquished' (Aremu and Buhari, 2017). Amnesty was granted to those who fought on the Biafran side, and the post-war programme of reconciliation, rehabilitation, and reconstruction (3Rs) was created by the federal government of Nigeria (Tedheke, 2007).

The programme was designed to pacify the conflict between the country's ethnic groups, reinstate facilities and homes damaged in battle, move internally displaced persons, and fight the socio-economic challenges of poverty, disease, and malnutrition of victims of

the war (Aremu and Buhari, 2017; Falola and Genova, 2009; Tedheke, 2007; Thomas, 2015).

There were several criticisms directed towards the programme and the federal government of Nigeria. They were accused of deception and non-effective implementation of the scheme, which made Igbos become sentimental and lack trust in the government's ability (Afinotan and Ojakorotu, 2014). The war greatly affected the socio-psychological impact on ethnic relations, socio-infrastructural and economic development. For example, the government 'reconstruction' showed the culture of waste of resources due to poor allocation and corruption (Aremu and Buhari, 2017). Also, the worst part of the post-war policy of the 3Rs was that the scheme was executed from funds that were supposed to be used for the second National Development plan (1970-1978). Even the oil boom experienced in 1973 was used for rebuilding old and decaying buildings destroyed by war (Aremu and Buhari, 2017).

It is not surprising that corruption and poor leadership did not allow the designated funds to reach the desired projects. This confirms Ojeleye's (2010; p 10) statement that 'civil wars destroy the structures needed for society; such wars divert much-needed available resources away from development projects.'

Unfortunately, the civil war did not answer the 'national question' (Aremu and Buhari, 2017). This means that claims by various ethnic groups or individuals were rejected for their right to equal involvement in government and life (Oriaku, 2002). Also, even after the civil war, ethnic gaps became prominent in the appointment, posting, and promotion of military officers (Aremu and Buhari, 2017). However, a significant advantage of the

aftermath of the civil war was that it brought back the unity of Nigeria and helped protect the territorial unification of the nation (Aremu and Buhari, 2017).

1.2.4 Nigeria as a Federal Republic

Nigeria became a republic again after a new constitution was created in 1979. However, the republic was temporarily shut down when the military took over in 1983. The army continued to rule until 1993, when a new federal republic was meant to be created. This was terminated again by Gen Sani Abacha. Abacha died in 1998, and a fourth republic was built in 1999. This ended three decades of sporadic military rule (Falola and Heaton, 2008). The nation's leadership was before 1999, ascertained by coup and military rule and not by civil rule. The country returned to democracy and civil rule in February 1999 and is still in power to date (United States AID, 2018).

Chief Olusegun Obasanjo became the first civilian president in the fourth republic from 29 May 1999 to 29 May 2007 under the People's Democratic Party. Alhaji Umaru Musa Yar'Adua was elected to office under the People's Democratic Party on 29 May 2007 and died in office on 5 May 2010. Dr Goodluck Johnathan, the then deputy vice president, was elected to office on 5 May 2010 until 29 May 2015. The current president is Muhammadu Buhari, elected to office on 29 May 2015 under the All-Progressive Congress party (Falola & Heaton, 2008). He secured a second term in the 2019 presidential elections (World Bank, 2020).

1.3 Overview of Nigeria

Nigeria is bordered on the west by the Republic of Benin, east by the Republic of Cameron, and north by Niger and Chad (Falola & Heaton, 2008). The federal republic of Nigeria has an area of 923,769 square kilometres, of which 909,890 square kilometres

are land area and 13,879 square kilometres are water area. The longest distance from east to west is approximately 1,127 km, and north to south is 1,046km (Ajayi et al., 2020; National Bureau of Statistics- Annual Abstract, 2017).

The geographic features are Adamawa highlands, Mambila Plateau, Jos Plateau, Ombud Plateau, the Niger River, and River Benue. The Niger Delta region is oil-rich and provides the primary source of mineral resources in Nigeria (National Bureau of Statistics-Annual Abstract, 2019; NBS Social statistics report, 2017).

There are three types of vegetation in Nigeria: the first is the forest with a massive amount of tree cover, the second is the savannah, which comprises grasses and flowers with little tree cover, and the third is montane land (this is the least common located mainly in the mountains near the Cameroon border). Nigeria has a tropical climate and damp environment with a temperature usually above 18 degrees (National Bureau of Statistics-Annual Abstract, 2019).

In the southern region, the rainy season is usually from March-November, while in the far north, the season lasts from the middle of May to September. There is usually a significant interruption in the rainy season in August in the southern region. There is also a short dry season called ‘August break’. Precipitation is heavier in the south, especially in the south-east, followed by the south-west, while the far north receives less rainfall.

The temperature and humidity are consistent throughout the year in the southern region. However, in the northern region, the seasons differ (Ajayi et al., 2020). The humidity is generally high in the north but falls during the harmattan season (a very dusty hot and dry easterly or north-easterly wind). The wind blows for more than three months in the north,

usually from December to February (Ajayi et al., 2020; Wylie, 2012; NBS Annual Abstracts of Statistics,2017; 2012; United States AID, 2018).

Nigeria has an estimated population of about 202,041,733 as of September 16, 2019 (World Bank, 2020; NBS National Population Estimates, 2016). The population is equivalent to 2.61% of the world population (United Nations Department of Economic and Social Affairs, 2019) and 20% of the total population of sub-Saharan Africa (National Bureau of Statistics, 2017; NBS National Population Estimates, 2016). However, due to political reasons, there have been several discrepancies with the census results thereby doubting the accuracy of the population figures (NBS, Annual Abstract of Statistics, 2019; 2017). According to the National Population Commission (2019), the annual growth rate has been 2.8% since 2013, of which 49.4% of the population are females. Forty-four percent of the population are the youngest aged 0-14 years, 15-64 years (54%), and 65 and above amount to only 3%. In addition, about three quarter of the population are younger than thirty (NBS, Annual Abstract of Statistics, 2019; 2017).

The United Nations Department of Economic and Social Affairs (2019) predicts that by 2050, Nigeria will become the third most populous country in the world. Nigeria's urban population has an average annual growth rate of over 6.5% without any corresponding increase in social amenities (National Population Commission and ICF, 2019). The life expectancy is 59.3 years (NPC and ICF, 2019). Infant mortality has declined since the mid-20th century, and life expectancy has gradually increased with population growth (NBS-National Population Estimates, 2016; Ajayi et al., 2020).

There are 36 states in the country divided into six geopolitical zones: the north-west zone, south-west zone, south-south zone, north-central zone, north-east zone, and south-east

zone. The zones were created for political purposes to reflect the federal characters when allocating appointments (NBS Annual Abstracts of Statistics, 2017; 2012; NBS National Population Estimates, 2016).

There are about 250 ethnic groups. The most populous ethnic groups are Hausa (20.4%), Fulani (17.6%), Yoruba (18%), Igbo (12.3%), Ibibio (2.8%), Ijaw (2%), Kanuri (4.7%), Tiv (2.2%) and others (23%) (Falola and Heaton, 2008). However, the three main ethnic groups are Hausa-Fulani, Yoruba, and Igbo (Ajayi et al., 2020).

The Hausa ethnic group is one of the major groups in the country. The Hausa group was integrated with the Fulani group when the Hausa group conquered the Fulani group in the early 19th century (Ajayi et al., 2020). Another major group is the Yoruba of south-west Nigeria. Ile-Ife is the ancestral home. Each Yoruba sub-group is governed by a chief or 'Oba.' The third ethnic group is Igbo. The Igbo of the southeast region of Nigeria has the largest political unit in the villages and is governed by a council of elders, who are chosen by merit and not inheritance (Ajayi et al., 2020).

Other ethnic groups are the Ibibio, who reside close to the Igbos and share ethnic characteristics with the Edo people. The Edo people created the prominent pre-colonial kingdom of Benin. In the middle belt or central region, there are about 1,800 ethnic groups, with the 'Tiv' and Nupe being the majority (Ajayi et al., 2020). Everyone in each ethnic group has the right to occupancy and inheritance. However, people who are not a member of a particular ethnic group but moved to live or work are sometimes considered to be outsiders (Ajayi et al., 2020).

There are over 500 indigenous languages spoken in Nigeria across different regions, and many of these languages are in written forms (Ajayi et al., 2020). Although English is the

official language of Nigeria, Hausa was an official language of the northern states from 1951 to 1967. It is still the most widely spoken language in the northern region.

Pidgin English language is also widely spoken. Nigerian pidgin is an English-based 'creole language' spoken widely across the country. It is sometimes referred to as 'pijin' or 'Broken'. The origin dates to trading between the British and the local population in the 17th century. Pidgin English is spoken across cities and states in the country.

Pidgin English was originally spoken mainly by the people without formal educational qualification, while the educated held negative attitudes towards the language speakers. However, in recent times Pidgin English has been spoken widely by both the educated and people without formal educational qualification. This had made Nigerians identify as more 'Nigerian.' Nigerian Pidgin English is popular among young Nigerians, writers, politicians, and musicians. The language is unique because it acts as an identity to Nigerians regardless of ethnicity, as the language is not specific to any ethnic group (Goglia, no date).

The major religious groups are Christianity (40%), Islam (50%), and traditional religion (10%) (NBS Nigeria Living Standards Survey, 2020; NBS-Annual Abstracts, 2017). In the 20th century, most Nigerians were traditional worshippers. However, British colonial policies discouraged this practice. By Nigerian's independence in 1960, most Nigerians were classed as Muslims or Christians.

In the 21st Century, about half of Nigerians are Muslims (50%), just a little more than Christians (40%), and very few were traditionalists (10%). However, even after professing Islam and Christianity, some still perform rituals and traditional rites. The largest population of Muslims is located in the northern states. There is also a significant

Muslim population in some of the states in the southern region. At the same time, the largest concentration of Christians is found in the eastern states (Ajayi et al., 2020).

Before the 20th century, tribes such as Yoruba, Hausa, Edo, and Kanuri were town dwellers. The Yoruba tribes were described as the most urbanised people in Africa (Kirk et al., 2003). The towns in the northern region of Nigeria were mainly administrative and trading centres in the northern region of Kano, Zaria, and Katsina. These towns were remote than Yoruba towns. However, due to trans-Saharan trade and agriculture, these towns grew into big cities.

Lagos state located in the southwest region, is a global city of islands and the mainland. The town was formerly the capital of Nigeria and is the biggest city in the country. The state was founded before the 15th century. The city was proclaimed a British colony in 1861. By the 21st century, the population had increased to over eight million. However, Abuja is the current official capital city centre of Nigeria. However, the state was declared the official capital in 1991. Even though some government offices are in Lagos, the decision to move the capital began in the mid-1970s, and implementation began in the 1980s (Ajayi et al., 2020).

Nigeria has natural resources such as natural gas, crude oil, tin, iron ore, coal, limestone, niobium, lead, zinc, and arable land. However, oil resources are the primary source of income to the country, but this growth has been hindered due to the instability in the Niger Delta region. In addition, the nation has just four refineries with low capacities that are highly insufficient to cater to the country's needs (NBS Nigeria Living standards survey, 2020; NBS-Annual Abstracts, 2019; 2017).

Crude oil amounts to over 80% of exports which is a third of the banking sector and half of the government revenues (NBS- Premium Motor Spirit Report, 2021; World Bank, 2020). Other domestic exports are minerals, agricultural, and manufactured products (NBS Nigeria Living standards survey, 2020; NBS Annual Abstracts of Statistics, 2017). The current decline in oil prices has harmed the economy (World Bank, 2020). In 2015, the oil price fell, and the country experienced its first recession in 25 years.

Currently, the excess crude account is exhausted and external resources depend majorly on short-term funds, which significantly impacts investors' confidence (World Bank, 2020). As a result, despite Nigeria's significant socio-economic development improvements, its human capital development is still weak due to low investment (World Bank, 2020). Thus, Nigeria continues to face developmental challenges due to dependency on oil and the non-diversity of the economy (World Bank, 2020; NBS Poverty and Inequity in Nigeria, 2019).

The gas sector is the seventh largest reserve in the world and the largest in Africa. However, one-third of the production is consumed locally, and 75% is consumed for power generation. There is a continuous lack of adequate infrastructure to produce and market natural gas resulting in a loss of income of about $2 billion (NBS- Liquified Petroleum Gas, 2021; NBS Annual Abstracts of Statistics, 2019; 2017; 2012; Barbour, 1982; Chute et al., 2014; NBS Social Statistics Report, 2017; 2016). For example, in 2016/2017, about 3.8% used charcoal as a source of cooking energy, while 45.5% used firewood, 3.1% used gas, 46% used kerosene, and 0.4% used generators (NBS- Annual Abstracts of Statistics, 2017).

The mining sector accounts for about 0.3% of the country's GDP (chute et al., 2014). The industry is underdeveloped, and the country manufactures materials that it can produce locally, such as iron ore. One of the sector's significant challenges is the prevalence of illegal mining activities (NBS- Mineral Production Statistics, 2021; NBS- Annual Abstracts of Statistics, 2017; Chet et al., 2014).

The power sector has a production limit of 0.13 billion kilowatts, and only 40% of the population has access to power. This led to the privatisation of the sector and the sale of government plants. The current power supply infrastructure is currently insufficient to meet the needs of the population. Because of these shortages, commercial and industrial sectors rely on diesel generators to generate electricity (NBS Nigeria Living standards survey, 2020; Social Statistics, 2020; NBS Annual Abstracts of Statistics, 2017; 2012).

For example, about 60% of households have an average of 35 hours of electricity per week (NBS Nigeria Living standards survey, 2020). During a blackout in year 2018/2019, 0.7% used firewood as a source of lighting, 37.7% used kerosene, 22.3% used rechargeable lamps, 23.1% used generators, 2.5% used candles, and 13.6% used batteries. The sources of electricity were 81.9% from Power Holding Company, 3% from Rural electrification, 0.9% from a private generator, 13.3% from PHCN and generator, and 0.8% from rural electrification and generator (NBS Nigeria Living standards survey, 2020; NBS Annual Abstracts of Statistics, 2019; 2017).

Some environmental hazards experienced in Nigeria are degradation, rapid deforestation, and water pollution. Over the years severe damage has been caused to air, water, and soil in the Niger Delta region. Oil spills in the region have led to land loss, water pollution, the killing of fish, and rapid urbanisation (NBS Nigeria Living standards survey, 2020;

NBS-Social Statistics, 2020; Mba, 2017; NBS Annual Abstracts of Statistics 2019; 2017; NBS Demographic Statistics Bulletin, 2017).

According to the current edition, which presents data over five years by the National Bureau of Statistics (2019); the public expenditure on health care is low, accounting for 1.7% of the total GDP. About 49.9% of under-fives year birth are registered. The infant mortality is 70 per one thousand while the under-five mortality is 120 per one thousand (NBS Nigeria Living standards survey, 2020; NBS Annual Abstracts of Statistics, 2019; 2017). Thus, the infant mortality rate is ninety-seven per one thousand live births and under-five mortality rates of one hundred and fifty-eight per one thousand live births (NBS Nigeria Living standards survey, 2020; NBS Social Statistics Report, 2020; 2017; 2016).

The fertility rate is 5.8 per one thousand women, while the adolescent birth rate is 120 births per one thousand women. The adolescent fertility rate is higher in rural areas (120) as against urban areas (35). The percentage of early marriages is 44.1%, while polygamy is 36.9% (NBS Nigeria Living standards survey, 2020; NBS Statistical Report on women and men in Nigeria, 2020; 2018; NBS Annual Abstracts of Statistics, 2017). In contraception use for women aged 20-49 years, 16.2% used modern methods, and 8.4% used traditional methods. For women aged 15-19 years, 2.2% used modern methods while 1.4% used traditional methods. In 2016, about 49.5% of Nigerians had access to insecticide-treated nets (NBS Statistical Report on women and men in Nigeria, 2020; 2018; NBS Annual Abstracts of Statistics, 2017).

Part of health care provision to Nigerians was the creation of the National Health Insurance Scheme (NHIS). The scheme was created in 2004 under the NHIS Act, cap 42.

The scheme aims to provide access to affordable and universal coverage of health care services (NBS- Social Statistics, 2020; Lawani, Ilimas, and Daso, 2012).

Unfortunately, less than 5% of Nigerians have access to healthcare services under the scheme. Major users of the scheme are federal and state government staff neglecting other population groups, especially vulnerable and rural populations (Mohammed, 2017; Olukoya, 2017; Ilesanmi and Ige, 2013). This means that less than seven million people are covered in the scheme (NBS Nigeria living standards survey, 2020; Popoola, 2017; Onwujekwe et al., 2010), with United Nations Children's Fund (UNICEF) scoring Nigeria with the highest rate of under-five and maternal mortality in the world (UNICEF, 2021).

The educational system comprises six years of primary school, three years of junior secondary school, three years of senior secondary school, and four years of university education. The federal government expenditure on education is 5% of the total GDP. The adult literacy rate is 60%. Primary school enrolment amounts to 63% and secondary school enrolment is just 26%. This means that a low number of pupils proceed to secondary schools while tertiary enrolment is just 10% (NBS Nigeria Living standards survey, 2020; NBS Annual Abstracts of Statistics, 2017; Falola & Heaton, 2008). About 25% of youths aged 15-24 years have no formal education, i.e., they have not completed primary education in Nigeria (NBS Nigeria Living standards survey, 2020; Mezger, 2016; NBS Social Statistics Report, 2020; 2017; 2016).

Data collected by NBS using the harmonised Nigerian living standard survey (2020) to ascertain poverty and inequality trends in households in Nigeria showed that poverty has increased with over 100 million Nigerians living on less than 1 dollar a day, 60.9% living in absolute poverty, and income inequality worsened from 43% to 49% from 2019. The

human development index rose from 0.454 to 0.505 between 2005 and 2019 (United Nations Development Report, 2020), but the poverty rate is still 46% (NBS Poverty and Inequity in Nigeria, 2019; NBS Inequity Snapshot, 2016; Chukwu, 2017; Garuba, 2006).

Data on socio-economic indicators of households in Nigeria using the General Households survey (GHS-Panel) and Multiple indicator cluster surveys (MICS 5) showed that the quality of building materials is substandard. This is because 30.4% used mud while15.2% used concrete (NBS Nigeria Living standards survey, 2020; NBS- Social Statistics, 2020; NBS Multiple Indicator Cluster Survey, 2017; NBS inequality snapshot, 2016). Rent is higher in urban city centres and a bit cheaper in less urban and rural areas. However, due to unemployment, poverty, and low income, areas that appear less expensive are still not affordable to an average Nigerian (NBS- Social Statistics, 2020; Campbell, 2019).

There was a major problem of unemployment and underemployment. A quarterly report on unemployment and underemployment in Nigeria by the National Bureau of Statistics (2020) showed that economically active populations aged 15-64 years who diligently seek work in quarter 4 of 2020 were about 69.67 million i.e.., 13.22% less than in quarter 2 of 2020. About 20.9 million (28.8%) out of those who diligently seek work aged 25-34 were unemployed. According to the NBS labour force report, the current unemployment and underemployment rates is 56.1% (NBS- Labour Force Statistics Report, 2020b).

The total number in employment in quarter 4 (2020) was 46.48 million, out of which 30.57 million were full-time workers (40+ hours per week) while 15.91 million were under-employed (20-29 hours per week). This is 20.6% less in quarter 2 of year 2020. In quarter four of 2020, the unemployment rate among youths aged 15-34 years was 42.5%,

up from 34.9%. The current unemployment rate is about 33.3% which is an increase from the previous percentage of 27.1% in 2020 (NBS Labour force Statistics, 2020a; 2020b; 2018).

Therefore, unemployment has led to youths being unproductive, which has a direct impact on the economy. This has led to the loss of goods and services and no tax payment, making the labour force unproductive (NBS-Social Statistics, 2020). It has also led to an increase in crime and violence among youths. There is also a significant gap between the rich and the poor. The resultant effect of idleness has led to poverty, making youths desperate therefore resorting to criminal activities (NBS Labour Force Statistics, 2020a; Adetoro and Fadayomi, 2012).

The transport systems in Nigeria are road, railway, air, and water transport. There is no proper research on transport costs in Nigeria (Agbigbe, 2016). Nigeria has the largest road network in West Africa and the second largest in sub-Saharan Africa (NBS- Annual Abstracts, 2017). The primary mode of transport is by road (NBS Road Transport Data, 2020; NBS Annual Abstracts of Statistics, 2019; 2017; NBS Demographic Statistics Bulletin, 2017) because it is more accessible and cheaper (NBS- Transport Fare Watch, 2021). For example, the Lagos state government set up a bus system called Bus Rapid Transit (BRT). It was estimated that the bus system would transport about 10,000 passengers in each direction (Igwe et al., 2013). An estimate of transport demand in Lagos showed that about 22 million passengers used road transport daily. About 95% used private cars, buses, and taxis, of which 80% used public transportation (NBS- Road Transport Data, 2021; Kayode et al., 2013).

Road transport costs depend on distance, road condition, terrain, and type of vehicle used (NBS- Transport Fare Watch, 2021; Ali et al., 2015). Unfortunately, road transport in Nigeria has been in a deplorable state for years, even though the federal government spends a considerable amount on repairs and rehabilitation. The sector is still in need of serious attention (Kayode et al., 2013). Most roads are damaged, poorly maintained, and prone to accidents, leading to fear of traveling by road (NBS Road transport data, 2020). According to the Federal Road Safety Corporation annual report (2019), an average of fifteen people were killed by road accidents daily in Nigeria. The corporation also stated that Nigeria is rated 191 of 192 countries globally with unsafe roads with 162 death rates per 100,000.

Rail transport is operated by Nigerian Railway Corporation (NRC) and has 3,984km of track. The government has made recent efforts to upgrade the railways after long neglect. Unfortunately, this had yielded unfavourable outcomes. For example, even after the recent rehabilitation of the Lagos-Kano rail tracks, the trains still experience many breakdowns. Studies have found that some trains were used only for short trips excursions, and transits by peasants and rural traders. However, the government is still creating more rail projects across the country (NBS Rail Transport Data, 2021; Misseriya, 2016). As a result, the federal government is trying to privatise the Nigerian Railway Corporation (NBS Rail Transport Data, 2021; Falola & Heaton, 2008; NBS Annual Abstracts of Statistics, 2017).

Air transport is the movement of passengers and cargo by aircraft and helicopters. This mode of transport is operated by the Federal Airport Authority of Nigeria (FAAN). The agency (FAAN) represents both local and international flights to both passenger and cargo airlines.

Finally, water transport is the movement of passengers or cargo on water. Nigerian Ports Authority is the agency that manages the operations of seaports in Nigeria. For example, the Tin Can Island Lagos is responsible for about 5.75 million tonnes of cargo each year (NBS Annual Abstracts of statistics, 2019; 2017; NBS Social statistics report, 2020; 2017; 2016).

One of the fastest-growing sectors in Nigeria is the telecommunications sector (NBS Annual Abstracts of Statistics, 2019; 2017). The Nigerian Postal Service (NIPOST) is a government-owned agency responsible for postal services in Nigeria. The agency was established in 1852 by the colonial administration (NBS Annual Abstracts of Statistics, 2019; 2017).

Growth in the telecommunication sector has brought an increase in both government-owned and private radio stations. The Nigerian Television Authority (NTA) is one of the biggest TV companies in Nigeria, with about 70 federal stations across the states and many private TV stations (NBS Annual Abstracts of Statistics, 2019). The cellular market started in 1992. Nigeria has about 150 million mobile subscribers (NBS Nigeria Living Standards Survey, 2020; NBS Annual Abstracts of Statistics, 2019).

Nigeria's information and communication technology (ICT) has grown over the years but not as expected compared to developed countries. The Bureau stated that some of the hindrances to ICT development include poverty as most Nigerians live on less than a dollar a day (NBS Annuals of Statistics, 2017), resulting in the inability to afford luxuries of ICT. Other hindrances include illiteracy, high import duties, etc., (NBS Nigeria Living Standards Survey, 2020).

Nigeria has continued to encounter security challenges since it gained independence in 1960. The dimensions of insecurity in Nigeria span economic, social, political, and religious reasons. These dimensions also include militancy, kidnapping, armed robbery, political thuggery, and tribal or ethnic crisis (NBS Annual Abstracts of Statistics, 2019; 2017; NBS Social Statistics Report, 2020; 2017).

One of the significant insecurity challenges facing the nation since 2002 is the emergence of the Boko Haram insurgency in the north-eastern region of Nigeria. This has resulted in continuous attacks on civilians, destruction of properties, kidnapping, and displacement of victims from their locations to become internally displaced persons in other states in the country (NBS Social Statistics Report, 2020; Jackson, 2007).

The Boko Haram group is a controversial militant Islamic sect set to impose Sharia law or its radical beliefs on the northern states in Nigeria. ‘Boko’ in Hausa means ‘Western education.’ In contrast, ‘Haram’ means ‘sin’ or ‘forbidden.’ According to Walker (2012), the Islamic sect believes that Muslims should not participate in any Western or secular activities regarded as forbidden. As a result, the group has succeeded in creating insecurity in many areas of the northern regions of Nigeria (Adofu and Alhassan, 2018).

Nwagboso (2012) described the group's activities to include but not be limited to suicide bombings, gunshots, and kidnappings which have destroyed the economic and social movements in the region. It has also made it unsafe for investment activities. This has led to an increase in internally displaced persons moving to other parts of the country for safety (Adofu and Alhassan, 2018).

In 2010, about seven hundred people were killed by Boko Haram insurgents, with one hundred and five Boko Haram prisoners escaping prison, including two churches burnt

(Adesoji, 2010). In 2011, United Nations headquarters was bombed with twenty-three dead and over one hundred injured (The Guardian, 2012; Peace and Security Council, 2012). In 2012, over one thousand nine hundred people were killed using a combination of car bombs, suicide bombs, and improvised explosive devices (IEDs) (Blair, 2012; Oboh, 2012). In 2013, a state of emergency was declared in three states in the northeast region, Adamawa, Borno, and Yobe state, with about six hundred and fifty thousand people displaced (Human Rights Watch, 2015).

In the year 2014, about seventeen people had been killed in a car bombing. Two hundred and seventy-six schoolgirls were kidnapped from Chibok, and fifty escaped (United States Department of State, 2013; Fox News, 2014). Remote towns of Gwoza, Bama, and Mubi were attacked and held hostage (British Broadcasting Corporation, 2014; Vanguard, 2014). The military later recaptured the town of Mubi with the help of vigilantes. However, as of 16 November 2014, over twenty towns and villages were taken over by the militants (BBC News, 2014; The Telegraph, 2014). Several people were killed, e.g., one hundred and twenty people died in an attack on the central mosque in Kano, and fifty people were killed with over one hundred women and children kidnapped.

In 2015, militants attacked the towns of Baga and Monguno but were later recaptured by the military. The media put the death toll in Baga to 2,000 (BBC, 2014). Suicide bombs killed three hundred people in Pakiskum and Kano. Over one hundred women and children were kidnapped in Damasak. Militant camps in the Sambisa Forest were destroyed, and three hundred women were rescued (BBC News, 2015). Over forty-eight men were killed, and seventeen boys were injured in the Kukawa massacre. There were several cases of bombings and killings using suicide bombings and shootings.

In 2016, eighty-six people were killed and sixty-two injured in a village in Dalori. United Nations estimated that Boko Haram militants killed over two hundred and forty-four people by the second quarter year 2016 (Allen, 2016). In 2017, UNICEF reported an increase in child suicide bombers with about 27 incidents in the previous three months of 2017 compared to 30 in 2016, 56 in 2015, and 5 in 2014 (Taft and Lawrence, 2016).

In 2018, about 110 schoolgirls from Government Technical College Dapche Yobe state were kidnapped, five were killed, and the remaining were released on 21 March 2018 after a hefty ransom was paid (Adebayo, 2018; Premium Times, 2018; February 23). In addition, the army killed militants in Gamara village and rescued four men, thirty-five women, and sixteen children (Premium Times, 2018; May 18). Finally, militants launched attacks in Baga town and seized military forces and operations two months before the presidential elections (The Guardian, 2018).

In year 2019, several army officers had been killed and injured (Gulf times, 2018). There were also several cases of civilians being massacred and bombings in Maiduguri. In 2020, there were several cases of bombings and killings of civilians, internally displaced persons, and soldiers in several villages in Borno state (France 24, 2020). In addition, over three hundred students were kidnapped from Government Science Secondary School in Kankara Katsina state (Associated Press, 2020). Alongside the killing of villagers, a church was burnt, and a priest was abducted in Pemi village, Borno state (BBC News, 2020). Finally, forty loggers were kidnapped and three killed in Gamberu town (The Guardian, 2020). At the moment, there are still rising cases of killings and abductions of villagers, school children, students, and the general public (Akinwotu, 2021).

Studies have shown that the emergence of the Boko Haram terrorist organisation is due to political and socio-economic circumstances of the region with issues such as economic disparity, poverty, unemployment, corruption in all levels of government, and dominance of Islamic law (NBS Social Statistics, 2020; Amusan and Ejoke, 2017; Human Rights Watch, 2013). These terrorist activities can be very traumatic to victims impacting negatively on their psychological and mental health. In addition, as shown above, some of their activities include killings, kidnappings, and this has short and long-term damage to the victims, families, communities, and society. Food Agriculture Organisation of UN (2018) also reports that food insecurity, in addition to insecurity challenges and displacements of people, has been strongly linked to activities of Boko Haram (NBS Poverty & Inequity in Nigeria, 2019; Akerele et al., 2013).

Another major dimension of insecurity in Nigeria is the underdevelopment of the Niger Delta region. The crisis started from a disagreement between representatives of Niger delta minority groups and multinational oil corporations. The majority of the residents in the Niger Delta region are fishermen, but due to pollution, most of their fish are dead. This has led to poverty and environmental pollution in the region (NBS- Nigeria Living Standards Survey, 2020; Afinotan and Ojakorotu, 2009).

Another significant agitation by the residents since the return to democracy in 1999 was the lack of resource control (Adofu and Alhassan, 2018). For example, the competition for oil wealth led to violence. In addition, the killing of Ken Saro-Wiwa (an activist) alongside nine Ogoni leaders during Abacha's military regime laid the foundation of insecurity in the region (Adofu and Alhassan, 2018). However, this disagreement resulted in ethnic and political unrest. In addition, the minority groups were agitated because they believed multinational companies such as Shell, Mobil, Chevron, Elf and Agip

(Maiangwa and Agbiboa, 2013) were exploiting their environment leading to environmental pollution making the region one of the most polluted regions in the world (NBS Nigeria Living Standards Survey, 2020; Osagie et al., 2010).

The Niger Delta region located in the south south region of Nigeria provides significant revenue through oil production. The Niger Delta region produces most of the oil used in the Nigerian economy (NBS Nigeria Living Standards Survey, 2020; Osagie et al., 2010). Thirteen percent of the federal government allocation goes to the region. Unfortunately, the region has one of the highest unemployment rates of over 40% with high-income disparity (World Bank, 2020). This has resulted in youths' agitation and the creation of militant groups, who have resorted to kidnappings due to injustice and discrimination (Ibaba, 2011).

Nwagboso (2012) agreed that the inability of the government to address the cause of the agitations, which were environmental pollution, poverty, unemployment, and lack of basic amenities, led to the creation of Niger Delta militants. The federal government attempted to address these problems by creating the Niger Delta Development Commission (NDDC) and the Oil Mineral Producing Areas Development Commission. Unfortunately, despite the creation of these agencies after the military regime, the security situation became worse.

This led to creation of more agitation groups like Niger Delta Vigilante (NDV) and Niger Delta people's Volunteer Force. In addition to these groups, more than a hundred smaller dissatisfied youths militants were fighting for their rights. A significant outcome was an increase in kidnapping by the militants. Therefore, the federal government under the

administration of President Umaru Yar'adua granted amnesty to the militants (Onifade, Imhonopi and Urim, 2013). However, insecurity is still prevalent in the region.

Another dimension is kidnapping as a result of unemployment. Kidnapping is the act of abducting a person and keeping them hostage to get a ransom for their release (Onifade, Imhonopi and Urim, 2013). The evil pattern began when the country returned to democracy in 1999, and due to spillage from the Niger Delta region, militants began to abduct people to gain ransom. This became economically attractive to unemployed youths. Some of the unemployed youths were used as political thugs in political elections. These thugs used the skills and guns given to them to engage in the business of kidnapping for personal gains (Adofu and Alhassan, 2018).

Nwagboso (2012) confirmed this when some apprehended kidnappers confessed that some politicians supplied guns to them to rig the elections. Unfortunately, the guns were not collected back, which the kidnappers subsequently used for personal gains. Although this menace began in the southern region, these criminals kept moving to other states to continue their evil crimes. Therefore, there is a rise in kidnapping cases in the country, and Nigerians are constantly afraid to move around as anyone could be a target (Adofu and Alhassan, 2018).

Recently, there has been an increase in abduction and kidnappings in Kaduna state. For example, in March 2021, shooters kidnapped three teachers from a primary school in Kaduna state. In December 2020, eight hundred secondary school students were abducted from a college. All of them were released except 39 students, primarily females. These kidnappings have created serious concerns about the rising cases of insecurity in northern Nigeria (BBC News Africa, 2021).

Religious conflict is another cause of insecurity. Since Nigeria's return to democracy in 1999, religious conflict has been prominent (NBS- Social Statistics, 2020; Adejoh, 2010). Some evident religious conflicts were the clash between Muslims and Christians in Kaduna over the proposed introduction of Islamic criminal law on February 21 and 22, 2001. The clash between Muslims and Christians in Tafawa Balewa Local Government area Bauchi happened from 19 June – 4th July 2001. Others were the religious clash in Kano over US-led military action on Afghanistan over asylum granted to Osama Bin Laden on 12 Oct 2001. Another conflict between Muslims and Christians in Kaduna happened on 22 November 2002 over a world beauty pageant and a newspaper publication referring to Prophet Mohammed (Adofu and Alhassan, 2018; Smith, 2006).

Nigeria has also had a long history of conflicts because of ethnic or religious reasons. The lack of unity among various ethnic groups resulted in ethnic conflicts and underdevelopment (Oyewole, 2013). There have also been reported cases of religious and ethnic clashes in the north-central region of Nigeria, which resulted in thousands of deaths and displacements (Kwaja, 2011). For example, the Human Rights Watch (2013) report stated that the sectarian violence in Plateau and Kaduna States in the north central regions had left over three thousand dead since 2010. At least 1,813 people have been killed from January 2018 across 17 states, with the death toll almost double in 2017 (Amnesty International, 2018).

Several reports all agreed that violence and clashes often present themselves as ethnic or religious clashes. However, these events can also be presented as political rivalries in connection with socio-economic inequalities (NBS Inequality snapshot in Nigeria, 2016; Akerele et al., 2013; Oyewole, 2013; Jackson, 2007; Idowu, 2013). Ali (2013) also agreed

that ethnic and civil clashes, youth militancy, kidnappings, and insecurity are caused by socio-economic dissatisfaction by Nigerians, especially among the youth population.

Corruption is another major challenge faced by the nation where the political class diverts funds for development and instead engages in embezzlement of public funds. Corruption has been described as a significant reason for the increase in poverty (NBS Corruption in Nigeria, 2019; McLoughlin and Bouchat, 2013).

1.4 Internal migration in Africa

Internal migration occurred in major parts of the continent due to disproportion and lack of clarity of the physical borders and land areas in the region. The central movement was being directed by the poor allocation of income-generating projects to urban centres. Most private and public investment projects were in the capital centres in most African countries (Oyeniyi, 2013; Adepoju, 2000).

The effects of internal migration in Africa are best understood in the contexts of colonialisation in the pre-colonial, colonial, and post-colonial eras.

In the pre-colonial era, people moved within Africa mainly due to the prevailing socio-political and ecological conditions, primarily due to civil riots, natural disasters, and the search for farmlands (Adepoju, 1998). However, these movements were not adequately structured and occurred in groups (Adepoju, 1979).

The colonial-era created a way for peace and stability. However, conflict arose with nations engaging in wars and a rise in refugees and internally displaced persons. For example, Ethiopia/ Somalia conflict, internal conflicts in Chad, Angola, Uganda, and Nigeria. This was including the liberation war in West, Central, and South Africa. Natural disasters also increased internal migration across the continent. For example, droughts in

the Sahel region of West Africa and parts of East Africa and the constant search for fertile land contributed to the number of landless poor people increasing, especially in East Africa (Adepoju, 2008).

In the colonial era, there was temporary migration of workers. This also involved international migration within Africa. Workers who moved between their homes of origin and the factories, coupled with poor income and welfare services, preferred to return to their homes permanently instead of the factories and plantations. The working conditions were not conducive to normal/ decent living. However, over time work conditions began to improve and became more stable. This began to attract more workers. For example, one of the plantations was in former Spanish Guinea, now called Zambia and Cameroun (Adepoju, 1998; 2008).

After the independence of most African countries, internal migration became attractive, and many indecent practices concerning family unification, residency, and contractual labour in West and East Africa were eliminated. In addition, internal migration became prominent in West Africa due to the emergence of political independence and distinct territorial boundaries. However, the merger of borders had a limited impact as people moved freely (Adepoju, 1998; 2008).

A major challenge in internal migration in Africa is the lack of recent data on internal migration literature (Awumbila, 2014). However, internal migration research has focused on theories, methodologies, policy papers, and reports. Most literature attempts to answer three basic questions, namely: (1) who migrates? (2) why do people migrate? And (3) what is the impact of remittance on source origin and relocation areas? (Adepoju, 1998; 2008; Oyeniyi, 2013). None of these have looked at the effect of internal migration on

health or mental health. Moreover, even though evidence on international migration has significantly increased in the last two decades, little observation is paid to internal migration (Oyeniyi, 2013).

1.5 Internal migration in Nigeria

Such as other countries of Africa, internal migration in Nigeria has continued to be diverse and has assumed different patterns such as rural-rural, rural-urban, urban-rural, and urban-urban. These movements may be free or forced, and many factors, some of which are not economic, are reasons for migration (Oyeniyi, 2013; Adepoju, 1998; 2008). However, the most prevalent internal migration in Nigeria is primarily rural-urban (Adepoju, 2008; Oyeniyi, 2013). Rural-urban pattern of internal migration has led to a disruption of social unity in rural communities and villages, resulting in a population crisis in urban areas (Oyeniyi, 2013; Adepoju, 1998; 2008).

Two generations of internal migrants exist in Nigeria. The first generations are the first people who moved and their family members who may move or join them. The second generation are those born in the places of relocation to which their parents migrated (Oyeniyi, 2013). For this study, participants are first-generation migrants, i.e., the first people who moved individually or moved with or to join their families.

Internal migration in Nigeria goes way back to colonialisation. Internal migration dates to these three-time frames: pre-colonial, colonial, and post-colonial times.

1.5.1 Pre-colonial migration era

Exiting studies showed that various ethnic groups had histories of movements due to slave trades. For example, the trade in slaves in Igbo and Ibibio areas by Itsekiri, Urhobo, and Efik led to thousands of Igbo and Ibibio people running into forests to avoid being

captured and enslaved, including forceful international migration of these people (Davidson and Buah, 1967). The captured slaves were sold and subsequently taken to Calabar, Badagry, and Elmina (Ghana) and then moved across the Atlantic to Europe (Lovejoy, 1978).

The Hausa-Fulani captured their neighbours in the central region and sold many of these slaves to merchants from the Maghreb before moving them to the deserts of North Africa, the Middle East, and Asia (Davidson, 1965). Many of the slaves ran to Yoruba areas. In addition, history showed that several ethnic groups or tribes moved both within the country and outside. For example, Emirs and 'Sarkins' in the Hausa states sent their children to various Islamic and Arabic training centres in Sokoto, Kano, and Ilorin and outside such as Mali, Songhai, Istanbul, etc. (Lovejoy, 1980). This also involved long-distance trading from merchants in central and western traders and traders in-country (Lovejoy, 1980).

The lack of physical borders in the pre-colonial era made it hard to distinguish between the two migration divisions (internal and international migrations). Thus, even though these movements in the pre-colonial era appear to be similar to internal and international migrations, the fluid and complex nature between pre-colonial groups made it difficult to differentiate internal from international migration (Ikime, 1985).

1.5.2 Colonial migration era

The first description of internal migration in Nigeria was during the colonial period in 1943 in a memo when Mr. E. A Miller, then labour commissioner, said that 'the move to the cities had begun and already presented difficulties of control and distribution' (quoted in Oyeniyi, 2010; p 57).

In the colonial period, there were two world religions (Islam and Christianity). Colonialism and western education helped the colonial administrators. Preachers, teachers, imams, and pastors moved mainly from urban to rural areas. While religion created urban-rural migration, Western education created rural-urban migration. These are where the early educational institutions are situated (Coleman, 1971).

The colonial rule in Nigeria brought new labour laws that allowed European traders to settle and open businesses in and around Lagos, Abeokuta, Ibadan, and other Nigerian cities. Also, internal migration increased the exportation of crops such as cocoa, coffee, cotton, and rubber. Coleman (1971) also said that tin mining in Jos influenced the internal migration of young men from eastern and western Nigeria to Jos. Similarly, coal mining in Enugu influenced internal migration from northern Nigeria to eastern Nigeria (Coleman, 1971).

Socioeconomic development in Yoruba regions began from the last quarter of the 19th century due to the labour migration of internal migrants. Developmental infrastructures such as construction of roads, rails and telecommunications in the colonial period led to mass movement of Nigerians from one place to another (Falola, 1989). During colonial times, male youths migrated more than females. This was due to the nature of employment during the colonial times involving mostly track, railway, and road construction (Adepoju, 1977; Oyeniyi, 2010).

In addition, earlier studies (Adepoju, 1974; 1976; 1977) suggested that the then colonial administration preferred males to migrate due to the search for economic capital (Findley, 1997; Babatunde and Martinetti, 2010). Therefore, the expansion of Nigeria's economy

encouraged internal migration of Nigerians and commodities and ideas, including the migration of foreigners into Nigeria (Oyeniyi, 2013).

1.5.3 Post-colonial migration era

Even though internal migration was the main focus in pre-colonial and colonial periods in Nigeria, it was seen in a negative light in the post-colonial period. This was because existing literature showed that the expansion of industries, government offices, public and private agencies, and infrastructural development in urban areas began in the colonial period. This continued to attract internal migrants, especially youths from rural areas (NBS- Annual Abstracts, 2017; Oyeniyi, 2013).

In the 1970s, Nigeria experienced an unexpected oil boom which led to infrastructural development in urban cities such as Lagos and other cities across the nation (Adepoju, 1977). As a result, in the 1970s and a large part of 1980, there were increased employment opportunities due to development projects in city centres. This attracted youths from rural and agricultural economies to urban and industrial areas. Therefore, from the independence in 1960 to the oil boom in the 1970s, internal migration encouraged economic growth.

At the end of the civil war, the displaced Igbo traders, and people not from the Hausa-Fulani ethnic group but resident in northern Nigeria moved to other states or returned to their states of origin. The military and democratic rule also encouraged internal migration because, in many cases, people moved to places where economic opportunities abounded and peace existed (Oyeniyi, 2013). Therefore, internal migration encouraged remittances and encouraged employment and exchange of culture, ideas, and other gains associated with international migration (Oyeniyi, 2013). Unfortunately, little attention has been

drawn to internal migration by the federal government of Nigeria since the return to democracy in 1999 (Oyeniyi, 2013).

1.6 Mental health in Africa

Mental health issues are mostly deficient in health service policies in Africa. Africa is constantly faced with infectious diseases such as Malaria, HIV, and AIDS (WHO Mental Health Atlas, 2015; Gureje and Saxena, 2006; Gureje and Alem, 2000). Therefore, most countries in Africa have a high prevalence of mental disorders (WHO, 2016; Daar et al., 2014). As a result, mental health issues are deficient in the priorities for policy development in Africa (Lund, 2010; Gureje and Alem, 2000; WHO Mental Health Atlas, 2015).

Gureje and Alem (2000) and Gureje et al., (2015) recommended that African countries create policies that will help change the negative perceptions of mental disorders and reduce the prevalence of mental disorders (Sankoh et al., 2018). These policies will also enable African countries utilise the available resources and support families by providing the best care to the mentally ill. In the long run, this will help create specific strategies to reduce disability associated with mental disorders and encourage research on mental disorders (Sankoh et al., 2018).

Lack of mental health research showed the inefficiency of mental health services in Africa (Eaton et al., 2017). According to World Health Organisation (2014) Mental health Atlas survey, 46% of countries in Africa do not have a standalone mental health policy. However, Abdallah and Gabr (2014) observed that some countries such as South Africa and Ethiopia had made progress by creating their national mental health policy framework and strategic plan.

According to WHO Mental Health Atlas (2015), public expenditure on mental health is extremely poor in developing countries with less than two American dollars per capita. A considerable amount of the funds is allocated to inpatient care, especially mental health hospitals. The median number of mental health beds per 100,000 is below 5. The African region has 1.4 mental health workers per 100,000 people compared to the world average of 9 per 100,000. The annual rate of mental health outpatient facilities is 14 per 100,000.

Children below the age of 15 years make up half of the population. It is estimated that 30% of children aged 0-9 years' experience mental disorders primarily due to these children's caretakers poor psychosocial support, especially mothers (Gberie, 2017; Okasha, 2002). The prevalence of mental disorders is also significant among the older adult population with 3-4% aged above 65 years. Even though the prevalence of dementia is not high, other conditions due to an infection or trauma of the central nervous system are common (Gberie, 2017; Okasha, 2002).

It was found that in many African countries that the most common presentation of mental disorders was acute or sub-acute psychosis. This usually occurs from cerebral involvement in infectious diseases such as Malaria, Typhoid fever, or HIV infection. This condition may be temporary, but it can cause significant suffering if not adequately treated (Okasha, 2002).

It was also found that the prevalence of epilepsy was high due to poor care at childbirth, malnutrition, malaria, and parasitic diseases (Mbamalu, 2019). It is also important to note that many countries in Africa experience conflicts, riots, and civil strife. This can have an adverse outcome on the mental health and wellbeing of those affected (WHO Mental Health Atlas, 2015; Darr et al., 2014; Okasha, 2002).

Alcohol, tobacco, and drug-related problems are increasingly becoming a problem in Africa. Other factors such as poverty, natural disaster, domestic violence, child abuse, etc., are major causes of psychological issues which negatively impact the mental health of those affected (Darr et al., 2014; Gberie, 2017). With the increasing population in the region (UN Department of Economic and Social Affairs, 2019), youths in the region struggle to earn a living due to competition in the labour market. This might result in psychological problems, with many turning to substance misuse as an attempt to relive their problems (WHO Mental Health Atlas, 2015).

HIV infections are increasingly becoming a major cause of mental disorders in Africa. This has created the need to provide extra support and counselling to those affected and their families, especially children (Lund, 2010; Gberie, 2017). According to the Joint UN programme on HIV/Aids (2002), most individuals recently infected by HIV are residents in sub-Saharan Africa, with 83% of all deaths from AIDS coming from this region.

Countries such as South Africa and Kenya have improved their mental health services in service delivery and implementation. However, there are still inequalities concerning service delivery of mental health services. For example, Kenya has few mental health personnel, spends 0.05% of its health budget on mental health, and 70% of its mental health facilities are in Kenya's capital, Nairobi. In South Africa, 14% of the population of 53 million have mental disorders, and 75% of patients with mental disorders have no access to psychiatric or therapeutic care at the community level (Gberie, 2017; Mbamalu, 2019). Ghana made giant steps in addressing its mental health issues by passing the mental health Act into law. As a result, the country became one of the few countries in Africa to have a mental health policy (Gberie, 2017).

1.7 Mental Health in Nigeria

Mental health legislation was initially created in Nigeria in the year 1916. This was called the Lunacy Ordinance. By 1958, this law gave medical professionals and magistrates the authority to perform restrictive practices to persons experiencing mental disorders (Westbrook, 2011). This law was changed to the lunacy Act of 1958 (Lunacy Act, 1958). This law has become outdated (Ugochukwu et al., 2020).

The mental health policy was recreated in 1991 and included the following elements, advocacy, promotion, prevention, treatment, and rehabilitation for persons with mental disorders. There have been no revisions or assessments since that time. However, the federal government recently reviewed the 1991 mental health policy to ensure regulation of practice and management. In addition, the review aimed to provide access and care to persons experiencing mental disorders and make plans for implementation in the national health budget. (Federal Ministry of Health, 2016; Ugochukwu et al., 2020).

Another mental health Bill was created in 2003 by the National Assembly. However, with no support or accomplishment for over six years, the Bill was removed in April 2009. The Bill was presented again in 2013. The Bill's aim was for mental health services delivery to reflect the delivery principles of care to people with mental disorders (Federal Ministry of Health, 2016). The National Council on Health in August 2013 recommended an updated policy. The new policy drew its recommendations from the WHO guidelines. This policy will help improve access and care to people with mental disorders and ensure implementation in the health budget (Gureje et al., 2015). The policy emphasises that mental disorders should be at the primary health level (Eaton et al., 2018).

The policy attempts to limit disability associated with mental disorders by reducing the treatment gap, encouraging human rights of people with mental disorders, and limiting the stigma associated with mental disorders (Eaton et al., 2018; Gureje et al., 2015). For example, 80% of persons with severe mental disorders receive no treatment. Only 10% of those who receive treatment have minimal care, and it takes an average of six years to receive care (Adepoju, 2020; Pederson et al., 2020; Gureje, 2002). Again, due to lack of support, this policy is not yet a law, and the policy's effect is yet to be felt in the lives of people living with mental disorders in Nigeria (Ugochukwu et al., 2020).

However, stakeholders in mental health care, such as the Association of Psychiatrists in Nigeria (APN), are leading by attempting to reform the mental health law and mental health legislation in Nigeria. For example, a desk officer for mental health was appointed at the federal ministry of health to ensure that work with relevant stakeholders is implemented when compiling aspects of the Bill to be granted an executive Bill (Ogunlesi and Ogunwale, 2012).

The WHO has helped provide legislation-related resources (WHO, 2015; Gureje and Saxena, 2006), including epidemiological data for a needs-based approach (Gureje et al., 2006). Finally, as recommended by the WHO, major stakeholders such as medical directors of federal psychiatric hospitals are critically thinking of positive outcomes in collaboration with the Federal Ministry of Health to pass the Bill into law successfully (Ogunlesi and Ogunwale, 2012).

The government share for health expenditure reduced from 29.1% in 1999 to 25.5% in 2003. About 3.3% of the health budget goes to mental health, out of which over 90%

goes to mental hospitals (Wada et al., 2021; Federal Ministry of Health Budget, 2016; WHO, 2015; Eaton and Agomoh, 2008; Gureje and Saxena, 2006).

Ten regional psychiatric departments provide a significant part of mental service. In addition, there are eight federal psychiatric hospitals in Nigeria (Federal Ministry of Health Budget, 2016). However, the medical personnel are very few and insufficient to cater for the needs of the population (Adepoju, 2020; Mbamalu, 2019). This is due to less emphasis on community health care and reluctance of medical professionals to specialise in psychiatry or mental health care (Adepoju, 2020). Unfortunately, according to Dr Sheikh (president of the Association of Psychiatrists in Nigeria), only 250 psychiatrists are available to provide services to a population of over 200 million people' (Adepoju, 2020).

Mental health services are mainly available at specialist hospitals such as Federal neuropsychiatric hospitals, university hospitals, and a few medical centres (Adepoju, 2020; Mbamalu, 2019). The private sector plays a minimal role, with many turning to spiritual or traditional healers for a cure (Mbamalu, 2019).

Recently, there have been rising cases of suicide in Nigeria. Nigeria is now the 30th most suicide-prone nation out of 183 countries and the 10th in Africa, with many attributing this to psychological and economic stress prevalent in the country (Olibamoyo et al., 2021; WHO, 2019a). About 264 cases of suicide were recorded in the last four years, and experts reported that the reasons for suicide among youths in Nigeria were economic hardships, marital issues, depression, and job loss/ unemployment (Mac-Leva et al., 2020).

Currently, there are no legislative or financial requirements to safeguard and provide support to mental health patients (Ugochukwu et al., 2020; Gureje and Saxena, 2006). In addition, there is currently no coordinating body overseeing education and awareness on mental health and mental health disorders. A commission was established in 1995 but has no specific monitoring activities; the commission only conducts visits to prisons occasionally at the moment (WHO, 2019a; Gureje and Saxena, 2006).

Furthermore, there is no adequate provision for emergency preparation for mental health in Nigeria (WHO, 2019a). Moreover, Nigeria is experiencing a major challenge in mental health underpinned by poor attitudes by society, lack of resources and infrastructure, and few mental health personnel (Suleiman, 2016; Ogunlesi and Ogunwale, 2012).

1.8 Literature Scoping Review

1.8.1A Introduction

A scoping review aims to show an overview of the existing research evidence. Scoping reviews are helpful to answer broad questions with several research questions. Some of these questions are ‘what information is shown on the topic in existing literature’ (Sucharew and Macaluso, 2019, p 416). In addition, scoping reviews present existing literature and other information such as different study designs and methods.

The outcome of a scoping review focuses on the scope of information identified and is usually limited to a range of several sources reporting a particular issue. Unlike systematic reviews that usually identify information from specific studies, e.g., randomised control trials focus on synthesising the data to answer a particular research question (Arksey and O’Malley, 2005).

A preliminary mapping of the literature was undertaken to determine the range of literature material available (Arksey and O'Malley, 2005). The scoping review explored the research study to identify gaps in the literature (Arksey and O'Malley, 2005). A scoping review was also used to systematically map the data as the study involved several research objectives. Therefore, the scoping review aimed to systemically summarise and disseminate the research findings and identified gaps in the literature (Okpalauwaekwe et al., 2017).

The scoping review was useful in this study as the topic was broad (migration and mental health) by exploring what information was presented in existing literature, with a particular focus on Nigeria. Scoping review was used in this study to evaluate peer-reviewed and grey literature and information on the impact of migration on mental health. This helped refine the research questions as the research has a broader topic with several research questions.

The results summarised the impact of internal migration on mental health, including views and attitudes of Nigerians towards mental health issues. The scoping literature review also aimed to identify the factors responsible for internal migration in Nigeria. The study identified themes relating to issues around knowledge and factors relating to mental health in Nigeria.

In addition, the review identified, and summarised factors associated with migration and internal migration and mental health in Nigeria, Africa, and globally. This was to ascertain if there is a consensus or dissent concerning the factors associated with the broader context of migration, (international and internal migration), and its relationship

with mental health. Finally, this section concluded by summarizing the main points and how these issues inform the need for this study.

This scoping review was divided as described by (Arksey & O'Malley, 2005) were as follows:

- Stage 1: identifying the research question
- Stage 2: identifying relevant studies
- Stage 3: study selection
- Stage 4: charting the data
- Stage 5: collating, summarising, and reporting the results.

1.8.1 Stage 1: identifying the research question

Arksey and O'Malley (2005) explained that identifying the research questions are the starting point to show how the search strategies are developed.

The review questions are:

1. What are the factors responsible for internal migration in Nigeria?
2. What are the perceptions and beliefs about mental disorders in Nigeria?
3. What are the factors associated with mental health in Nigeria?
4. What is the impact of internal and international migration on mental health in Nigeria, Africa, and globally?

1.8.1.2 Aim of Review

The review identified the impact of migration on the mental health of migrants.

The objectives were to identify:

1. The factors responsible for internal migration in Nigeria
2. How mental health was perceived in Nigeria
3. The contributing factors associated with mental health in Nigeria.
4. The impact of migration and internal migration on mental health in Nigeria, Africa, and globally.

1.8.1.3 Eligibility criteria

Studies included in the scoping review focused on mental health, including knowledge, prevalence, and experiences concerning mental health. In addition, studies that focused on mental disorders because of temporary or reactive factors were included. Studies on migration, its characteristics, including its relationship with mental health, were also included. The scoping review involved adults and young people who moved from one geographical region to another. Priority was given to studies on Nigerian-born migrants in Nigeria and/or outside Nigeria. Finally, studies ranged from year 1970 to 2021.

Studies excluded from the review focused on mental disorders because of biological/ permanent factors, and studies on mental disorders attributed to being an outcome of other medical conditions. Also, studies not mentioned above and individuals with other medical conditions were excluded.

1.8.2 Stage 2: Identifying relevant studies.

An extensive and systematic search was undertaken to explore and identify relevant studies on migration and mental health globally and within the research context. The investigation was conducted between December 2017 to March 2021. The search terms contained four facets (1) mental health, (2) migration, (3) internal migration (4) migration.

Studies were located in Nigeria~ Africa ~ worldwide. Exact search words used were ‘knowledge’, ‘perceptions’, ‘factors’, ‘mental health’, ‘migration’ and ‘internal migration’. Terms were searched for in the title and abstract fields, and controlled vocabulary terms were used where available.

The search was primarily on the following electronic database: ASSIA (ProQuest interface), CINAHL Complete (EBSCO interface), Google Scholar, MEDLINE (EBSCO interface), PsycINFO (ProQuest interface), Scopus, Sociological Abstracts (ProQuest interface). Studies were also selected from key papers (review papers), reference lists, and citations (Janes, 2016; Higgins and Green, 2011). The search strategy included all studies that addressed the scoping review questions irrespective of studies and study designs. In addition, citation searching was undertaken from key papers (Janes, 2016).

Studies that focused on voluntary internal migration and mental health in Nigeria were not found. Therefore, I had to expand the search to Africa and globally. Studies in Africa and other continents around the world were used to ascertain the link between migration, internal migration, and mental health. The search was also undertaken to ascertain if there is a consensus or dissent concerning the factors associated with the broader context of migration, i.e.., international and internal migration, and its relationship with mental health.

Duplicates and those with no relevance to the study were excluded from the review. Studies were accepted after reading the title and abstracts. I attempted to include some grey literature or studies not formally published to help expand my search due to limited results (Higgins and Green, 2011). Finally, all these searches (including grey literature) were undertaken to ensure more reliable results were obtained instead of focusing on

database searches due to limited results related to my specific subject (Janes, 2016; Greenhalgh and Peacock, 2005).

1.8.3 Stage 3: Study selection

All results were exported to RefWorks. RefWorks is a web-based reference management software. It is a software that allows creation of a personal database by importing reference from text files or online databases. It can also be used to manage citations, references lists and bibliographies (RefWorks, no date). RefWorks was used to remove duplicate results. The primary researcher (I) screened papers to determine their eligibility.

The selection process involved two stages: stage one involved manual screening of papers for their relevance with the study's aim by reading the title and abstract. The second stage was retrieving and reading the full text of the papers to identify their eligibility for inclusion in the review. All papers selected in the review were subject to thorough reading, and data were extracted and recorded in a Microsoft Excel spreadsheet.

1.8.4 Stage 4: Charting the data

This stage involved 'charting' critical items of information from primary research studies. Charting is described as a technique for synthesising and interpreting research data by sorting the data based on key themes. The data was charted into a data charting form using an Excel spreadsheet (Arksey and O'Malley, 2005).

Numerical summary and thematic analysis were used to extract information from included studies. Numerical summary involved data extracted such as: (1) author(s) names, (2) year of publication, (3) study design/ methodology, (4) study population, (5) intervention, (6) study setting, (7) aim of study, (8) geographic location, (9) outcome of study, (10) conclusion.

1.8.5 Stage 5: Collating, summarising, and reporting the results

The data were presented in two ways. The first was a numerical analysis of the nature and overview of studies included in the scoping review. A total of 717 papers met the inclusion criteria and were used in the scoping review (see appendix 1 showing the PRISMA diagram for further details).

Secondly, the literature was arranged and presented thematically using Braun and Clarke's (2006) approach in the following steps: (1) became familiar with the data by taking notes and recording ideas, (2)systematically generated codes across the data and allocating data relevant to each code, (3)searched themes by collating codes into potential themes, (4) reviewed the themes, (5) defined and named each theme by generating clear definitions, (6) and produced a report of the analysis.

The scoping review is presented in the following headings:

1. Factors responsible for internal migration
2. Causation and description of mental disorders
3. Treatment options for mental disorders
4. Attitudes towards mental disorders
5. Risk factors of mental disorders
6. Migration and mental health globally
7. Internal migration and mental health

1.8.5.1 Theme one: Factors responsible for internal migration in Nigeria.

This theme explored factors responsible for internal migration, i.e., the main reasons why Nigerians moved within Nigeria. Research has found that the most common internal migration pattern in Nigeria was a rural-urban pattern of migration (Oyeniyi, 2013; de Haas, 2007; Adepoju, 1998; 2008). In addition, the studies used in this theme were identified in the post-colonial era i.e.., after the country's independence in 1960.

The internal migration survey by Oyeniyi (2013), showed that males and females migrated. It also found that internal migration depends not on education and skill acquisition because both educated and people without formal educational qualification, skilled, and unskilled, migrated. Adepoju (1998) and Oucho (1998) confirmed that most internal migrants in Nigeria are primarily young rural-urban migrants aged 15-29 years. It was also found that rural-urban migrants were usually single, educated, young, and sometimes students. In terms of gender, male migrants were more likely to move to urban centres after embarking on skill or educational training. In contrast, internal female migrants usually accompany their families or spouse to urban cities. Christians were also more likely to move than Muslims (Mberu, 2005; Lacey, 1985; Ango et al., 2014; Chukwuemeka et al., 2013).

The main reasons for internal migration as identified by the internal migration survey (2010) were economic, education, marriage, civil service, National Youth Service, leaving parents, human trafficking, etc (Oyeniyi, 2013). A recent study by Mbaka and Nwaolikpe (2020) found that domestic violence and abuse was also a cause of internal migration among youths aged 18 and above. The study was a content analysis of 196

studies in newspaper dailies. Out of which, 75% were internal migration stories and published as inside stories in the newspapers.

Other studies found that significant determinants of internal (rural-urban) migration were ability to speak English, ability to speak two Nigerian languages including the spoken language in the state of relocation and ethnicity (Mgbakor et al., 2014; Chukwuemeka et al., 2013; Mustapha, 2009; Anyanwu, 1992).

Other existing research conducted across different states in Nigeria also showed that factors influencing internal migration (usually rural-urban pattern of migration) in Nigeria were unemployment and inadequate social amenities, especially in rural communities (Oyeniyi, 2013; Ogunmakinde et al., 2015; Ango et al., 2014). Other reasons were avoidance, and boredom in the agricultural sector in the rural communities by youths, absence of industries and neglect of rural communities.

Existing literature argued that factors that attracted Nigerians to urban cities were inadequate healthcare facilities, etc. In addition, terror and oppression by politicians, slavery and forced labour, natural disasters such as drought, famine, and bad weather conditions, especially in northern Nigeria, attracted people to urban areas (Oyeniyi, 2013; Adepoju, 2008; Dike, 1982; Mabogunje et al., 1978).

Several quantitative studies using surveys and questionnaires also confirmed that the push factors for Nigeria's internal migration were poor income opportunities, leaving unfavourable conditions, and escaping insecurity or conflict. On the other hand, pull factors include seeking better economic status, joining a spouse or family, finding a career or personal development, enjoying a conducive environment, and engaging in politics or business (Eze, 2016; Okpara, 1986).

Existing literature has also linked internal migration with environmental problems, especially urban pollution, and ghetto development (Oyeniyi, 2013; Adepoju, 2008; Dike, 1982). However, it was found that internal migration positively influenced human development through increased access to education, life expectancy, and living standards (Oyeniyi, 2013).

Internal migration is significant in Nigeria, especially between the north and the south. Many southern internal migrants relocated to the northern cities of Kano, Sokoto, Kaduna, and Jos. At the same time, seasonal migrants moved for agricultural purposes between the northern states of Sokoto and Kano, where Cacao is grown (Gimba and Kumshe, 2011; Abdul-Azeez and Opoola, 2011; Johnnie, 1988; Essang and Mabawonku, 1974). Also, internal migrants moved from the southeast region to urbanised cities like Lagos, Oyo, Osun, and Ondo and Edo states (Falola, 2020). In addition, the availability of better resources and amenities like roads, etc., between region or state of origin and the urban centre were reasons why Nigerians moved (Koubi et al., 2016; Ogunmakinde et al., 2015; Ango et al., 2014; Aromolaran, 2013; Ajero et al., 2013; Nnadi et al., 2012).

A recent survey conducted by the NBS (2020) found that Lagos state in the southwest region had the highest number of internal migrants (80.8%). According to the National Population Commission (2012), across twenty states, 23% of internal migrants were resident in FCT (Abuja), with the remaining 16 states having lower percentages. Youths aged between 20 and 35 from the northern and western regions moved more within the country (NPC, 2012; Oyeniyi, 2013).

The effects of rural-urban internal migration can put pressure on urban housing, encourage low agricultural productivity, and lead to a high rate of population growth

(Nnadi et al., 2012). In addition, it promotes a lack of family bonds, disrupts village activities, and result in overpopulation which can likely result in poor quality of life. Therefore, rural-urban internal migration can lead to crime and slow down the degree of development in rural areas (Nnadi et al., 2012; Gimba and Kumshe, 2011; Johnnie, 1988).

Additionally, rural areas are deserted due to the lack of youths to help parents on farms because agriculture is the primary source of income in the rural community. Lack of basic amenities leads to the movement of youths to urban areas for job opportunities, leaving behind the aged and children who cannot engage in agricultural activities, which negatively impacts agricultural and rural development in rural communities (Pam, 2014; Ofuoku, 2013; Iruonagbe, 2009). However, most internal migrants who have spent many years in the urban cities usually return for retirement or transfer for work purposes (Ofuoku, 2015; Adewale, 2005).

Several studies have shown that rural-urban migration has contributed to the development of rural communities through monetary remittances and improvement in the internal migrant's status (Ajero, Madu, and Mozie, 2013; Akinyemi et al., 2005). Some studies showed that 94% of households received remittances through internal migrants and less than 5% through international migrants. This helped improve economic status and reduced poverty (Agbonlahor and Philip, 2015; Chiwuzulum et al., 2010; Bankole, 1988). However, rural-urban internal migration has negatively impacted the agricultural sector due to youths moving to urban centres (Afolabi, 2007).

Also, the place of residence, household asset, household size, level of education, and marital status, positively impacted remittances. In addition, being male, having a child or being the head of a household, having a rural origin, and type of employment were strong

factors that had a significant positive impact on remittances to families (Ehirim et al., 2012; Emmanuel et al., 2012; Odaman, 1988).

Findings also showed that many internal migrants reported visiting home frequently, but these declined with age. Household participants reported that the remittances were usually used for home maintenance, education, trading, the building of houses, savings, and other purposes like weddings, funerals, festivals, and debt repayment (Adepoju, 1974; Adepoju, 2008; 1998). Unfortunately, these remittances did not make a meaningful contribution to the agricultural sector in rural communities (Ofuoku, 2015).

Rural-urban migration through remittances had some positive impact on care for the elderly (Oketayo and Olaleye, 2016). The survey by Oyeniyi (2013) found that internal migration increases access to education, especially in rural communities, and contributes to improved living standards for internal migrants and their dependents after making a living for themselves (Oyeniyi, 2013).

In summary, individual and country-wide specific factors were responsible for internal migration decisions and their dynamics (Orji and Agu, 2018). Some of those factors included unemployment, education, marriage, and lack of social amenities. However, internal migration negatively impacted rural communities due to the movement of youths into the city, thereby leaving the agricultural sector in the rural communities in disarray. On the other hand, the regular remittances of migrants to their families, especially in the rural communities, led to an increase in the standard of living.

1.8.5.2 Theme two: Causation and description of mental disorders

This theme identified and described the causes of mental disorders among different population groups in Nigeria. The theme also identified how several population groups describe people with mental disorders in Nigeria.

The findings were categorised across different population groups such as the (1) general population at community levels, (2) medical professionals, (3) teachers, (4) community workers, (5) traditional and spiritual healers. Other groups were (6) adolescents and children, (7) patients with mental disorders, (8) university students, (9) caregivers, and the (10) movie industry.

The aim was to understand the views and perceptions of different population groups in Nigeria. Their reported causation and beliefs towards mental disorders in Nigeria will help reduce mental health stigma, enhance awareness, and improve access to mental health delivery in Nigeria.

1.8.5.2A General population

The most-reported causation of mental disorders was supernatural factors such as a spiritual attack, possession by evil spirit/ witchcraft, punishment from God, brain injury/ illness, and God's will (Agofure et al., 2019; Chukwu and Onyeneho, 2015; Ikwuka et al., 2014; Aghukwa, 2012; Ewhrudjakpor, 2010; Ukpong, 2006; Akighir, 1982).

In the northern region, the reported evil spirit causation of mental disorders was popular, followed by personal weakness (Murtala et al., 2020; Andrew et al., 2017; Habib, 2020; Zever, 2017). In the southern region, participants had poor knowledge and stigmatising attitudes (Agofure et al., 2019; Egwuonwu et al., 2019; Ikwuka et al., 2016).

In the southwest region, recent studies found that participants knew about mental disorders and mental health issues (Adewumi, Oladipo and Adewuya, 2020; Mojiminiyi, 2020; Coker et al., 2019; Olawande et al., 2018). The majority of the participants were females, people who frequently used the media and internet and spoke English language (Kuyinu et al., 2020). These studies also found that participants in the southwest region held lesser beliefs in supernatural beliefs as causes of mental disorders. However, a previous scoping review by Labinjo et al., (2020) conducted in the southwest region ascribed supernatural causes as reasons followed by drug misuse. The studies conducted in the scoping review was between 2001 and 2010 (Adewuya and Makanjuola, 2008a; Gureje et al., 2006; Olugbile et al., 2009; Adebowale and Ogunlesi, 1999).

The second most reported causation was drug misuse due to intake of Indian hemp and other psychoactive substances (Akinsulore et al., 2018; Adewuya and Makanjuola, 2008a; Gureje et al., 2005). The strong belief in drug abuse was common among residents in the southwest region (Akinsulore et al., 2018; Gureje et al., 2005).

Some participants described environmental factors like stress and trauma as causes of mental disorders (Ukpong and Abasiubong, 2010; Gureje et al., 2005). Finally, a fewer amount attributed biological, genetic, or hereditary factors as causes of mental disorders (Ukpong and Abasiubong, 2010).

Participants reported the description of people living with mental disorders (such as depression) to depict depressed mode, social withdrawal, and loss of interest (Akinsulore et al., 2018). Ayonrinde and Erinosho (1977) and Olugbile et al., (2009) reported that participants described people living with schizophrenia and mental disorders to depict shyness and drunkenness. Most of the studies described people with mental disorders as

shy, hot-tempered, ’flirt, ‘drunkard, aggressive, talkative, wandering, and a nuisance. People with mental disorders were also described as mentally retarded, a public nuisance, and dangerous. They were also reported to appear abnormal or exhibit dysfunctional thinking and behaviour (Olugbile et al., 2009; Kabir et al., 2004).

1.8.5.2B Community or primary health workers

Studies specific to community and primary health workers attributed the cause of mental disorders to supernatural causation such as charm or evil spirits possession followed by psychosocial causation such as alcohol and drug abuse (Ekwueme and Aghaji, 2006; Abiodun, 1991; Ogunlesi and Adelekan, 1988). A few attributed the cause to biological factors or brain disease, genetic inheritance, and traumatic events (Adewuya et al., 2017; Iheanacho et al., 2016). However, some recent studies showed that after mental health training, participants could identify and treat common mental disorders, and there was an overall improvement in the quality of mental health knowledge (Makanjuola et al., 2016; Gureje et al., 2015; Adebowale et al., 2014).

In addition, participants described persons with mental disorders as a ‘nuisance’ (Kapadia et al., 2015). Finally, participants did not know mental health first aid and had not experienced it before (Odunmayowa & Tinuola, 2020).

1.8.5.2C Medical professionals

Studies identified that the cause of mental disorders was drug and alcohol abuse followed by supernatural causes such as evil spirits, witches, and sorcery (Adewuya & Oguntade, 2007; Erinosho, 1977). Other factors identified were stress, brain injury, infection of the brain, and heredity (Ighodaro et al., 2015; Iheanacho et al., 2014). Biomedical abnormalities were also identified as a cause of depression (James et al., 2012). However,

Ewhrudjakpor (2009) said that irrespective of some knowledge about mental disorders, the belief in supernatural factors is still prevalent in these population groups.

Some studies found that very few doctors were confident of their diagnostic skills and had the belief that depression was a sign of poor stamina (Ighodaro et al., 2015; Lotsu, 2014). In addition, participants described people with mental disorders as unpredictable, dangerous, lacking self-control, aggressive, and dependent on others (James et al., 2012; Adewuya and Oguntade, 2007).

However, recent studies (Aluh et al., 2019a; Anosike et al., 2019; Coker et al., 2018; Omoniyi et al., 2016) found that medical professionals have become quite knowledgeable about the causes of mental disorders with less emphasis on evil spirits and supernatural causation. However, some still held negative opinions about mental disorders but have more positive attitudes (Coker et al., 2018). Mental health nurses explained the importance of community mental health nursing to help reduce institutionalising mental health care. However, many shared that they did not practice community mental health at work because of workload and limited staff (Omoniyi et al., 2016).

1.8.5.2D Traditional and spiritual healers

Studies showed that participant traditional healers held strong beliefs in supernatural causes followed by drug or alcohol abuse, while a few cited genetic inheritances, physical abuse, biological and hereditary factors (Iheanacho et al., 2018; Makanjuola and Jaiyeola, 1987). A few studies explained that participant spiritual healers had a better understanding and aetiology of mental disorders after training, and reducing eccentric or dangerous practices (James et al., 2014; Adelekan et al., 2001).

Almost all participant spiritual healers had no previous training on suicide prevention, and some had knowledge of mental disorders but had not encountered someone with suicidal ideation (Dangana et al., 2020; Ogbolu et al.,2020).

1.8.5.2D Adolescents and children

Young participants, i.e., adolescents and teenagers attributed the most-reported causation of mental disorders to drug abuse followed by supernatural factors such as punishment of evil deeds and stress (Akinbode and Tolulope, 2017; Ezeala-Adikaibe et al., 2013; Dogra et al., 2012). However, after mental health awareness training, there was a significant improvement in knowledge (Isa et al.,2018; Oduguwa et al., 2017; Bella-Awusah et al., 2014; Olowokere and Okanlawon, 2014).

Studies showed that participants identified people with mental disorders through speech, behaviour, and appearance. Participants described people with mental disorders using derogatory terms like ‘mad’ or ‘mental.’ Statements such as ‘handicap,’ ‘brain disorder,’ and ‘brain illnesses’ were used. They described their appearance as abnormal with statements like ‘dirty clothes,’ ‘naked,’ and exhibiting strange behaviour like ‘talking to oneself’ (Bella-Awusah et al., 2014; Ronzoni et al., 2010).

A few could correctly identify a labelled mental disorder (depression) example during a mental health awareness training and few would recommend help from a psychiatrist. However, females had higher knowledge and showed greater compassion. But, overall, adolescents had little understanding of mental disorders (Ogunfowokan et al., 2020; Aluh et al., 2018; Olawande et al., 2018; Jack-Ide et al., 2016b).

1.8.5.2E Patients with mental disorders

Most of the participants described the causes of mental disorders as psychosocial causes, such as lack of social support followed by supernatural causes. The majority also attributed the cause to medical or genetic causes (Aghukwa, 2012; Adebowale and Ogunlesi, 1999; Ilechukwu, 1988).

Participants who reported supernatural attribution reported high levels of self-stigma (Makanjuola et al., 2016). Participants preferred treatment in their homes. Persons with mental disorders explained that adequate knowledge, acceptance, and support would help their well-being. In addition, spirituality provided hope and emotional support (Nwedu, 2019).

The majority of parents of children with mental disorders had a poor perception of childhood mental disorders. The most common symptom described was abnormal external behaviour. The reported causation was an inheritance, head injury, epilepsy, and lack of consistent discipline (Habib, 2020).

1.8.5.2F Teachers

Study participants in these population group identified psychosocial factors (such as drug and alcohol misuse) as causes followed by supernatural causes such as evil spirit possession (Ibeziako et al., 2009). Poor knowledge about mental disorders was prevalent, and many felt children with mental disorders should not be in close contact or the classroom (Mustapha et al., 2013). However, participants reported improvement in the quality of mental health knowledge after training (Omolayo et al., 2020; Makanjuola et al., 2012).

Most of the participants could not identify the labelled mental disorder (depression) example and described persons with mental disorders as unable to concentrate (Aluh et al., 2018). They also described persons with mental disorders as ‘morons’ and ‘insane’ (Bella et al., 2011).

1.8.5.2G Entertainment

Studies conducted in the movie industry reported and displayed scenes attributing the primary causation of mental disorders to spiritual attack, witches and occult, sorcery, enchantment, and repercussion of evil deeds (Atilola & Olayiwola, 2013; 2012; Aina, 2004). Studies found that Nigerian movies represented mental disorders poorly and perceptions of violence and aggression were linked to persons with mental disorders in Nigerian media (Aroyewun- Adekomaiya and Aroyewun, 2019).

1.8.5.2H University students

The most reported causation of mental disorders was stress followed by drug abuse. Very few cited supernatural causes (Oluwole et al., 2016). However, students had poor beliefs and knowledge about mental disorders even though they agreed that people with mental disorders needed help (Anosike et al., 2019; Chukwujekwu, 2018).

Participants described persons with mental disorders as a public nuisance, dangerous, and exhibiting violent behaviour (Oluwole et al., 2016). In addition, very few were able to identify the labelled mental disorder (schizophrenia) example and participants used stigmatising terms like ‘crazy’ and ‘mad’ (Aluh et al., 2019a).

1.8.5.2I Caregivers of people with mental disorders

The most reported causation was supernatural factors of mental disorders followed by drug and alcohol abuse, brain injury, and hereditary factors.

Others also attributed the causes to natural or physical illness as additional causes (Igberase and Okogbenin, 2017; Ewhrudjakpor, 2009; Issa et al., 2008; Ohaeri and Fido, 2001; Adebowale and Ogunlesi, 1999).

1.8.5.3 Theme three: Treatment options for mental disorders.

This theme describes the treatment options available to persons with mental disorders in Nigeria. This theme is divided into two sub-themes: preferred treatment option and burden of care.

The preferred treatment is the treatment preference for mental disorders. The theme also identifies the burden of care of persons with mental disorders in Nigeria.

1.8.5.3A Preferred treatment

All studies that focused on treatment options showed that patients with mental disorders contacted traditional or religious healers as the first point of treatment. This led to a significant delay in medical treatment (Aina et al., 2020; Aina, Otakpor, and Israel-Aina, 2016; Akinsulore et al., 2014; Adewuya and Makanjuola, 2009; Adewuya and Oseni, 2005; Adeyemi, Abiola, and Solomon, 2016; Aghukwa, 2012; Aina, 2001; Makanjuola, 1985). The main reasons for the preferred traditional and/or spiritual treatment options were confidence in treatment, ignorance of existing mental health facilities, and belief that mental disorders cannot be treated medically (Adeyemi, Abiola, and Solomon, 2016; Aghukwa, 2012; Nonye and Oseloka, 2009). The treatment practices by traditional healers were usually chemotherapy, incantations, divination, sacrifices to deities, and physical restraints (Adeyemi, Abiola, and Solomon, 2016; Odejide et al., 1978).

More than half of the participants in the selected studies recommended spiritual treatment in the country's southwest region, followed by traditional treatment and then medical

treatment. A few preferred a combination of all methods (Olawande et al., 2020; Coker et al., 2019; Adewuya and Makanjuola, 2009). In the southeast region, patient medicine vendors (chemists) were the most common primary care source following the onset of initial symptoms (Agofure, Okandeji-Barry, and Ume, 2019; Ezeme et al., 2016; Onyeonoro et al., 2016). However, participants in the southeast region recommended psychiatric hospitals followed by the church (Chukwujekwu, 2018; Johnson and Benson, 2017; Ikwuka et al., 2016). Therefore, factors such as educational status, income, and occupation were significantly associated with help-seeking behaviours (Onyeonoro et al., 2016).

Even though there were a few mental health units in primary care centres in the northern region, none provided formal mental health services (Argungu, Ahmed, and Sa'idu, 2020; Anyebe et al., 2019). Studies focused on parents found that most parents attended primary care centres on advice by neighbours, relatives, friends. They also obtained referrals from health institutions, schools, and religious organisations. In addition, the majority of the parents said they consulted spiritual homes with the perceived causation to be the possession of evil spirits, febrile convulsion, and accident or trauma (Jidong et al., 2021).

In summary, younger people aged below forty, educated, Christians, and urban dwellers were more likely to visit a faith healer as the first treatment. In comparison, older people over forty were more likely to visit traditional healers (Odinka et al., 2014). Higher education and religious beliefs were substantial factors in the medical model's preference. Therefore, the choice of traditional or spiritual routes were due to poor mental health infrastructures, lack of association between the medical culture and the peoples deeply rooted cultural/ religious backgrounds, and stigma around mental disorders (Agofure,

Okandeji-Barry, and Ume, 2019; Ezeme et al., 2016; Onyeonoro et al., 2016; Ikwuka et al., 2016).

1.8.5.3B Burden of care

All studies focused on the burden of care to persons with mental disorders identified family and next of kin as primary caregivers. Also, findings showed that the lack of organised social welfare services makes the family the only consistent source of social support for patients with mental disorders (Abayomi et al., 2015; Adewuya, Owoeye, and Erinfolami, 2011; Jegede, 1981). Participant caregivers explained that patients who lose contact with families might become homeless and wanderers. Also, poor knowledge and lack of social support affected caregivers' experiences (Jack-Ide et al., 2013). Patients who finally went to hospitals for treatment were accompanied by parents, siblings, and spouses (Aina et al., 2016).

The risk factors associated with the high burden of care were financial difficulties, the inability of caregivers to socialise, lack of support from relatives, physical health problems, and mental disorders (Abayomi et al., 2015). The level of the caregivers' burden i.e., socioeconomic status was associated with the patient's functioning (Adewuya and Makanjuola, 2009; Abiodun, 1995). Some studies also found that patients with families with histories of mental disorders had better social support (Lasebikan and Ayinde, 2013; Adewuya et al., 2011).

Rural families experienced more burdens, especially in areas of financial hardship (Martyns-Yellowe, 1992). In addition, the responsibilities of care increased with female caregivers. Also, the burden of care was worse when the level of education of caregivers,

the relationship of caregivers to patients, income, the distance of residence to the health facility, and family functioning were involved (Olagundoye et al., 2017).

Studies summarised that Nigerians lived in a society where traditional and modern medicine is utilised and usually determined by belief systems and influenced by distance and costs (Abayomi et al., 2015; Omorodion, 1993). Therefore, the belief in the causation of mental disorders to traditional or spiritual causes determines the mental health-seeking behaviour (Abayomi et al., 2015; Ugwu et al., 2012). The cost of mental health drugs and treatment is funded from personal and family pockets (Abayomi et al., 2015; Olugbile et al., 2013).

1.8.5.4 Theme four: Attitudes towards mental disorders in Nigeria.

This theme describes the attitudes of different population groups in Nigeria towards persons living with mental disorders in Nigeria. The findings are categorised across different population groups such as the (1) general population at community levels, (2) medical professionals, (3) teachers, (4) community workers, (5) traditional and spiritual healers. Other groups were (6) adolescents and children, (7) patients with mental disorders, (8) university students, and the (9) entertainment industry.

The aim was to identify the attitudes of different population groups in Nigeria. Their reported attitudes towards persons with mental disorders in Nigeria will identify the level of stigma and identify ways to reduce and possibly eliminate these stigmas towards persons with mental disorders in Nigeria.

1.8.5.4A General population

Studies focused on the general population showed that participants had negative attitudes and social distance towards mental disorders. Furthermore, the social distance and

negative attitudes increased when intimacy was involved and with those who have never cared for persons with mental disorders (Adewuya & Makanjuola, 2008b; Abasiubong et al., 2007).

Significantly few people were willing to be friendly, marry or relate with persons with mental disorders due to fear of violent behaviour and aggressive tendencies (Audu et al., 2013). Participants also described that they were afraid to converse with a person with a mental disorder (Akinsulore et al., 2018; Argungu, Ahmed, and Sa'idu, 2020; Gureje et al., 2005). Studies also found that older people, rural counterparts, and those with low education who believed in supernatural causation of mental disorders exhibited more negative attitudes (Ikwuka et al., 2016; Ihaji et al., 2013; Olubunmi, 2009; Makanjuola, 2006; Odebiyi and Ogedenge, 1990).

In the southwest region, even though participants had some knowledge of mental disorders, studies found that a significant amount had negative attitudes towards persons with mental disorders. Also, these negative attitudes increased when intimacy questions were involved. However, highly skilled participants and those who had cared for a person with mental disorders had some positive attitudes (Adebiyi et al., 2016; Adewuya and Makanjuola, 2008; Olubunmi, 2009; Makanjuola, 2006).

In the northcentral region, it was found that many participants had negative attitudes towards people with mental disorders with little knowledge about mental disorders (Afolayan et al., 2019; Ihaji et al., 2013). Likewise, in the northeast region, participants found that people who had families and aged less than thirty years had higher levels of perceived stigma (Argungu, Ahmed, and Sa'idu, 2020; Adeyemi et al., 2016). It was also

found that negative attitudes towards psychiatrists were significantly associated with low education (Argungu, Ahmed, and Sa'idu, 2020; Audu et al., 2013).

In the south-south region, the majority had negative attitudes with feelings of shame, unwillingness to share rooms with persons with mental disorders, and avoid all contact. In addition, persons with mental disorders were considered a nuisance and mentally retarded (Johnson and Benson, 2017; Ikwuka et al., 2016; Abasiubong et al., 2007).

Studies exploring specific mental disorders such as dementia showed that many participants said they would hide their status if they had dementia and would be ashamed or embarrassed to have dementia. They also said they would not agree to marry into families with dementia (Adegunloye, Buhari, and Abiodun, 2018; Adebiyi et al., 2016).

Studies exploring specific mental disorders such as schizophrenia showed that patients experienced high rates of stigma, unfair treatment, and discrimination across all aspects of life, especially with family and close relationships. In addition, the widespread belief in supernatural causation added to the increasing stigma (Adeosun et al., 2014; Ukpong & Abasiubong, 2010).

1.8.5.4B Students

Students' participants identified that being a member of a minority ethnic group (non-indigene) was associated with increased stigma among people needing mental health services. Social support from family, friends, and religion was associated with lower stigma among students (Pederson et al., 2020). Studies found high levels of negative and stigmatising attitudes with little knowledge of mental disorders. Student participants explained that they would be afraid if diagnosed with a mental disorder (Jombo and Idung, 2018; Jyothi et al., 2015).

Medical students showed positive attitudes to people with mental disorders. They held non-superstitious beliefs about the cause of mental disorders and believed that stress and abuse were part of the causation of mental disorders. Graduate medical students who had completed a course in psychiatry had positive attitudes. However, some physicians still held stigmatising attitudes even after mental health training (Ubaka et al., 2018; Ighodaro, 2017; Ighodaro et al., 2015; Adewuya and Oguntade, 2007).

Among nursing students, females were known to have positive attitudes but showed negative attitudes to psychiatric nursing as a profession. Also, clinical experience indicated positive experiences and attitudes (Jack-Ide et al., 2016a). After training and evaluation, knowledge of mental disorders was higher, but overall, there was no change in attitudes towards mental disorders (Olley, 2007).

Negative attitudes were still prevalent with the belief that patients with mental disorders were dangerous and participants said they would not marry one even though they had good knowledge and less belief in magical or spiritual aetiology (Jidda et al., 2013).

Among non-medical university students, participants showed negative attitudes and social distance. Participants also had the belief that persons with mental disorders were a threat to society and should be avoided (Afe and Ogunsemi, 2016; Olade, 1983; 1979).

Even though most of the participants had a family member with a mental disorder, only a few participants had previous contact with a person with a mental disorder. Participants said they would be ashamed if people knew their family member had a mental disorder because of the stigma associated with mental disorders due to poor knowledge levels (Adewuya and Makanjuola, 2008b).

1.8.5.4C Community, Primary health workers and Medical Professionals

Community and primary health workers were afraid to have patients with mental disorders admitted to the hospital and did not want their workplace next to a psychiatric ward because of the stigma associated with mental disorders due to poor knowledge levels (Tungchama et al., 2019; Adewuya et al., 2017; Chikaodiri, 2009). However, some participants agreed that mental disorders were illnesses like any other and should not be treated differently (Jombo et al., 2019; Adebowale et al., 2014).

Most of the participants felt that persons with mental disorders were a danger to themselves and others. However, health workers with more than ten years work experience showed more positive attitudes than those with less than ten years work experience (Mosaku and Wallymahmed, 2017; Ekwueme and Aghaji, 2006).

Studies found that negative attitudes and high levels of stigmatising behaviours led to social distance. These were significantly associated with professional orientation, fear of danger of persons with mental disorders, and family history of mental disorders. In addition, people with poor knowledge, exposure to religious teachings, and having no medical background were prone to having higher stigmatising attitudes (Jombo et al., 2019; Tungchama et al.,2019; Ogunlesi and Adelekan, 1988).

Overall, the majority of the medical professionals had non-stigmatising attitudes. However, medical professionals who had not come in contact with persons with mental disorders, had fewer years of experience, and who were male had significantly higher stigmatising attitudes (Ighodaro et al., 2015; Adewuya and Oguntade, 2007). On the other hand, professional psychiatric nurses were more compassionate (Ubaka et al., 2018; Iheanacho et al., 2014).

1.8.5.4D Patients with mental disorders

Studies showed that the most common elements of discrimination among persons with mental disorders were unfair treatment in intimate relationships and problems keeping a job. Internalized stigma was higher among patients with a diagnosis than those without one (Ogueji et al., 2020; Adeosun et al., 2014; Oshodi et al., 2014; Adebowale and Ogunlesi, 1999).

Persons with mental disorders explained that they regularly experienced stigmatising attitudes and discrimination from family members, co-workers, employers, and the general public (Olatunji, Idemudia and Olawa, 2020; Adewumi, Oladipo and Adewuya, 2020; Coker et al., 2018).

1.8.5.4E Adolescents, Children, Parents and Teachers

Adolescent and child participants had high stigmatising attitudes towards persons with mental disorders and were not willing to associate with one. Also, urban children and boys had more negative attitudes than rural children and girls (Akinbode and Tolulope, 2017; Dogra et al., 2012; Ronzoni et al., 2010).

It was found that majority of parents had negative attitudes to childhood psychiatric disorders. However, parents who identified psychological causation component tend to have positive attitudes (Abdullahi et al., 2021; Habib, 2020; Afolayan et al., 2011).

Teachers expressed more liberal attitudes toward persons with mental disorders. However, rejections were observed when intimate social situations were involved. Participants believed that people with mental disorders were unpredictable and dangerous to themselves and others. Almost all participants did not want a person with mental

disorders to hold a reputable position (Bella et al., 2011; Ibeziako et al., 2009; Aghukwa, 2009).

1.8.5.4F Media

Studies focused on the media found that some sociodemographic factors such as years of experience and educational attainment were significantly associated with attitudes towards people with mental disorders (Aroyewun-Adekomaiya and Aroyewun, 2019; Oluwole, Obadeji and Dada, 2016; Oluwole and Obadeji, 2014).

1.8.5.5 Theme five: Risk factors of mental disorders in Nigeria.

This theme identified risk factors of mental disorders across different population groups in Nigeria. The findings were categorised into several population groups such as (1) general population, (2) university students, (3) post-natal women, (4) pregnant women, (5) infertile women, (6) patients with mental disorders, (7) children, adolescents, and (8) medical professionals. Other groups were (9) management executives and bankers, (10) prison inmates, (11) security personnel and (12) internally displaced persons.

The aim was to identify risk factors associated with mental disorders among these different population groups and to ascertain if there were similarities or differences in risk factors across different population groups concerning mental health in Nigeria.

1.8.5.5A General population

Studies focused on risk factors of mental disorders among the general population found that female participants, singles (separated/ divorced/ widowed), unemployed, elderly, youths, first-born children, and people with poor physical health were prone to mental disorders. In addition, people with a low level of education, financial difficulties, or large family size were significantly associated with symptoms of common mental disorders

(Adewuya et al., 2018; Akpunne and Uzonwanne, 2015; Shittu et al., 2014; Amoran et al., 2012; Tomlinson, 2008; Abiodun and Ogunremi, 1990; Awaritefe, 1988; Emovon, 1976).

Females had higher rates of fatigue, guilt or feelings of worthlessness, poor concentration, and suicidal ideation. However, males tended to have poor appetite and alcohol abuse. In addition, females below 45 years with higher economic status had higher rates of depression (Adewuya et al., 2018). Additional risk factors were the use of drugs, pregnancy and childbirth, and family history of mental disorders (Mba et al., 2008). The most common mental disorders were anxiety and depression (Gureje et al., 2010; 2008; 2007; 2006; Binite, 1981).

In the southwest region, a many had depression with factors such as age, female gender, poor social support, especially from family was significantly associated with mental disorders. Physical illness, considerable alcohol use, and functional disability were also associated with mental disorders. Also, good mental health status was significantly related to the utilisation of health care services combined with access to social amenities like water supply, toilet facilities, constant electricity, and housing (Adewuya et al., 2021; Olagunju et al., 2015). In the northcentral region, the prevalence of depression was significantly associated with age (Sanni et al., 2020; Adeyemi, Abiola and Solomon, 2016).

The most common mental disorder in the southeast region was depression, substance use disorder, and anxiety disorder. Females commonly had depressive disorders, while substance use disorders were common in males. Age, higher education, and unemployment were risk factors (Stanley and Chinwe, 2020; Ikwuyatum, 2018). In the

south-south region, a study found that crude oil exploration greatly impacted residents' health status, especially the mental health status of affected inhabitants (Okwuezolu et al., 2020).

Factors associated with suicidal ideation across the general population in Nigeria were older age, female gender, being single, low economic status, depression, anxiety, and disability (Adewuya et al., 2016; Oladeji and Gureje, 2011). In addition, the risk factors of suicidal ideation were prevalent among people with a history of combat and exposure to war. Also, the risk of suicide attempts was common among persons with experience of interpersonal violence (Uwakwe et al., 2012).

The prevalence of suicidal ideation was higher in rural areas than in urban areas (Gureje et al., 2010; Amoran et al., 2007; 2005). Mood disorders had the highest correlation with suicidal behaviours.

Among children, risk factors such as separation from biological parents, being raised in a home with conflict, being physically abused, being raised by a woman with depression, anxiety, or attempted suicide were associated with suicidal attempts (Oladeji and Gureje, 2011; Gureje et al., 2007).

Finally, in terms of how Nigerians coped during the COVID lockdown, married people, people from the Igbo ethnic group, postgraduates, and self-employed individuals fared better due to less stress and better self-esteem. However, less qualified educational holders and the unemployed were highly stressed and had low self-esteem which negatively impacted their mental health (Orok et al., 2020; Lawal et al., 2020).

1.8.5.5B University students

Most student participants who experienced psychological distress were unable to meet academic expectations. Non-attendance at religious activities, financial difficulties, accommodation problems, and being born into a large and polygamous families were associated with mental disorders. In addition, female gender, heavy cigarette smokers, and high alcohol consumers were likely to experience mental disorders (Nwachukwu et al., 2021a; Akanni and Adayonfor, 2015; Adewuya, Ola and Adewumi, 2007).

Most of the student participants in the studies had minor depressive disorders and anxiety (Nwachukwu et al., 2021; Adewuya and Ologun, 2006). In addition, most of the student participants felt that the COVID pandemic significantly affected their mental health, social life, safety, and formal learning (Orok et al., 2020).

1.8.5.5C post-natal women

The prevalence of common mental disorders was high among the post-natal women (Abdullahi et al., 2021). The risk factors of mental disorders among postnatal women were younger age, first-time pregnancies, being single, preterm delivery, and not having the desired gender child (usually male sex). Having in-law relationship problems, hospital admissions due to pregnancy complications, emergency caesarean section, removal of placenta, and poor maternal experience during childbirth were additional risk factors (Ebeigbe and Akhigbe, 2008; Abiodun, 2006; Adewuya et al., 2006; 2005).

1.8.5.5D Pregnant women

Factors associated with mental disorders among pregnant women were younger age, first pregnancy, being married for less than a year, having an unsupportive husband, and a previous history of induced abortion (Abiodun et al., 1993). Additional factors were being

single, divorced or separated, polygamous family, having a prior history of stillbirth, and a perceived lack of social support (Adewuya et al., 2007). Also, having only female children and interpersonal violence were significantly associated with mental disorders (Ola et al., 2011).

1.8.5.5E Infertile women

Women with infertility had a high prevalence of mental disorders (Makanjuola et al., 2010). In addition, the risk factors of mental disorders were a history of induced abortion, previous marriages, having no children, complaints of menstrual abnormalities, chronic pelvic pain, and having an unsupportive husband and in-laws (Abiodun et al., 1992).

Women with infertility for longer than five years and who experienced marital disharmony experienced anxiety (Obajimi et al., 2019). The common mental disorders were depression and anxiety among gynaecology patients, and factors like the duration of illness, pain, and lack of social support were associated with depression (Lebimoyo et al., 2020; Oladeji and OlaOlorun, 2018).

1.8.5.5F Patients with mental disorders

Older people, female gender, being widowed/separated/divorced, having medical problems, and having a long duration of physical illness were likely to experience worse outcomes (Ezeme et al., 2016; Mosanya et al., 2014). In addition, those who were unemployed, had low education, poor social support, or experienced a late onset of disease were significant risk factors (Ezeme et al., 2016; Mosanya et al., 2014; Akinsulore et al., 2014; Gbiri et al., 2011; Adewuya and Makanjuola, 2009; Abiodun, 2000; 1993; Ihezue and Kumaraswamy, 1986).

Furthermore, additional factors such as poor living conditions, lack of transport, and financial difficulties were associated with patients with mental disorders' low quality of life (Amoo and Ogunlesi, 2005; Ihezue, 1983). Adverse childhood experiences such as family violence and neglect in the family, usually before the age of 16, were additional risk factors of mental disorders in patients (Oladeji et al., 2010).

Young people constituted the highest number of patients with mental disorders (Asibong et al., 2010). Depression was more common among youths under 30 years, while bipolar disorder was common over 30 years. Bipolar disorder was common among rural dwellers, while depression was more common among urban dwellers (Asibong et al., 2010; Ihezue and Kumaraswarry, 1986). It was also found that schizophrenia was common among people with low economic status, while bipolar disorder was common among the higher economic status (Nwaopara et al., 2016; Ihezue et al., 1986).

The most common mental disorders were depression and anxiety disorders (Abiodun, 1993), dementia, and substance use disorder (Ajiboye et al., 2012). Other common mental disorders were neurological disorders (epilepsy), schizophrenia, and affective disorders (Ogunsemi et al., 2010; Aina, 2001; Binite and Ofili, 1978). In addition, long-stay patients in psychiatric wards were diagnosed with schizophrenia followed by mental retardation with seizure (Nwaopara et al., 2016; Taiwo et al., 2008; Odejide, 1981).

1.8.5.5G Children and adolescents

A significant number of children were found to have symptoms of mental disorders. Factors such as disturbance of emotion, children from disrupted families due to separation, divorce, or death were associated with symptoms of mental disorders (Olowokere and Okanlawon, 2014; Abiodun, 1993). Other factors were the presence of

chronic medical illness, frequent visits to the hospital, younger age, and maternal parenting distress (Abdullahi et al., 2021; Abiodun et al., 2011).

It was found that parental panic disorder and substance abuse were associated with suicidal ideation in offspring. Parental panic disorder was linked with suicidal attempts in children (Oladeji & Gureje, 2011).

Common mental disorders among children were a behavioural disorder of conduct followed by attention deficit hyperactivity disorder (ADHD), depression, anxiety, and mental retardation (Abiodun et al., 2011; Abiodun, 1993).

Among adolescents, many participants had mental disorders such as mild depression. Factors associated with mental disorders were poor family relationship, mother's occupation, peer problems, character problems, hyperactivity, emotional problems, lack of social behaviour, low self-esteem, history of sexual risk behaviour, drinking alcohol, and having a large family size were significantly associated with mental disorders among adolescents (Nnajekwu et al., 2021; Nwachukwu et al., 2021b; Famodu et al., 2018; Adewuya et al., 2007; Adewuya & Ologun, 2006). In addition, traumatic events among youths such as sexual assault, physical abuse, road traffic accidents, sickness, armed robbery attack, and bad dreams were significantly associated with an onset of mental disorders in adolescents (Nwachukwu et al., 2021b; Omigbodun et al., 2008).

The most common mental disorders were anxiety and depressive disorders (Adewuya et al., 2007; Adewuya and Oseni, 2005). Adolescents in long-stay psychiatric hospitals were diagnosed with schizophrenia, followed by seizure disorders. The prevalence of mental disorders among adolescents with mental disorders was higher in males. Depression was higher among females, while substance abuse disorder and neurodevelopment disorders

were common among males (Ogbonna et al., 2020; Adewuya et al., 2007). The least prevalent disorders were autism spectrum disorders, enuresis, adolescent postpartum psychosis, and adjustment disorders (Bakare et al., 2011).

Among orphans, it was found that orphans had poor mental health status. Orphans were prone to experiencing poor self-concept, low self-esteem, less social support, less life satisfaction and were prone to child abuse. Gender was not significant (Elegbeleye, 2014; Olowokere and Okanlawon, 2014). Finally, it was found that there was a significant relationship between addictive smartphone use and depression and anxiety (Ayandele et al., 2019).

1.8.5.5H Medical professionals

Risk factors of mental disorders among medical doctors were lack of job satisfaction, being married, non-participation in social activities, and perception of work as being 'heavy' (Adeolu et al., 2016; Issa et al., 2014). In addition, age, female gender, years of medical practice, religion, ethnicity, and marital status were associated with stress (Adeolu et al., 2016). The most common mental disorders reported were depression and anxiety symptoms (James et al., 2017; Lotsu, 2014).

Factors associated with stress among medical students were lack of finances, weak or non-adherence to religious activities, anxiety symptoms, excessive alcohol use, and where the choice of study was influenced by parents (James et al., 2017; Omigbodun et al., 2006). In addition, medical students also described factors such as overcrowding, school strikes, excessive school load, competition with peers, inadequate learning materials, and lack of holidays as significantly associated with stress and subsequently depression (Yussuf et al., 2013; Omigbodun et al., 2006).

Factors associated with stress among nurses were doctor/ nurse conflict, inadequate personnel, frequent night duties, and poor wages (Lasebikan and Oyetunde, 2012). Nursing students also described noisy environments, security, and transport problems as factors associated with mental disorders (Omigbodun et al., 2006; Anosike, Aluh, and Onome, 2020; Obi et al., 2015).

Seun-Fadipe et al. (2019) examined workplace violence among medical professionals and found that the prevalence of workplace violence was significant. Factors associated with workplace violence were young age, female gender, worrying about workplace violence, and being a victim of workplace violence (Seun-Fadipe et al., 2019).

Therefore, family abuse, stress, self-criticism, social relationship, and economic factors are significantly associated with depression (Anosike, Aluh, and Onome, 2020; Seun-Fadipe et al., 2019).

1.8.5.5I Management executives and bankers

The prevalence of mental disorders among management executives in several cross-sectional studies was low, and they appeared to be moderately stressed. However, female, and unmarried executives were vulnerable to mental disorders (Olatona et al., 2014; Adebowale and Adelufosi, 2013). Participants who were civil servants had depression and was common among females. In addition, factors such as stress of job demand and poor remuneration were associated with mental disorders (depression) (Yusuf and Adeoye, 2011).

1.8.5.5J Prison inmates

Factors such as drug abuse were significantly associated with mental disorders, and studies among prison inmates showed no association between offences committed and mental disorders (Okoro et al., 2018; Agbahowe et al., 1998).

Other factors associated with mental disorders were poor accommodation, older age, single marital status, poor physical and mental health, previous history of mental illness, and lack of access to health care services (Okoro et al., 2018; Osasona and Koleoso, 2015).

The most common mental disorders among prison inmates were schizophrenia, mild depression, and anxiety disorder (Agbahowe et al., 1998). In addition, past traumatic events were significant among juvenile inmates with mental disorders (Atilola et al., 2014b).

1.8.5.5K Security personnel

Factors associated with the prevalence of mental disorders were older age, lack of social support, no job satisfaction, and occupational stress (Lawrence, 2021). The majority reported experiences of stress such as feeling depressed at work and having head/body ache (John-Akintola et al., 2020). In addition, in the context of stress and traumatic stress (lack of resilience, lack of optimism, lack of self-efficacy, lack of hope, and lack of workplace social capital) was negatively and significantly associated with mental disorders among police and security officials due to the negative influence on development of mental health problems. (Ojedokun & Balogun, 2015).

1.8.5.5L Internally displaced persons (IDPs)

A majority of internally displaced participants had at least one symptom of mental disorders and functional impairment associated with mental disorders, which were higher among men.

The common mental disorders were anxiety, depression, and Post Traumatic Stress Disorder (PTSD) (Kaiser et al., 2020; Atsua, Garba and Oludi, 2017).

The prevalence of suicidal ideation was higher among IDPs than non-IDPs. Female IDPs were more predisposed to mental disorders. Factors identified were poverty, unemployment, poor physical health, poor housing, discrimination, stigmatisation, and insecurity.

Due to these factors, their mental health and quality of life were regarded as deficient. This was because internally displaced persons were three times more likely to have poor mental health (Akinyemi et al., 2016; 2015; 2012). Females IDPs were more likely to have depression (Sheikh et al., 2015).

1.8.5.5M Older adults

Risk factors associated with mental disorder among the elderly were financial difficulties, female gender, age, prolonged stay in current residence, and living in less developed areas. In addition, being separated, lonely, having a physical illness, not having children, and low social support were also significantly associated with mental disorders among the elderly (Adegunloye et al., 2018; Baiyewu et al., 2015; Olutoki et al., 2014; Uwakwe, 2000; Sijuwade, 1994; Makanjuola, 1985).

The most common mental disorders were schizophrenia and depression (Adegunloye et al., 2018; Uwakwe, 2000).

1.8.5.5N National Youth Service Corps Members (NYSC)

Factors associated with mental disorders among National Youth Service Corps (NYSC) members were being from a different ethnic group or state, had a low income, aged above 26 years, and those who schooled outside their states of origin (Balami, 2015).

1.8.5.5O Summary

In summary, across different population groups in Nigeria, the most common mental disorders were depression and anxiety disorders. Factors such as female gender, older age, single marital status, low economic status, lack of social and family support were significantly associated with mental disorders. Also, poor working conditions, poor housing conditions, poor physical health, lack of engagement in religious activities, and traumatic events, especially in the home such as physical violence, etc., were also significantly associated with mental disorders in most population groups in Nigeria. Therefore, it can be summarised that there is a consensus of factors impacting mental health across different population groups in Nigeria.

1.8.5.6 Theme six: Migration and mental health globally.

This theme explored the factors impacting mental health among immigrants across different continents of the world. The findings were categorised across different continents of the world to explore and understand the factors influencing the mental health status of immigrants on a global level.

Even though the focus of this study is on internal migration, the aim of this theme is to ascertain if there are similarities or differences between immigration experiences and its impact on mental health across different continents of the world by identifying factors associated with mental disorder among immigrants globally.

1.8.5.6A Africa

Factors such as young age and being a black African were associated with mental disorders (Ajaero et al., 2017; Tomita et al., 2014). Young people and racially or ethnically marginalised individuals are very likely to experience mental disorders (Ajaero et al., 2017).

In addition, factors such as harsh working conditions and not following recognised rules with employers were related to mental disorder symptoms. For example, when the migrant worker refuses to accept the work conditions, work access is denied and distressing for young migrants, mainly men without social support (Waage, 2015; Olagunju et al., 2015).

1.8.5.6B Europe

Females reported a higher prevalence of poor mental health with factors such as short duration of stay, unemployment, ethnic identity, language barriers, single marital status, poor housing, poor social network, having a low level of education, economic insecurity, inability to adapt to host culture, and traumatic events being strongly related to mental disorders (Steel et al., 2017; Sidorchuk et al., 2017; Tinghog et al., 2010; 2007; Thapa and Hauff, 2005).

Immigrants had a higher prevalence of psychological distress (Taloyan et al., 2008). Anxiety and dissatisfaction with life were responsible for most mental disorders (Neto & Barros, 2000). In addition, having a physical disease, negative feelings about being a immigrant, racial discrimination, experiencing a negative situation, lack of life satisfaction, cultural differences, and daily life stressors were also associated with mental disorders (Nesterko et al., 2017; Idemudia, 2014; Irfaeya et al., 2008). Family support

was a significant protector against mental disorder symptoms, as well as other coping strategies like religious practices (Silveira & Allebeck, 2001).

A Factor associated with mental disorder symptoms among students were feeling inferior (Kurre et al., 2011). Students were also shown to experience less social support (Kramer et al., 2004). Among immigrant youths, the symptoms of mental disorders were linked to low self-esteem, frequent monitoring by parents, poor relationship with parents, association with religion, inability to adapt to hosts culture and ethnic identity (Adriaanse et al., 2016). It was also found that immigrant youths were socially disadvantaged, contributing to the prevalence of mental disorders (Adriaanse et al., 2014).

Also, youths born in the host country (second-generation immigrants) experienced high levels of symptoms of mental disorders. This was associated with severe maternal complications in childbirth and parents with psychological distress (Das-Munshi et al., 2014). In addition, immigrant youths born in the host country had higher scores for symptoms of mental disorders due to traumatic life events and poor physical health conditions (Steinhausen et al., 2009).

1.8.5.6C North America

Most studies focused on Latino immigrants. The findings showed factors such as an inability to adapt to the host culture, single marital status, overworking, unemployment, poor job satisfaction, financial distress, and language barriers, especially among new immigrants, were associated with poor mental health. In addition, poor housing, poor physical health, having no health insurance, poverty, stressful or traumatic experiences, especially racial discrimination were associated with poor mental health status (Cleary et al., 2018; Ro and Goldberg, 2017; Hounkpatin et al., 2015; Breslau et al., 2011; De Castro

et al., 2008; Vega et al., 1987; Bagley, 1968). On the other hand, social support such as having a spouse, and contact with friends, and relatives were associated with good mental health status (Sugisawa et al., 2002).

It was also found that migration experiences and a non-residence permit were factors associated with perceived discrimination, ultimately resulting in mental disorder symptoms (Torres et al., 2016; Salgado et al., 2014). In addition, frustrated aspirations, and longer duration in the host country were associated with mental disorders (Zvolensky et al., 2016; Warfa et al., 2012; Kirchner and Patino, 2011; Breslau et al., 2011; 2007; Belizaire and Fuertes, 2011; Potochnick and Perreira, 2010; Alegría et al., 2008).

Immigrants were found to have a high level of mental disorder symptoms compared to non-migrants (Grant et al., 2004; Salgado de Snyder et al., 1990). However, recent young immigrants reported better mental health than long-term immigrants (Salami et al., 2017). Age of migration was also highly significant, with results showing that those who migrated as a child had higher levels of mental disorders (depression) in adulthood (Mossakowski, 2007). However, factors such as reuniting with families, aspirations to learn other languages and cultures, social support, and spirituality helped reduce symptoms of mental disorders (Yang, 2017; Ornelas and Perreira, 2011).

Among youths, positive relationships, having a purpose, and the ability to adapt to the environment were positively related to good mental health status (Archuleta, 2015; Hoffman, 2013). Among students, social supports were practical protective measures against symptoms of mental disorders (Yu and Berryman, 1996). Even though students had a low level of acculturation, they had a significantly high level of self-esteem. This may be due to cultural activities and social support through family (Abdallah and Gabr,

2014; Yu and Berryman, 1996; Zea et al., 1995). However, the inability to work, financial challenges, language barriers, and missing families were significant for students (Fritz, Chin, and DeMarinis, 2008).

Migrant workers had poor mental health with high levels of depression and anxiety (Crain et al., 2012). Factors associated with poor mental health among migrant workers were excess work, dysfunctional family, lack of social support, low self-esteem, inconsistent decision to migrate, lack of religion, low education, acculturative stress, and poor employer/ supervisor relationship. Other significant factors associated with poor mental health status among migrant workers were language barriers, poor housing, low income, older age, being single, family challenges, and separation from family (Pulgar et al., 2016; Winkelman et al., 2013; Magana and Hovey, 2003; Hovey and Magana, 2002).

In summary, the major identifiable factors associated with mental disorders were unemployment, financial challenges, language barriers, and inability to adapt to the new country. However, social support was found to act as a coping mechanism (Padilla et al., 1988). In addition, females and newly arrived immigrants were prone to have higher common mental disorder symptoms (Pulgar et al., 2016).

1.8.5.6D Middle East

Immigrants were found to have high psychological distress and psychiatric morbidity (Mirsky, 2009). Factors like duration of stay in the host country, immigration status, and ethnicity were significantly associated with mental disorders (Mirsky et al., 2008). The symptoms of mental disorders were significantly higher in women than men. Additional factors such as family challenges, poor climate conditions, fear and uncertainty about the

future, and poor health status are described by women as factors impacting their mental health status (Ritsner et al., 2001).

Factors responsible for symptoms of mental disorders among migrant workers were excess work, being culturally isolated, lack of cultural identity, and inability to achieve expectations or goals (Anbesse et al., 2009).

It was also found that older immigrants had higher levels of symptoms of mental disorders. Factors such as age, marital status (single), and long duration of stay were significantly associated with mental disorders (Ritsner and Panizovsky, 2003). Studies also found that social-cultural differences between immigrants and the host country among older immigrants, and the lack of knowledge of these differences by expert professionals impacted mental health care (Delbar et al., 2010).

Younger immigrants described climate changes and fear about the future as factors negatively impacting their mental health. At the same time, factors such as being a female, low education, unemployment, and long duration of stay were significant factors among middle-aged immigrants (Ritsner and Panizovsky, 1999). The family and relationship with parents played a vital role in youths' immigration experiences (Assouline, 2015). In addition, religious attendance was also associated with mental disorder symptoms (Kim et al., 2015).

1.8.5.6E Continent of Oceania

Mental disorders were associated with traumatic experiences, the stress of migration, and adjusting to a new country (Leung, 2001; Krupinski, 1984). Additional factors such as female gender, poverty, low education, no immigration status, and loneliness were associated with poor mental health. However, the most significant factors linked to mental

disorder symptoms were traumatic events, challenges of gaining employment, and racial discrimination (Copelj and Kiropoulos, 2011; Silove et al., 1997).

Students experienced less social support (Khawaja and Dempsey, 2008). Social support was necessary for physiological and academic advancement (Leung, 2001), with highly significant factors such as immigration status negatively impacting their mental health (Leung, 2001).

1.8.5.6F Asia

Immigrants showed significant symptoms of mental disorders with factors such as socio-demographic elements (such as female gender and unemployment), acculturative stress, language barriers, and discrimination being significantly associated with mental disorders. However, personal resilience and family social support reduced symptoms of mental disorders (Falavarjani et al., 2019; Yu et al., 2014; Li et al., 2014; Wong and Chang, 2010; Fu Keung Wong and Song, 2008).

Temporary migrants were at higher risk of symptoms of mental disorders (Yang et al., 2018). Studies showed that even though poor migration planning among new migrants did not show any signs of mental disorders after one year, it negatively affected the quality of life due to high stress levels (Chen et al., 2020; Chen, 2011; Chou et al., 2011). Therefore, immigrants described survival challenges and losses to be stressful and negatively impacted their quality of life (Chen et al., 2016; Chou et al., 2011).

Most immigrant migrant workers reported poor mental health, with ethnicity and social support providing significant protection against poor mental health (Kumparatana et al., 2017; Li et al., 2014). Male migrant workers showed that insecurity and forceful working conditions were associated with mental disorder symptoms, while female migrant

workers reported that daily stress was related to mental disorder symptoms (Meyer et al., 2016; Fu Keung Wong and Song, 2008). Risk factors of mental disorder symptoms among migrant workers were being unemployed over a long time, long working hours, employment challenges, married migrants, and doing menial work. Additional risk factors were migrants experiencing financial difficulties, migrants experiencing stress due to conflict with relationships, and cultural differences were more likely to experience poor mental health (Chen et al., 2019; Wong and Chang, 2010; Wong et al., 2008).

Immigrant youths whose parents were workers and were male, older in age, and experiencing parental conflicts were likely to develop mental disorders. In addition, being disciplined by teachers, youths who experienced discrimination, lack of social support, economic pressure, and experienced low-income were associated with mental disorder symptoms (Hao and Cui, 2015; Wong et al., 2009). Generally, immigrant youths reported lower levels of resilience which was associated with poor mental health and physical abuse (Wu et al., 2018; Zhao et al., 2014).

Family support was a significant protector against mental health challenges among second-generation immigrants (Chen et al., 2019). Social support helps youths adjust psychologically and reduces the negative impact of academic stress (Song et al., 2019). Also, youths who lived with at least one parent was associated with better mental health (Wang et al., 2019). Youths with the ability to learn from situations and apply these while exhibiting self-control and empathy experienced less distress and better mental health (Wong et al., 2004).

Therefore, there is a consensus across developing and developed countries across several continents of the world that immigrants experienced economic, social, and socio-cultural

challenges. The inability to adapt to the environment, language barriers, cultural differences, and traumatic events negatively impacted immigrants' mental health.

On the other hand, strong family and social support are associated with good mental health. Therefore, irrespective of location, immigrants experience similar challenges, especially as new immigrants. In addition, discrimination, and economic problems such as lack of jobs/ poor working conditions affect all categories of immigrants, i.e., immigrant workers or immigrant youths and students.

1.8.5.7 Theme seven: Internal migration and mental health.

This theme explored the factors impacting mental health among internal migrants across different continents of the world.

The findings were categorised across different continents around the world to explore and understand the factors influencing the mental health status of internal migrants in different continents of the world.

1.8.5.7A Africa

After an extensive search of the literature, research linking voluntary internal migration to mental health in Nigeria was not found. However, recently, research has begun to explore the experiences of internally displaced persons (IDPs) in Nigeria. This is due to the rise in insecurity challenges in the country. There has been an increase in IDPs, especially in the northern region of the country, from the insurgency of Boko Haram in the northeast region to communal clashes with herders, kidnappings, and religious conflicts (Adofu and Alhassan, 2018; Garga, 2015; Bakwai et al., 2014; Osumah, 2013).

Few studies were found that focused on forced internal migration involving internally displaced persons (IDPs). All six studies were found in the northern region, especially in the northeast region, where insecurity is higher (Mukhar et al., 2020; Ogechi and Ezadueyan, 2020; Taru et al., 2018; Aluh et al., 2019b; Amusan and Ejoke, 2017; Dunn, 2018). A few additional studies were conducted in the western region of the country (Akinyemi, Owoaje and Cadmus, 2016; Akinyemi, Atilola and Soyannwo, 2015; Akinyemi et al., 2012). Refugee participants explained that factors that negatively impacted their mental health and quality of life were poverty, unemployment, poor physical health, poor housing and experiences of discrimination, stigmatization and insecurity or conflicts.

The research found a high burden of mental health needs among IDPs, with the majority having at least one mental health symptom and functional impairment associated with mental disorders (Mukhtar et al., 2020; Ogechi and Ezadueyan, 2020; Taru et al., 2018). It was found that IDPs in the northeast region were mostly females and resided in host communities while the rest lived in formal and informal camps. They all fled conflict and communal clashes (Mukhtar et al., 2020). It was also reported that private care initiatives (non-governmental organisations) were the primary source of rehabilitation of these IDPs (Okwuwa, 2016).

Unfortunately, rural dwellers, mainly farmers, were affected by the insurgency of Boko Haram by fleeing their homes and source of survival to become IDPs making them physically and psychologically vulnerable (Ogechi & Ezadueyan, 2020). The primary health issues experienced by IDPs were febrile illnesses like diarrhoea and post-traumatic stress disorder. They coped mainly by donations and used traditional medicine (Ogechi & Ezadueyan, 2020).

The majority were unemployed with low education and no income. Additional factors like marital status were associated with symptoms of post-traumatic stress disorder (PTSD) (Taru et al., 2018). In addition, almost all IDPs were depressed, and the chances of being depressed were higher in older age and being unemployed (Aluh et al., 2019b).

Voluntary internal migrants in other African countries such as South Africa were found to experience good mental health status after some time, with factors such as marital status, income, and place of residence being significantly associated with mental health status (Govera and Bayat, 2020; Ajaero et al., 2017). On the other hand, voluntary internal migration was also found to reduce objective well-being due to negative expectations and the financial constraints of being away from family and home (Mulcahy & Kollamparambil, 2016). However, some studies found that voluntary internal migrants experienced stress due to environment and specific embedded stressors, especially in the first two years of residence (Pheko et al., 2014; Tuller, 2013).

Studies across African countries also found that voluntary internal migrants were less likely to consult mental health care services than non-migrants, and if they did, they would likely consult private sector facilities. It was also found that voluntary internal migrants had higher depressive symptoms compared to non-migrants. In addition, voluntary internal migrants with low socioeconomic status were likely to have poor mental health (Ginsburg et al., 2016; Govera & Bayat, 2020). Also, access to water, sanitation, and hygiene was associated with health-seeking behaviour for voluntary internal migrants and non-migrants, while education was significant for voluntary internal migrant's health-seeking behaviours (Fadlallah et al., 2020).

1.8.5.7B Europe

Physical health status was related to internal migration in male migrants, while smoking behaviours were linked to internal migration in females. (Westphal, 2016). People with poor health status migrated due to poor health and social disparities (Greene et al., 2020; Green et al., 2015). Economic challenges, marital status and being from a minority ethnic background were significantly associated with poor health, especially mental health (Wilding et al., 2016).

There were positive effects of internal migration on physical health but not on mental health, irrespective of gender (Ajefu, 2017; Westphal, 2016). It was also found that individuals without a good mental health status were more likely to migrate (Wilding, 2018). Internal migration resulted in an increased life satisfaction for internal migrants regardless of marital status (Switek, 2012). Overall, internal migrants reported better health than non-migrants (Wilding, 2018; Lund et al., 1998). However, internal migrants who had a low level of income and low-skilled migrants were likely to have poor mental health (Jestl et al., 2017). In addition, male internal migrants who experienced harsh working conditions, poor living conditions, and poor health status were likely to experience poor mental health (Atella et al., 2019).

Findings among internal migrant youths and second-generation internal migrants showed that they were at a higher risk of symptoms of mental disorders (Cardano et al., 2018), with age and gender being significant factors (Tarricone et al., 2016).

1.8.5.7C South America

There was a significant association between internal migration status and poor mental health (Arenas, 2008; Almeida-Filho et al., 1982). Furthermore, internal migrants also

reported a high prevalence of mental disorders due to a long duration of stay and migrated at a young age (Ruiz-Grosso et al., 2015). Furthermore, additional risk factors such as age, gender, educational status, marital status, place of residence, and employment status were significantly associated with symptoms of mental disorders (Coutinho et al., 1999). These studies were located in countries of Brazil and Mexico (Arenas, 2008; Almeida-Filho et al., 1982).

De Mola et al., (2012) found no difference in the prevalence of common mental disorders between internal migrants and rural population groups.

In comparison with urban groups, internal migrants showed a lower quality of life concerning psychological health and living conditions but reported higher scores on physical health (Marquez-Montero et al., 2011).

1.8.5.7D North America

There was a positive relationship between subjective wellbeing and internal migration. However, factors such as economic status and place of destination reduced these impacts (Hummel, 2016; Archuleta, 2015). Those aged twenty and older experienced positive health, while those who were younger experienced adverse mental health. Poor physical health was highly associated with poor mental health status (Arenas, 2008; Torres, 2016).

Racial and ethnic discrimination was significantly associated with depressive symptoms. In addition, increased mortality among internal migrants was linked to increased smoking and alcohol consumption (Johnson and Taylor, 2019; Mossakowski, 2003). Overall, internal migrant youths had a lower risk of experiencing symptoms of mental disorders (Maggi et al., 2010), but after migrating, their mental health deteriorated (Leon-Perez, 2019).

1.8.5.7E Asia

The majority of the studies were located in China. It was found that internal migrants easily integrated into the culture of the destination area. Integrated internal migrants had better-reported health and mental health status, while segregated or marginalised migrants had lower mental health status (Zhu et al., 2019). In addition, internal migrants' social cohesion and high social participation were significantly associated with a positive mental health status (Zhou and Wang, 2020).

Socioeconomic status played a vital role in internal migrants exhibiting better mental health (Ma et al., 2020). Therefore, perceived social stigma, single marital status, poor health status, low income, social exclusion, daily discrimination, and inequality experiences significantly affected psychological distress and quality of life among internal migrants (Li and Rose, 2017; Wang et al., 2010).

It was also found that multiple migrations between the place of origin and the final destination significantly affected mental health outcomes (Yang et al., 2020). This means that the sequence of internal migration between the place of origin and the final destination was significantly associated with mental health outcomes (Yan et al., 2019; Zhang et al., 2019; Zhong and Piquero, 2017; Yue et al., 2017; Lin et al., 2011). Therefore, internal migrants who stayed at their place of destination experienced better mental health. Also, return migrants experienced some significant improvement in mental health status (Nauman et al., 2015).

Internal migrants exhibited poor physical health and high levels of psychological distress (Tong and Piotrowski, 2012; Chen, 2011). Female internal migrants usually internalised the stress, especially in internal migration, thereby displaying symptoms of mental

disorders (depression), while male internal migrants externalised the stress by engaging in smoking behaviours. However, family social support reduced the impact (Lu, 2010).

A significant amount was regarded as 'mentally unhealthy' with stress and internal migration impacting mental health (Xuesong et al., 2010). However, recent migrants were found to have reported better self-rated health, while those migrating from rural areas being affected by internal migration report lesser health outcomes (Gao, Wu, and Li, 2019).

Internal migrants were also found to have limited access to medical help due to lack of awareness of available community and public health support, lack of insurance, and high cost of healthcare. In addition, internal migrants experienced excessive workloads which led to poor mental health (Yu et al., 2019; Zhuang and Wong, 2017; Hong et al., 2006).

Among older internal migrants, there were strong associations between migration status and mental health, especially among temporary migrants (Hou et al., 2019). Factors associated with poor mental health status were unstable housing, high substance abuse, and dissatisfaction with life and work (Li et al., 2017).

Among internal migrant workers, there was a high prevalence of mental disorders among internal migrant workers with factors like being a minority, short duration of stay, low economic status, and migrating without a partner. In addition, poor relationships with family and peers, occupational hazards, long working hours, being a smoker, being a frequent internet user, inability to adapt, age and better education were associated with symptoms of mental disorders (Li et al., 2014; Mou et al., 2011; Wong and Chang, 2010; Wong et al., 2008).

Suicidal behaviours and poor quality of life were also associated with poor mental health (Dai et al., 2015; Hoi et al., 2015; Zhong et al., 2013; Mou et al., 2011; Li et al., 2007). Furthermore, female internal migrant workers were at higher risk of poor mental health (Ismayilova et al., 2014).

Households where internal migrant workers moved from, were more likely to report mental disorders due to the absence of family members. However, the monetary remittances from the internal migrant workers helped with the mental health costs (Lu et al., 2012). On the other hand, families with unemployed internal migrants tend to have financial difficulties and a lack of available care (Guo et al., 2018; Ma et al., 2020; Guan, 2017; Chen et al., 2016).

Internal migrant youths, especially second-generation migrants, had higher symptoms of psychological distress and stress. On the other hand, factors associated with good mental health status were social integration, personal freedom, life satisfaction, and good physical health (Chen et al., 2019; Ying et al., 2019). Furthermore, family support helps relieve symptoms of mental disorders and low self-esteem. Peer relationships and social support played major roles. Factors like gender, age, socioeconomic status, and inability to adapt were significantly associated with poor physical and mental health (Wang et al., 2019; Wu et al., 2017; Mao and Zhao, 2012).

Therefore, healthy internal migrants were more likely to move from their place of origin, while those with poor health were more likely to return (Lu and Qin, 2014; Chen, 2011). Young internal migrants were likely to experience health deterioration after internal migration. It was also found that emotional state and social trust change affected internal migration (Xu et al., 2020; Chou et al., 2011). Thus, even though internal migration may

be beneficial to the health of migrants, issues like age, type of migration, and social support are important (Gao et al., 2020; Chen et al., 2020; Guan, 2017).

1.8.6 Critical appraisal of key studies in scoping literature review

Two-hundred and eighteen (86%) of the selected were quantitative studies, twenty-four (9.5%) were qualitative studies and nine (3.5%) were mixed method studies. Questionnaires and survey instruments were used as the primary mode of data collection for all 218 quantitative studies identified. Interviews (one to one interview and focus groups) were used to collect data from the qualitative studies while focus group discussions, key informant interviews and surveys were used in mixed method studies. This showed that a majority of the studies were quantitative studies and non- of the qualitative studies focused on the lived experiences of the selected study participants. Instead, most of the studies focused on the knowledge, attitudes, and risk factors of mental disorders among participants.

The studies included in the scoping review used different key words to describe mental health. Twenty-three (9.2%) focused on mental health, eighty (31.8%) mental illness, fifty-one (20.3%) psychiatric conditions, thirty-one (12.3%) depression, twenty-eight (11.2%) mental disorder, and twenty-three (9.2%) schizophrenia. Others are autism spectrum disorder 1 (0.4%), Epilepsy; 1 (1.2%), Dementia; 2 (0.8%), Post-Traumatic Stress Disorder; 2 (0.8%), Anxiety; 2 (0.8%), Suicide; 4 (1.6%) and Insomnia; 1 (0.4%). None of the studies considered the positive aspects of mental health and wellbeing but instead, all the included studies focused solely on the causes of, and attitudes associated with mental illness, and descriptions of persons with mental illness. Mental health was regarded as a condition and not as a concept.

Fifty-one (20.3%) studies were published between 1970 and 2000, 69 (27.5%) between 2001 and 2010, 121 (48.2%) between 2011 and 2018 and, 10 (3.9%) between 2019 and 2021. The findings from this scoping review indicate that the views and knowledge about mental disorders in Nigeria have not changed significantly over time. This view emphasised on supernatural causation followed by drug abuse. However, few recent studies between year 2019 and 2021 found that the perceptions of residents in the southwest region improved with less emphasis on supernatural causation.

One hundred and fourteen (45.4%) of the studies were undertaken in the southwest region, twenty-two (8.8%) in the southeast, forty-three (17.1%) in the south-south, twenty-four (9.6%) in north-central, seventeen (6.8%) in northwest, three (1.2%) in northeast region and twenty-eight (11.2%) in unstated regions in Nigeria. Majority of the studies were conducted in the southwest region of Nigeria. The southwest region of the country is known to have better education, improved standard of living and better access to opportunities (NBS, 2020). For example, Lagos state in southwest region of Nigeria is regarded as the economic hub of Africa (Ryan, 2015). Unfortunately, few studies are conducted in the northern region of the country. The northern region has the highest rate of poverty, youth unemployment with a low level of education. Furthermore, the region has the highest rate of insecurity especially in the northeast region (Adofu and Alhassan, 2018; Iwueze, 2020).

1.8.7 Limitation of selected studies in literature scoping review

Mental health issues were viewed as a condition instead of a concept. Mental health is not the absence of mental disorders (Galderisi et al., 2017; WHO, 2001). therefore, all studies in existing literature were focused on mental health as an existing condition. Even studies that focused on mental health did not focus on the positive aspects of mental health

such as social, emotional, and psychological including the ability to cope with adverse life events.

The northern region of the country had very few studies especially in the northeast region. This raises a concern as the region is the poorest with prevailing insecurity challenges such as insurgency, ethnic/ regions crises etc (Adofu and Alhassan, 2018).

Across different population groups in Nigeria, a major population group ignored in all studies were internal migrants. These population group constitute over 40% of the general population within the country (NBS, 2019; 2017).

There was a dearth of qualitative studies conducted in Nigeria in relation to mental health. At the moment, none of the qualitative studies explored the lived experiences and meanings of mental health issues directly from the perspective of Nigerians to identify factors impacting on the mental health of Nigerians.

1.8.8 Summary

An overview of Nigeria's historical background showed that the long history of slave trade, colonialism, military rule, and current civil rule paved the way for migration especially internal migration within Nigeria and across Africa. In addition, the poor socio-economic state of the country due to poor leadership, corruption, insecurity, and lack of necessary amenities had negatively impacted internal migrants and Nigerians as a whole.

Young Nigerians moved from rural communities to urban centres due to industrialisation to seek jobs and better life opportunities which began in the colonial era and continues to date. This led to a decline in agricultural-based rural communities. Male internal migrants

usually moved for job and educational purposes, while married female internal migrants usually moved for family and marriage purposes.

It was found that there was an improvement in knowledge about mental disorders among the general population group in the southwest region of the country. However, there was still some negative attitudes among various population towards persons with mental disorders. In contrast, there was still poor knowledge about mental disorders in the northern region of the country. The strong belief in supernatural causation of mental disorders led to traditional and spiritual health-seeking behaviours and negative and stigmatising attitudes towards persons with mental disorders.

Among medical professionals, those with specialised skills or knowledge in psychiatric or mental health care had better knowledge and attitudes towards mental health issues. Particular attention should be paid to community health care, as medical professionals believed this would help improve the care and wellbeing of persons with mental disorders.

Mental health issues were perceived in the literature as a condition rather than a concept. The focus was on mental illness or mental disorders, including their causes, descriptions, and risk factors. None of the studies included in the review looked at the positive aspects of mental health.

The risk factors of mental disorders were identified across different population groups in the country and recently internally displaced persons. It is pertinent to note that voluntary internal migrants as a group were non-existent in existing literature in relation to mental health outcomes in Nigeria. However, there is a consensus of risk factors across different population groups in Nigeria that factors such as single marital status, low income, poor physical health status, and long duration of place of residence negatively impacted on the

mental health of Nigerians. In addition, poverty, low educational attainment, lack of support, unemployment, and lack of social amenities were prevalent across the different population groups in the country.

The most common mental disorder were depression, anxiety, and post-traumatic disorder. The most recommended treatments were traditional and spiritual. This was due to the belief in supernatural causation and treatment paid out of pocket, which placed the burden of care on families and loved ones.

Migration is a complex process where the individual experiences a series of adjustments and a series of stressors. Younger migrants experience stressors from migration and are more likely to be at risk of mental disorders. However, resilience and social support helped migrants adjust and settle better (Bhugra, 2004).

In other countries in Africa, migrants (internal and international) with low socioeconomic status, ethnic discrimination, and lack of social support were prone to mental disorders. Migrants who experienced a lack of social amenities like water, sanitation, electricity, etc., were less likely to contact mental health care and had high symptoms of mental disorders.

In developed countries, low socioeconomic status, and racial and ethnic discrimination were associated with poor mental health status. Migrants were found to have better mental health before migration. It was also found that marginalised migrants had lower mental health status, with social support highly significant in their adaptation. Finally, migrants who moved regularly before reaching their final destination had poorer mental health.

Therefore, the scoping review found a clear consensus relating international migration and internal migration with mental health due to a similarity of factors. Factors such as

lack of social support, ethnic discrimination, cultural/language barriers, financial difficulties/ job problems, etc., impact the mental health status of migrants irrespective of the location, i.e., internal, or international. Oyeniyi (2013) cautions that migration policies and legal requirements may make migration experiences different. However, this scoping review ascertained migrants both internally and internationally experienced similar experiences that significantly impact their mental health, life satisfaction, and self-esteem. Adepoju (1998) suggests that this is possibly due to the similarity of the migrants drive for migration which is for economic and social wellbeing.

The next chapter introduces a reflection using the ‘silences framework’ of my research identity, research subject, and research participants in the study.

Chapter Two: Stage 2: Hearing ‘silences’

2.1 Introduction

This stage was completed by reflecting on the silences in the relationship between the researcher, research subject, and research participants (Serrant-Green, 2011; Eshareturi, 2016). These components underpin this study and the research design, data generation and analysis, and recommendations arising from the findings.

Therefore, this chapter explores my identity as a researcher, followed by issues relating to the research subject and matters relating to the marginalised perspectives of the study participants. Finally, the chapter concludes by summarizing the ‘silences’ uncovered to identify how these silences inform the overall study design.

2.2 The researcher identity

Self-identification is crucial as it creates the central component through which all other silences are discovered (Eshareturi, 2016). It provides an opportunity through which potential participants can understand the study through the eyes of the researcher. I identified and critically reflected from personal experiences concerning the study. The following questions to be answered by myself included

- What is my relationship to the study?
- What made me study the issue of mental health among internal migrants?
- What are my personal/ professional drivers leading to the investigation of mental health in Nigeria?

My identity as an internal migrant drove my interest in the study by seeking to explore mental health issues among internal migrants in three geographical locations in Nigeria.

I have also provided a reflective account of matters concerning decisions around interpretation, and stating biases in the research (Eshareturi, 2016).

I ensured a conscious and continuous placing of myself in the research by examining my own identity in the study (Serrant-Green, 2011). I also made a conscious decision not to place myself ahead of the stakeholders in the study by keeping my internal migration experiences aside. These include study participants, gatekeepers, and other collaborators in the research. This is called positionality, and this relates to the status of the researcher in the study. Asselin (2003) explained that issues of positionality and research identity require reflection throughout the research process to produce a more trustworthy and honest account (Pelias, 2011). Reflexivity is defined as 'reflexive monitoring of action' (Alasuutari, 2004, p26). The reflexive process includes exploration of factors underpinning personal values, experiences and assumptions, and my identity as a researcher.

Serrant-Green (2011) suggests that the researcher must initially identify and conceptualise the silence. The silence became apparent as mental health issues are hardly discussed in Nigeria resulting in widespread stigma (Pederson et al., 2020), especially among internal migrants (NBS- survey report on irregular migration, 2020; Food and Agriculture Organisation, 2018). From my personal experiences of being an internal migrant and the scoping literature review, it was discovered that internal migrants had been ignored, which constitutes a 'screaming silence.'

I, therefore, conceptualise the study from the perspective of an internal migrant with a passion for exploring issues about mental health that are hardly talked about in Nigeria

(Gureje et al., 2006; 2005). This framework situates the researcher ‘as the main conduit through which silences are heard, identified, and prioritised’ (Serrant-Green, 2011).

I am a married black female of Nigerian, African heritage. My parents both hold degrees at the master’s level. My parents are from ‘Ayedun’ in Kwara state (northcentral region), Nigeria. However, they relocated to Kaduna State (northwest region), Nigeria. My father relocated to pursue further studies in medicine at Ahmadu Bello University, Zaria, Kaduna State. My mother moved to join her husband and to pursue a career as a banker. My brother and I were born in Kaduna state (residence of relocation) and spent a significant part of our lives in this town.

Growing up as a second-generation internal migrant in a place outside my state of origin was rather difficult. The language of communication apart from English is the Hausa language. I could not speak Hausa because my parents isolated me from my peers who spoke the language. This made me experience social interaction issues. This resulted in discrimination and made me feel disconnected from associations with peers and friends. I was also subjected to feelings of isolation due to my inability to speak the language.

Over the years, while growing up in Kaduna state, I observed that individuals who could not speak Hausa and were not a member of the ethnic group experienced discrimination irrespective of how long they resided in the state. Yet, internal migrants never benefited from opportunities in government establishments such as school admissions, scholarships, employment, and obtaining government contracts. Irrespective of how qualified they appear.

I also situate myself as a first-generation migrant. As a young adult, I moved temporarily to Ogun state (south-west region) for my undergraduate study at Covenant University,

Nigeria. After my studies, I relocated to Abuja, FCT (north-central region), to undertake a youth internship programme called National Youths Service Corps Scheme. It is a requirement for every Nigerian graduate under 30 to enrol in a one-year internship programme. Under the scheme, the government will post the graduate to another location (state) apart from their state of origin to explore new places and have new experiences.

The National Youth Service Corps Scheme (NYSC) was created on 22nd May 1973 to restore and integrate the country after the Nigerian civil war. This led to the establishment of the NYSC scheme by decree No 24, which stated that the NYSC was created 'with a view to the proper encouragement and development of common ties among the youths of Nigeria and the promotion of national unity' (p 1). The purpose of the scheme is mainly to instil in Nigerian youths the spirit of selflessness in their communities with an emphasis on unity regardless of cultural or social backgrounds (NYSC Directorate Headquarters, 2017).

I got married a few years after and I decided to remain (permanently) in the new location (Abuja) after the one-year internship programme because I was retained in the company of placement in which I served.

I situate myself both as an insider and an outsider to the research. I consider myself an insider being a first-generation internal migrant with some first-hand experiences of internal migration in Nigeria. In addition, my knowledge and experience as an internal migrant helped the data generation process by using a video conferencing platform called Zoom, considering the cultural and language similarities I share with the study participants (internal migrants). For example, although all participants spoke English, it

would be difficult for a non-Nigerian to understand the accents, dictations, and contextual explanations of their lived experiences during the interviews.

I also consider myself an outsider being a second-generation internal migrant born in the place my parents migrated to. I did not have the first-hand experience of internal migration to the state in which I was born and grew up. However, I had some experience as a temporary internal migrant outside my state of residence. Therefore, the study's inclusion criteria were specifically designed to select individuals who had first-hand experiences of internal migration and reflected on their mental health experiences.

My experience of internal migration accompanied with data from the literature will bring about trustworthiness to the research. Even though I have some experiences as a first and second-generation internal migrant, my role is to serve as the 'conduit' through which the participants' experiences will be delivered.

Another way to remain trustworthy is to use the triangulation approach. This means I approached the study from different perspectives by using different methods to answer the research question. These perspectives involved using several methods and theoretical approaches to crosscheck data from several sources to ensure quality in the research data (Flick, 2008; O'Donoghue and Punch, 2003). It is an attempt to explore fully the richness and the complex nature of human behaviour through studies from more than one perspective (Cohen and Manion, 1986).

I made use of different sources of information (literature scoping review), methods (phenomenology), theories (interpretive framework, intersectionality theoretical framework and the 'silences' Framework) (Serrant-Green, 2011; Miles & Huberman, 1994; Erlandson et al., 1993; Glesne and Peshkin, 1992; Ely et al., 1991; Lincoln & Guba,

1985; Patton, 1990; 1980). In addition to the different methods, member checking from research participants and collective voices (experienced experts in the field of study) was used. This member checking process involved the relevant stakeholders reviewing and providing feedback on the findings report to ascertain if they truly reflect the voices of the study participants. This process involves using various sources of information to shed light on an issue, as in this case, internal migration, and mental health in Nigeria.

A challenge for any researcher is identifying their position early in the research process (Gregory, 2019). My initial concerns were being an early researcher and how to interact with individuals and groups. However, the ‘silences’ framework (Serrant- Green, 2011) and the critical perspectives that underpin it, combined with my philosophy as a researcher with the study aims, provided an appropriate conceptual framework to guide the study. The initial assumptions regarding the ‘researcher’ voice were made from my experience as an internal migrant in Nigeria, similar cultural backgrounds, passion for mental health, and relevant education and training.

Therefore, my unique contribution to the study was my positionality as an academic researcher with some experience as an internal migrant in Nigeria. This specific positionality resulted in the initial creation of the study. However, I also used my academic and research training to seek guidance from the literature and found no studies on internal migrants in Nigeria concerning mental health. This led to the identification of a gap in the body of knowledge.

`2.3 Research Subject

The scoping literature review identified a gap in the current evidence base regarding Nigeria's internal migration and mental health. Currently, there are no existing studies

exploring experiences, knowledge, and attitudes of voluntary internal migrants in Nigeria, including contributory factors that could impact mental health. There is also a dearth of qualitative studies exploring mental health issues of study participants' internal migration lived experiences. Data were obtained directly from an under-researched group of people, completely ignored from the evidence base (voluntary internal migrants in Nigeria).

There were also no reported studies exploring the positive aspects of mental health. Mental health was perceived as a 'condition' rather than a 'concept.' According to WHO, 'mental health is a state of wellbeing in which the individual realises his/her abilities, cope with normal stresses of life, work productively, and contributes to the community' (WHO, 2001, p1). Therefore, positive mental health according to WHO involves an individual realising own potential, working productively, and coping with normal stresses of life.

Existing studies focused on mental illness and/or mental disorders and not on the WHO definition of mental health (Abasiubong et al., 2007; Adewuya and Makanjuola, 2008a; Adeyemi, Abiola and Solomon, 2016; Omolayo et al., 2020). Mental health is more than the absence of mental disorders or illness or disabilities. Mental illness results in the inability of an individual to function over some time. Therefore, mental health reflects on aspects of an individual's emotional, psychological, and social wellbeing. It also impacts interaction with people, solving problems, and making decisions (Felman, 2020).

There were very few studies related to mental health that were published in the northern regions of Nigeria. However, the northern region is regarded as one of the poorest due to insecurity, under-development, low level of education, and poverty (Iweze, 2020; Ngbea & Achunike, 2014). In addition, there were no studies related to internal migration and

mental health published in Federal Capital Territory (Labinjo et al., 2020), except for very few recent studies focused on internally displaced persons forced out of their communities by insurgents. The Federal Capital Territory (Abuja) is the capital city of Nigeria, with a population of approximately over 2.4 million (NBS Annual Abstracts of Statistics, 2019). Principal occupants are civil servants, government workers, politicians, and business owners. The National Bureau of Statistics (2020) survey report on migration in Nigeria revealed that 85.1% of internal migrants reside in urban areas while 14.9% reside in outskirts or neighbouring towns in the Federal Capital Territory.

Based on the gaps identified, this study used a qualitative approach to identify and explore the knowledge and lived experiences and its influencing factors among an under-researched group of internal migrants in two states in the northern region (Kaduna state and Federal Capital Territory) and a state in the south-west region (Lagos state). This makes a major contribution to existing knowledge in Nigeria by studying an under-researched group of internal migrants with regards to a sensitive topic of mental health (Adepoju, 2020; 1998; Gureje et al., 2006; 2005). This study will assist in creating further research to assist relevant stakeholders in providing more access and delivery of mental health services in Nigeria.

2.4 Research participants

This stage identified the ‘silences’ by identifying the responses being said by the study ‘listeners’ (participants). The target population were internal migrants in three geographical locations in Nigeria. This study was created to explore and understand their experiences, including internal migration experiences and its impact on their mental health. The scoping review identified other population groups such as the general

population across different regions in the country, youths, pregnant women, medical professionals, internally displaced persons, and people with mental disorders (Pederson et al., 2020; Adewuya et al., 2018; 2006; Ezeme et al., 2016; Ola et al., 2011; Makanjuola et al., 2010; 2016; Gureje et al., 2006). This population (voluntary internal migrants) was chosen to address the current knowledge gap, as this population group was excluded from existing literature.

2.5 Summary

This chapter describes silences inherent in this study. I situated myself as an insider and outsider in this study due to being a first- and second-generation internal migrant in Nigeria. I focused on the 'listeners' experiences (voluntary internal migrants) but placed power with the study participants while putting my personal experiences aside and reflecting on my identity in the research process (Serrant-Green, 2011; Eshareturi, 2016). In recognition of the 'silences' inherent in the research subject, the lack of evidence about a sensitive topic such as mental health among internal migrants in Nigeria created a gap in existing knowledge.

Therefore, the 'silences' theoretical framework (TSF) underpins the need for this study. These 'silences' are presented in three fronts, the researcher, the research subject, and research participants, which exist and dynamically complement each other.

Chapter Three: Stage 3: Voicing ‘silences’ (Methodology)

3.1 Introduction

After establishing the theoretical framework underpinning this research, it was vital to provide an account of the research strategy. This chapter provided an understanding of the methodological perspective governing the study. This chapter also discussed the philosophical assumptions (ontology, epistemology, axiology, and methodology) associated with the interpretive framework.

It also involved examining the research approach, its nature, and its use in the study. It also gave a detailed description of the study selection criteria, and participants recruited. In addition, a description of the data generation instrument and how it is administered was provided. Finally, this chapter explained the method of data analysis and introduced the intersectionality framework.

3.2 Study aims and objectives.

This study aimed to identify and explore factors that impact the mental health of internal migrants in Nigeria.

The objective of this study includes the following:

1. Explore the experiences of selected voluntary internal migrants and the impact their internal migration experiences had on their mental health using a new theoretical framework (Serrant-Green, 2011).
2. Improve knowledge level and awareness about mental health issues in Nigeria.

3. Assist in creating further research to assist stakeholders in providing more access and delivery of mental health services in Nigeria.
4. Test the application of the ‘silences’ framework (Serrant-Green, 2011) for researching an under-researched group about a sensitive issue in a new context.

The research questions guiding the study are:

1. What are the views, knowledge, and experiences of internal migrants in Nigeria concerning mental health issues?
2. What are the influencing factors concerning mental health among internal migrants?
3. What is the impact of migration on mental health?

3.3 Philosophical assumptions

Philosophy is described as the use of abstract ideas and beliefs that inform research (Denzin & Lincoln, 2011; Creswell, 2007). According to Denzin & Lincoln (2011), the research process begins with considering my input to the research, such as my personal history, background, personal identity, cultural and political stance, etc. Phase two brings into the research paradigms 'a basic set of beliefs that guides action’ (Guba, 1990, p.17). I also discovered the philosophical and theoretical frameworks in this phase. Phase three describes the research approach used in the study, and phase four describes the methods of data collection and analysis. Finally, phase five provides the interpretation and evaluation of the data.

According to Denzin & Lincoln (2011; 2008; 2002; 1995), philosophical assumptions guide qualitative research. These beliefs are called paradigms (Lincoln, Lynham & Guba, 2011). The following philosophical assumptions are explained concerning this research.

Ontological assumption relates to the 'nature of reality. This means the researcher embraces multiple realities between the study participants and the readers. These individuals all embrace different truths. These multiple realities involved multiple forms of evidence using actual words of different people and presented different perspectives (Denzin & Lincoln, 2011).

Epistemological assumptions relate to what counts as knowledge and how knowledge claims are justified. Intuitive knowledge is gathered based on personal views. Knowledge is acquired through the personal experiences of people and, studies done in the field location (Denzin & Lincoln, 2011).

Axiological assumptions relate to values brought to the qualitative research (Creswell, 2007).

Methodology refers to the procedures of conducting the research. It comprises inductive reasoning leading to the generation and analysis of data.

Philosophical assumptions are embedded within research paradigms when conducting a qualitative study. The research paradigms consist of the following:

3.3.1 Post positivism

This belief system is grounded in the scientific approach. It does not believe in strict cause and effect but recognises the effect as a problem that may or may not occur. This is appropriate with pure quantitative research and where qualitative research plays a

supportive role (Denzin & Lincoln, 2011; Creswell, 2007). However, this framework was not used in this study as it does not fit into the study aims, and this research is purely a qualitative study.

3.3.2 Transformative framework

The basic assumption of this framework is that knowledge is not biased and shows the relationship between power and society. Therefore, knowledge aims to help people to improve in society (Mertens, 2007). This framework contains agenda to bring reform or change to marginalised groups. It is also called participatory research. This framework was not used in this study as it does not fit into the aims and objectives of the study.

3.3.3 Postmodern perspectives

Thomas (1993) described a postmodernist as a person who focuses on changing the ways of thinking rather than asking for action-based reform. The basic concept is that knowledge must be set within the conditions of the world today using multiple perspectives of class, gender, race, and other groups.

This framework was well accepted by individuals such as Foucault, Derrida, Lyothd, Giroux, and Freire (Bloland, 1995). This framework was not used in this study as it does not fit into the aims and objectives of the study.

3.3.4 Pragmatism

This framework focuses on the research outcome, for example, the consequences of an injury instead of the precursor conditions. Therefore, this framework was not used in this study as it does not fit into the aims and objectives of the study (Creswell, 2007).

3.3.5 Feminist theory

This framework concentrates on problems relating to women's diverse situations and the institutions that surround them. The subject usually covers gender domination within a patriarchal society. The approach aims to establish a non-exploitative relationship that puts the researcher within the study to avoid objectification and conduct transformative research (Creswell, 2007). This framework was not used in this study as it does not fit into the aims and objectives of the study. Even though some elements of gender were discussed, that was not the overall focus of the study.

3.3.6 Critical Theory

Critical theory involves empowering humans to overcome the challenges caused by race, class, and gender (Fay, 1987). However, this framework was not used in this study as it does not fit into the aims and objectives of the study.

3.3.7 Critical race theory (CRT)

Critical race theory focuses on the theoretical attention to race and how racism is deeply embedded into the framework of American society (Parker and Lynn, 2002). The goal is to first present stories about discrimination from the perspective of people of colour. The second is to argue for eradicating racial domination while recognising that race is a social construct and address other areas of difference such as gender, class, and other inequities (Parker and Lynn, 2002).

This framework was not used in this study as it does not fit into the aims and objectives of the study. Even though some elements of discrimination were discussed, this was not the overall focus of the study.

3.3.8 Queer theory

This involves various methods and strategies relating to an individual's identity (Plummer, 2012; Watson, 2005). It explores the complexities of identity and how identities are reproduced on social platforms. Its focus is on how identities are culturally and historically constituted, linking gender and sexuality. This framework was not used in this study as it does not fit into the aims and objectives of the study.

3.3.9 Disability theories

This addresses the meaning of inclusion in schools and associations such as administration, teachers, and parents with children with disabilities (Mertens, 2010). Mertens (2003) explained that disability research has moved from the medical model (sickness and role of the medical community) to research involving participants. However, this framework was not used in this study as it does not fit into the aims and objectives of the study.

3.3.10 Interpretivism

The interpretive approach explores interest in the meanings and experiences of human beings. The belief is that people are constantly involved in interpreting their ever-changing world. Interpretivism believes that people construct the social mind. Interpretivists encourage naturalistic inquiry and embraces an inductive style of reasoning. The primary role of this approach is to ‘understand how various participants in a social setting construct the world’ (Glesne and Peshkin,1992, p: 6).

In opposition to positivism, ‘the interpretive approach shows the relationship between the researcher and the participants and their influence’ (Guba, 1981, p.77). In this framework, individuals seek to understand the world they live in by creating personal

meanings of their experiences of a phenomenon. These meanings are usually multiple, making the researcher look at the complexity of these views instead of narrow meanings. This framework aims to concentrate on the participant's views and experiences of the phenomenon.

These meanings are usually formed by interaction with individuals (social construction) and through historical and cultural norms and values and how they interact in the environments in their daily lives. Regarding practice, the questions in the framework are broad and general to enable participants to construct the meaning of the phenomenon. The constructivist researchers address the process of 'interaction' among people. They also focus on specific contexts in which people live to understand the historical and cultural environment of the participants.

This research study sought to identify and understand the factors that impact the mental health of a selected group of internal migrants in Nigeria. I also interpreted the research findings, shaped by participants personal experiences and background. The interpretive research paradigm that views the truth as multiple realities socially constructed by the individuals researched was adopted. The concept of truth in this study was that internal migrant participants in Nigeria have different migration experiences and how these experiences impacted their mental health. I, therefore, conclude that this research paradigm is consistent with the aims and objective of the study.

Qualitative research starts with philosophical assumptions and interpretive or theoretical frameworks that attempt to answer the research problems by addressing the meanings individuals ascribe to a social or human problem. Then, data is generated in a natural setting and analysed by establishing themes or patterns to study this problem. Finally, the

written report includes the voices of the participants, a reflexive account, complex description and interpretation of the problem, and contribution to knowledge (Creswell, 2007).

This study is qualitative because the research studied internal migrants in Nigeria and attempted to understand mental health issues by studying selected participants' meanings and lived experiences. A qualitative study was necessary because the issue of mental health among internal migrants needed to be explored, and an understanding of the contexts where potential internal migrants' experiences can help address mental health problems in Nigeria.

3.4 Research design

As Denzin & Lincoln (2011) explained, the next stage in the research process is identifying the approach to be used in the study. The following are different types of research approaches/ strategies used in qualitative research.

3.4.1 Narrative research

A 'narrative' can be described as a phenomenon being studied, for example, a narrative of an illness, or it can be defined as a method used in a study, e.g., a procedure for analysing stories (Pinnegar & Daynes, 2007; Chase, 2005). The research starts with the experiences expressed in lived and told stories of people. Czarniawska (2004) defines narrative as a specific type of qualitative design, which is understood as a spoken or written text giving an account of an event or a series of events. The procedure involves a focus on studying a few individuals. Data is collected through their stories, reporting these individual experiences, and chronically ordering the meaning of those experiences.

Narrative studies focus on specific stories told by individuals or organisations and are guided by an interpretive framework (Czarniawska, 2004).

This approach may be helpful when participants wish to give stories of their experiences as internal migrants concerning mental health. However, understanding and making sense of participants experiences may be complex because the study explored the participants experiences and did not just provide a narrative account. In addition, the study also explored their knowledge and perception of mental health issues. Therefore, this approach was not used in the research.

3.4.2 Grounded theory

Grounded theory aims to move beyond description and create a 'theory.' This is called 'a unified theoretical explanation' (Corbin & Strauss, 1990, p.107). Participants in the study must experience the theory's process and development, which will help provide a framework for further research.

The main idea is that this 'theory development' is not just a description but 'grounded' in data from participants who experience the process (Strauss & Corbin, 1997). Grounded theory is therefore defined as a process where the researcher creates a general explanation (theory) of a process, action, or interaction shaped by many participants' views (Creswell, 2007). This design is used when a theory is not available to explain a process. According to Creswell (2007), the significant outcome of the study is to create a theory with specific components such as central phenomenon, casual conditions, strategies, contexts, and consequences.

This was not the chosen methodology at this stage because the core aim of this study explored the lived experiences of internal migrants and underlying factors concerning

mental health. The window opportunity to interview was small as the research field (Nigeria) is far away from my research residence (UK). Hence, the structured approach of grounded theory would not have been achievable. The current study explored the internal migration experiences of selected participants and the impact it had on their mental health. In addition, the study examined the knowledge and perceptions of participants about mental health.

Hence, developing a theory from participants' views would have been impossible as the study focused on their experiences and their knowledge and perceptions about mental health (McLeod, 2001). It is essential to use a method of analysis that aligns with the research question (Wertz, 2011). However, it may be helpful in future studies.

3.4.3 Ethnographic research

This approach focuses on an entire ‘culture-sharing’ group. The cultural group may be small, but it usually involves many people who interact over time (for example, teachers in a whole school). Therefore, ethnography is defined ‘as a qualitative design where the researcher describes and interprets a culture-sharing group's shared and learned patterns of values, behaviours, beliefs, and language’ (Harris, 1968, p 545). In terms of the process or outcome of the research (Agar, 1980), it is a way of studying a culture-sharing group, including the final written report of the study.

The ethnography process involves extensive observation of the group through participant observations. The researcher is embedded in the participants daily activities, observing the behaviour, language, and interaction among members of the culture-sharing group. Its focus is on developing a complex description of the culture of the group. Wolcott

(2008) says ethnography is a study of culture and an identifiable group of people (Creswell, 2007).

Ethnography involves a cultural group that usually consists of members who have been together over a period of time. Also, ethnography does not describe the essence of the group's experiences (internal migrants) and their meanings to their experiences. Therefore, there is uncertainty regarding identifying internal migrants in Nigeria to a culture, as this study looked at internal migrants in different locations in the country.

Therefore, I will not be able to recruit participants using this approach as they will not be in a specific place. Furthermore, the method of data collection using a video conferencing application tool called Zoom will not make it appropriate because ethnography involves the researcher immersing his/herself with the study participants.

3.4.4 Case study

This approach involves the study of a case or cases within a real-life context (Yin, 2009). Stake (2005) explained that case study research is not a methodology but a decision of what is studied. Others look at it as a strategy of inquiry, a method, or a comprehensive research strategy (Denzin & Lincoln, 2008; Merriam, 1998; Yin, 2009). This is, therefore, a qualitative or sometimes quantitative approach where the researcher explores real-life, contemporary bounded systems (a case) or multiple bounded systems (cases) over time. Data is collected through numerous in-depth sources of information such as observations, interviews, audio-visual material, documents, and reports. The written reports are case descriptions and case themes.

While this approach may be appropriate to study internal migrants and mental health in Nigeria as a ‘bounded system’ focusing on an issue of concern, the study aimed to explore

the experiences of internal migrants and understand factors that impacted mental health. In addition, the study sought to understand their knowledge about mental health issues. Therefore, I concluded that this approach was not appropriate.

3.4.5 Phenomenological research

A phenomenological study describes the common meaning for several individuals of their lived experiences of a phenomenon. Its focus is on describing what all the participants in the study have in common as they experience a phenomenon. I identify a phenomenon as 'an object of human experience' (Van Manen, 1990, p.163). The human experience may be a phenomenon such as mental health, insomnia, etc. (Moustakas, 1994). This description comprises what they experience and how they experience it (Moustakas, 1994). Phenomenology has a solid philosophical component, it relied on the writings of German mathematician Edmund Husserl (1859-1938), and it was elaborated more by Heidegger, Sartre, and Merleau-Ponty (Spiegelberg, 1982).

The philosophical assumptions studied the lived experiences of individuals (Van Manen, 1990), and created the development the essence of the lived experiences, not just descriptions (Moustakas, 1994). Furthermore, these lived experiences allowed me to understand how events, activities, and meanings are shaped by the unique circumstances in which they occur (Creswell & Poth, 2016).

The philosophical assumption asserts that meaning comes into reality through association with our world (Crotty, 1998). Thus, philosophical beliefs are the fundamental level on which research is based. Mills et al. (2007) said researchers are more aware of their ontological and epistemological beliefs when creating questions and selecting a

methodology. These assumptions represented the philosophical beliefs upon which research was based.

Grix (2002) explained that these include assumptions with regards to the nature of the world which underpin the ontology (assumptions about the world) and epistemology (relationship between the researcher and researched) as well as the methodology (i.e., approach to creating that knowledge to the research) (White & Dotson, 2010). Therefore, the underpinning philosophy of a phenomenological approach was appropriate to the philosophical assumptions that focus on this project as outlined earlier.

I attempted to bracket myself out of the study by exploring my personal experiences with regards to the phenomenon (see chapter two). This helps focus solely on the participant's experiences in the description without bringing self into the picture (Creswell, 2007). Therefore, phenomenology is described as an interpretive process where the researcher interprets the meanings of the lived experiences.

The following are types of phenomenology:

According to Van Manen (1990), hermeneutical phenomenology is research created toward the lived experiences and interpreting the 'texts' of life. Peoples lived experiences are thematically analysed through languages and directed through philosophical and theoretical assumptions and a reflective account through the researcher's eye. Thus, the findings are interrelated with the researcher's interpretation and context of the research.

Also, according to Moustakas (1994), transcendental or psychological phenomenology focuses less on interpretation but more on a description of participants' experiences. It also focuses on one of Husserl's concepts called epoche (bracketing). This is where researchers set aside their experiences to take a new perspective toward the phenomenon

being studied. Transcendental means ‘in which everything is perceived freshly, as if for the first time’ (Moustakas, 1994, p, 34).

This study explored the common meanings of internal migrants in Nigeria about their lived experiences of mental health. It focused on exploring what all internal migrants have in common as they experience the underlying factors concerning mental health. The research understood the effects of contextual features and influences on participants’ experiences such as social, political, economic, etc. The phenomenological approach is appropriate because it seeks to understand several individuals’ common or shaped experiences of a phenomenon (Creswell, 2007).

The phenomenological research design questions fall under two broad categories: (1) what have you experienced in the phenomenon? (2) what contexts/ situations have impacted your experiences of the phenomenon? (Moustakas, 1994). These questions are precisely what this study sought to ask, (1) what are the experiences or common meanings of internal migrants in Nigeria in terms of mental health? (2) what contexts, situations or factors have influenced experiences of mental health? Thus, the features of phenomenology are consistent with this study, emphasising a hermeneutic phenomenon and exploring a group of individuals who have all experienced a phenomenon and their interpretation of these experiences. Therefore, I opted for the hermeneutic phenomenological approach to understand the experiences of internal migrants regarding mental health and the meaning they ascribe to that experience.

The research was focused on a way of being instead of a method to enable focus on the participants’ personal experiences and not just a fixed perception of the topic being studied. Instead of focusing on casual explanations, the study sought on uncovering the

inherent process of the participants existence or experiences (Madison, 2006). The ontological assumption which embraces multiple realities between the study participants and the readers and epistemological assumption related to knowledge is acquired through the personal experiences of people. In addition, hermeneutic phenomenology understands individuals and their meanings, interactions with others, and their environment (Lopez and Willis, 2004). Therefore, the hermeneutic phenomenological approach was used because the focus was not to build theory but to explore the lived internal migration experiences of study participants (Troy et al., 2007). This study used this approach as it fit with the ontological and epistemological assumptions underpinning the study due to its ability to focus on in-depth human experiences as internal migrants in Nigeria (Troy et al., 2007).

Hermeneutic phenomenology is recommended as the approach to inquiry that corresponds with understanding individuals and their meanings, interactions with others, and their environment (Lopez and Willis, 2004). I, therefore, concluded that the hermeneutic phenomenological approach was appropriate to addressing the aims and objectives of this study.

3.6 Study location

The study was in three states in Nigeria, namely, Kaduna state in the north-west region, Federal Capital Territory (Abuja) in the north-central region, and Lagos state in the south-west region of Nigeria. According to the National Population Commission's (2012) National Internal Migration survey, 85.1% of internal migrants reside in Federal Capital Territory urban areas while 14.9% live in rural FCT. In addition, 68.4% of internal migrants reside in Kaduna state urban areas, while 31.6% reside in rural Kaduna state.

Finally, 97% of internal migrants live in Lagos state urban areas, while 3% reside in Lagos state rural areas.

Abuja (Federal Capital Territory) became the capital city of the country on 12 Dec 1991. It has an estimated population of 1 million in urban areas and 2 million in suburban and settlement towns (NBS- Annual Abstracts of Statistics, 2019; 2017). The state was chosen to be the country's capital due to its central location, easy accessibility, good climate, low population, and availability of land for expansion (Working Group on Environmental Audit Conference, 2016). The Federal Capital Development Authority (FCDA) manages the Federal Capital Territory (FCT). It organises the construction and infrastructure development in the nation's capital city.

The increase of construction (real estate) and being the capital of administration of government parastatals and private businesses led to an influx of Nigerians into the nation's capital for a better life and employment (UNDP-National Human Development Report, 2018). As a result, Abuja is becoming one of the fastest-growing cities in Nigeria due to rapid population growth, increasing GDP, and increasing household consumption, as well as vast opportunities in construction, mining, agriculture, ICT, and real estate (Oxford Business Group, 2021).

Accommodation in Abuja is dependent on lifestyle, especially for those who are considered wealthy. For example, the cost of rent for a mini flat in the city of Abuja can be as high as 1,000,000 naira (approximately 2,000 pounds) per year and as low as a 120,000 (approximately 300 pounds) for a year. Accommodations with lower rent are usually located in the suburb area of Abuja like Gwagwalada (Campbell, 2019).

Lagos is regarded as Nigeria and Africa's financial centre and economic hub (NBS- Social Statistics Report, 2020; Ryan, 2015). The city is also considered one of the fastest-growing cities globally (NBS- Social Statistics Report, 2020; Diop et al., 2014). As a result of rapid urbanisation, the city continued to increase and attract internal migrants. The city of Lagos creates about 10% of the country's GDP. Many financial businesses, including commercial banks, financial institutions, and many other organisations, are in the central business district on the Island in Lagos state. In addition, Lagos is also home to the creative sector, manufacturing industries such as automobile, radio assemblies, food and beverage processing, metal works, and the production of paints and soap. There is also a fishing industry and a significant port area (NBS- Social Statistics Report, 2020; Ryan, 2015).

Lagos also accounts for over 60% of industrial and commercial activities in Nigeria. In addition, the informal sectors such as trading and small businesses are increasing due to the increased population in the state (NBS- Social Statistics Report, 2020; Olurinola et al., 2014). Therefore, it is not surprising that many young people have dreams of moving to Lagos due to the possibility of opportunities.

The city of Lagos is ranked as one of the most expensive cities globally (Ryan, 2015). Lagos state also attracts internal migrants due to the availability of specialised healthcare centres, hospitals, better schools, more access to electricity, and better pipe-borne water. In addition, there continue to be increased jobs in the construction industry, for example, the construction of the new commercial centre called 'Eko Atlantic.' Lagos also has a strong film industry (Nollywood) and an attractive music industry (NBS- Social Statistics Report, 2020; Ryan, 2015).

The city of Lagos is overcrowded, with over 22 million inhabitants (NBS-Annual Abstracts of Statistics Report, 2019; Campbell, 2019). A household is considered congested when two or more teenagers of same gender aged 12-17 occupy one room and at least two children under 12 years occupy one space (Makinde, Björkqvist, and Österman, 2016). According to Adeyemi et al. (2009), about 77% of residents in the metropolitan area of Lagos lived in a room with about five to ten occupants. A factor responsible for overcrowding in Lagos are due to internal migrants moving to cities from rural areas for a better life. This problem had led to the poor standard of living of residents (Makinde, Björkqvist, and Österman, 2016).

Kaduna city is the state capital of Kaduna state, located in the north-west region of Nigeria. The city is a trade centre and a major transport centre for surrounding agricultural regions (Adeleke, 2020). The state has a population of about 8,252,400 as of 2016 due to rapid urbanisation (Kaduna State Nigeria, 2018). Kaduna is regarded as the centre of learning and education, which is evident with many educational institutions in the state. Kaduna state consists of 23 local government areas and is populated by about 63 different ethnic groups (Kaduna State Nigeria, 2018). Christian Mission activities began in the 1900s with the establishment of the Sudan Interior Mission (SIM). People from the Southern part of Kaduna state are Christians (Adeleke, 2020).

Kaduna state is also regarded as the industrial city in northern Nigeria. This is due to manufacturing industries such as textile, machinery, steel, aluminium, etc. However, the textile industry has declined due to neglect by military leaders and the import of foreign wares. On the other hand, the agricultural sector thrives with exports such as cotton, peanuts, sorghum, and ginger (Adeleke, 2020). This justifies the reason for choosing these three geographical locations in the study.

3.7 Study population

This study involved internal migrants in Nigeria and their experiences concerning mental health knowledge and exploration of factors related to mental health. I planned to collect data from internal migrants about mental health issues in Nigeria using in-depth, face to face and semi-structured interviews (using an online application called Zoom) with 30 participants resident in Kaduna, the Federal Capital Territory, and Lagos states. However, data was generated from 19 participants when data saturation was reached. This was due to themes being repeated by the participants. This will be explained in detail in the next chapter.

The focus of this study is on internal migrants, and these are people who voluntarily moved from their state of origin to reside in other states in the country. Existing literature focused on forced migrations such as internally displaced persons (Mukhar et al., 2020; Ogechi and Ezadueyan, 2020; Taru et al., 2018; Aluh et al., 2019b; Amusan and Ejoke, 2017; Dunn, 2018; Akinyemi, Owoaje and Cadmus, 2016; Akinyemi, Atilola and Soyannwo, 2015; Akinyemi et al., 2012).

This study focused only on voluntary internal migrants because the context and rationale for voluntary migration are entirely different from forced migration. Also, including forced migration will make the study too broad and will not allow the completion of the study within the appropriate time.

A purposive sample was selected based on a non-probability sample of 19 internal migrants across three geographical locations in FCT (Abuja), Kaduna, and Lagos States. Purposive sampling is a non-probability sampling technique that depends on the researcher's discretion to choose the sample population. This also allows the researcher

to target hard to reach population specific to the research (Creswell, 2007). Purposive sampling was used to select members of this population group to address the study aim. Using purposive rather than convenience sampling for qualitative studies is encouraged to choose relevant participants (Janes, 2016).

Participants in Kaduna state were recruited through access from an educational institution (T&T Schools, Kaduna) by recruiting its staff. Participants in FCT (Abuja) were recruited through access from a church (Living Life Church) by recruiting its members. Out of a population of over 200 million in Nigeria, approximately 88,906,000 are Christians comprising 46.3% (World Watch Research, 2019). A snowballing sampling technique was used to recruit few participants in Abuja (FCT) through a referral from existing participants. In addition, secured access was obtained from the Nigerian Institute of Medical Research (NIMR) to recruit participants in Lagos state from their institute.

The eligibility criteria are as follows:

- A Nigerian adult aged 18 years and above. This is to ensure the individual has experienced social, economic, and cultural experiences concerning internal migration.
- The individual must also be an adult (above 18 years) at the time of relocation, i.e., the individual must be a first-generation internal migrant.
- The individual must be an internal migrant who has moved from the state of origin to another state and must have resided in the new state for at least one year.
- The individual must be able to speak and write the English language. English is the official language and means of communication in Nigeria.

3.8 Study access

Access was granted from participants in Kaduna state from the staff of T & T Schools Kaduna (appendix 4). Participants in Federal Capital Territory were recruited through Living Life Church Kubwa, Abuja (appendix 5), and a few were contacted directly through a referral from existing participants. Participants in Lagos state were recruited from Nigerian Institute of Medical Research (NIMR) to recruit some of their staff (appendix 6).

3.9 Ethical approval

The Sheffield Hallam University Review board gave ethical approval with the number ER7565232 (appendix 3).

3.10 Risk assessment

The risk assessment aimed to evaluate the potential risks to the researcher and research participants and its possible benefits (Polit & Hungler, 1999). There were minimal risks as approved by the Sheffield Hallam University Review Board.

The study has potential benefits to internal migrants by ascertaining their knowledge and lived migration experiences concerning mental health. The study will help create further research to assist relevant stakeholders; provide more access and delivery of mental health services. There were no physical or emotional risks anticipated. However, adequate measures were provided to deal with such situations. Appropriate safeguards were provided in the risk assessment (appendix 7). All information regarding data protection on personal data for research was provided with appropriate information for further details.

3.11 Recruitment

Recruitment was comprised of two stages.

Stage 1: Potential participants were contacted via (1) email, informing them about the study (appendix 2), (2) attaching the recruitment letter, (3) information sheet, and (4) consent form, including a reply slip. These documents have been reviewed by the university ethics board. This stage is designed to provide information to potential participants to enable them to make an informed choice about whether they want to participate in the study. This helped reduce the time of recruitment and data generation to allow appropriate planning of participants to interview.

In addition, details on who to contact for further information or queries was provided. This also allowed the individual to consider participation in the study at their convenience and helped avoid the prospective participants being coerced as they might feel obliged to participate if I had face-to-face contact with them.

Stage 2: Consent forms and replies slips were returned by participants via email. The initial contact served three primary purposes:

1. Confirm eligibility for study by confirming the state of origin and current state of residence, and length of stay in current residence.

2. Arrange interview: An interview schedule was arranged by stating the interview's date, time, and venue. This was sent to the participants to confirm suitability preference, and adjustments were made when needed.

3. Begin building rapport before the interview: A brief conversation of essential background information such as age, employment, etc., was used to build rapport.

In addition, a background overview with regards to the year of relocation helped provide an opportunity for participants to ask questions regarding the study.

4. Help familiarisation with the data generation tool called Zoom video conferencing by discussing the tool checklist (appendix 10) to ensure smooth usage of the internet tool during the interview.

3.12Data generation instruments

Interviews were used in this study because it is a means for researchers and study participants to work together (Nolan, 1995). Serrant- Green (2005) supports this assertion that interviewing helps researcher and participant involvement and is an inclusive approach to discussing experiences. Brinkmann and Kvale (2015) defined inter-view as a personal interaction of those involved in the study and knowledge created due to this interaction. This method aligns with my study as well as the aims and underpinning philosophical framework.

A telephone interview provides information when the researcher does not have visual access to participants. However, a challenge is the researcher cannot visually access individuals, and the researcher will not see the informal communication and non-verbal cues. Focus groups are good when the interaction between a group is involved. However, there is limited time to collect data. In addition, the individuals may be hesitant to comment on sensitive issues like mental health over different geographical locations in three Nigeria states, especially in a group setting. Therefore, this approach will not be helpful (Krueger and Casey, 2009; Morgan, 2002).

One-to-one interview encourages individuals who are not reluctant to speak or share their experiences. However, Creswell (2007) advises that one to one interview may be useful

in situations where participants seem less eloquent or shy. Therefore, one to one and face-to-face interviews are preferred because they allow participants to express their views, especially on sensitive issues such as mental health. This is very important for interpreting meaning, necessary for the interpretive and participant-led philosophy underpinning this study (Janes, 2016).

Open-ended and minimal structured interviews were chosen as this approach helps oral first-person accounts (Huberman and Miles, 2002). Appendix 8 showed a minimal structure of the interview guide on internal migrants' experiences of mental health in Nigeria. A time estimate of one and a half hours per interview was part of the study design. This provided enough time for participants to share their experiences in detail, considering their comfort, convenience, and the interview venue (Zoom conferencing tool).

A narrative or minimally structured interview is appropriate for capturing the experiences of study participants based on their own experiences (Janes, 2016). Therefore, minimally structured interviews with detailed descriptions of participants' experiences were used in this study (Geertz, 1973 cited in Huberman and Miles, 2002). This approach was appropriate for the study as internal migrants are under-researched in Nigeria, especially in relation to sensitive issues such as mental health, which are hardly discussed in Nigeria (Onyeji, 2020; Oyeniyi, 2013).

Nineteen (19) interviews were completed. These were one to one interview of up to one and a half hours with internal migrants residing in Kaduna, Federal Capital Territory, and Lagos States, to explore participants' experiences with regards to mental health in Nigeria. Data were collected from August 2019 to May 2020 and analysed using an

inductive, data-driven thematic analysis using the six-step process described by Braun and Clarke (2006) with the four-phase cyclical data analysis process required by the Silences Framework (Serrant- Green, 2011). The aim was to ensure a participant/ interviewer conversation through which participants shared their experiences while ensuring the process was guided by participant priorities (Green, 2006).

3.12.1 Zoom as a data generation instrument.

Online interviews are research methods conducted online using computer-mediated communication (CMC) (Salmons, 2014). There are two types of online interviews: synchronous (real-time) and asynchronous (non-real time). Asynchronous (non-real time) online interviews are usually in the form of emails, discussion groups, etc. (Hooley et al., 2012). Synchronous (real-time) online interviews are generally in the form of text-based chat rooms, videoconferencing, instant messaging, etc., (Steiger and Gortiz, 2006).

More recently, with advances in communication technology and internet usage, video conferencing has been widely used as an alternative to traditional interviewing methods in qualitative research. Research showed that advances in information and communication technology offered a new opportunity for interviewing research participants (Kenny, 2005). Online methods can assist, and possibly improve traditional methods such as in-person interviews and focus groups (Archibald et al., 2019; Irani, 2019; Braun, Clarke and Gray, 2017; Deakin and Wakefield, 2014; Cater, 2011).

Research in digital technology using online communication as a data generation tool is still very scarce (Archibald et al., 2019). Digital technology has many benefits, such as convenience and cost-effectiveness of online methods compared to in-person interviews, especially when researching a large geographical area (Irani, 2019; Horrell, Stephens,

and Breheny, 2015; Hewson, 2008). This is the case with this study as interviewed participants were resident in three geographical locations in Nigeria.

In many research contexts, online methods are useful where there is a need to communicate with multiple individuals in geographically dispersed areas with limited research resources (Archibald et al., 2019). This is the case of this research, as the researcher interviewed participants in three urban geographical locations in Nigeria, with limited resources as the study is self-funded.

Another significant aspect is nonverbal cues of eye contact, which are absent in non-real-time online interviews. An essential advantage of online interviews is that they allow researchers to identify non-verbal cues to build trust and encourage engagement while generating rich textual data (Hesse-Biber & Griffin, 2013). Studies found that researchers reported the ability to respond to nonverbal cues like facial expressions and gestures. This improved engagement and built trust whilst promoting natural and relaxed conversations.

Researchers also reflected that the ability to view and respond to the participant's body language improved when the participants were familiar with videoconferencing technology, allowing for the generation of rich qualitative data (Archibald et al., 2019; Deakin and Wakefield, 2014; Cater, 2011).

Zoom is a communication software combining video conferencing, online meetings, interviews, chat, and mobile collaboration (Maldow, 2013). This research used Zoom web-based video conferencing as a data generation tool to interview participants. Zoom is a web-based conferencing tool with a local desktop client and a mobile application that allows users to meet online. Zoom users can record sessions, engage in meetings, and

share each other's screens using an easy platform. In addition, Zoom offers quality video, audio, and wireless-sharing performance (Keanu, no date).

Zoom is a mobile-friendly application with IOS and Android features allowing for a virtual connection for any location with an internet connection. Users can meet conveniently by starting an instant or scheduled meeting, using a personal ID assigned to create MP4 and M4A recordings. Security when using the application is the topmost priority. Apart from having a private login username and password, Zoom also utilizes both secure socket layer (SSL) encryption and Advanced Encryption Standard (AES) 256-bits encryption (Zoom Video Communications Inc, 2019a).

Zoom video conferencing has been successfully used in qualitative data collection. This has offered more opportunities for conducting qualitative research. A recent qualitative study (Archibald et al., 2019) asked participants about their experiences of using Zoom. Most participants described their interview experience as satisfactory and recommended Zoom as an alternative to traditional mediums such as face-to-face, telephone, and other videoconferencing service platforms. The study suggests using Zoom as a qualitative data generation tool due to its ease of use, cost-effectiveness, data management features, and security options (Archibald et al., 2019).

Zoom conferencing tool has also been successfully used to supervise work across teams in different geographical regions in the health sector. For example, one study found that Zoom was helpful during emergencies for building 'virtual training' across hospitals (Bolle et al., 2009). Another study used Zoom to provide guidance and supervision to junior medical officers in rural areas of Australia. As a result, all medical officers expressed positive attitudes during training sessions. Zoom also assisted the participants

during the interviews to build relationships and rapport and improve communication between rural and tertiary facilities (Cameron, Ray, and Sabesan, 2015).

There has been a lot of debate about the use of video conferencing as a data generation tool for sensitive qualitative research. However, a recent qualitative study (Mabragana, Carballo-Diéguez, and Giguere, 2013) sought to determine whether video conferencing is an effective data generation tool for obtaining a sexual history from participants in a vaginal micro blade study. Most of the participants preferred video conferencing interviews. They explained that the sensitive nature of the interviews and geographical distance from the interviewer encouraged disclosure.

Participants felt they would be embarrassed when discussing sensitive topics like sexual behaviour face to face with the interviewer (Mabragana, Carballo-Diéguez, and Giguere, 2013). Therefore, in this study the use of Zoom as a data generation tool was appropriate because participants may be embarrassed when discussing sensitive issues such as mental health face to face with the interviewer.

Despite technical difficulties such as time delay and loss of connection as identified in several studies, there was a high-level of satisfaction (Archibald et al., 2019; Mabragana, Carballo-Diéguez, and Giguere, 2013). These studies recognised that video conferencing was a feasible alternative to conducting in-depth interviews on a sensitive topic.

A significant advantage of using Zoom as a qualitative tool is that it allows researchers to go beyond geographical boundaries by eliminating the need to visit an agreed location for an interview (Lo Iacono, Symonds, and Brown, 2016; Rowley, 2012). Therefore, researchers can widen the range of study samples and connect with participants from a wide range of cultures, thereby eliminating barriers of time and space (Burkitt, 2004).

King, Horrocks, and Brooks (2018: p29) said ‘researchers seek to recruit participants who represent a variety of positions concerning the research topic, of a kind that might be expressed to throw light on meaningful differences in experience.’ This is the case of this research, as the study explored the experiences of mental health among internal migrants across three geographical locations in Nigeria, namely, Kaduna, Federal Capital Territory (FCT), and Lagos states.

With Zoom, time is also flexible around the needs of participants while maintaining ‘synchronism’ with the interviewer (Lo Iacono, Symonds, and Brown, 2016). Without Zoom, I would need more financial and time resources to travel to reach the same variety of participants. Unfortunately, I do not have these financial resources, as the study is self-funded, and there is a time limitation (four years) to complete the study.

Fleitas (1998) argued that distance is a component that does not accurately encourage participants in most qualitative studies. However, Zoom eliminates the challenge of distance. For example, I am undertaking my research in the UK, and my study participants are residents in Nigeria. Travelling to Nigeria for just one month to collect data in a short time will not allow adequate completion of the study due to time constraints. Zoom interviews allow for greater flexibility with the interviews' timing and allow the participants to choose a location and time at their convenience (Archibald et al., 2019; Lo Lacono, Symonds & Brown, 2016).

However, some challenges were identified by studies who used Zoom as a data generation tool. Even though Zoom is user-friendly, some participants in existing studies had challenges joining the meeting due to low internet connection or outdated hardware. This was common among participants rather than researchers (Archibald et al., 2019; Bolle et

al., 2019; Mabragana, Carballo-Diéguez, and Giguere, 2013). This showed that familiarity and access to Zoom, and high-speed internet were more common among researchers than participants.

There is also a potential to lose participants who cannot afford a device or access internet or constant electricity (Archibald et al., 2019). This was the case in this study as there were reported cases of poverty and infrastructural challenges (NBS, 2019; 2017).

Studies also identified technical difficulties of video and audio quality due to poor internet connection or older devices leading to lost contact. Studies explained that these challenges were overcome by participants familiarising themselves with the tool and having a video conversation before scheduled interviews to make the participant conversant, collect demographic data, and obtain informed consent. The checklist was also designed to assist participants who lack confidence in using the technology (Archibald et al., 2019; Bolle et al., 2009; Mabragana, Carballo-Diéguez, and Giguere, 2013).

New and continuous use of online communication technology like Zoom has a significant implication on the practice of research and data generation tools (Archibald et al., 2019). Even though videoconferencing research is not meant to replace traditional interview methods, it can be a reasonable cost and time-saving tool in qualitative research. Furthermore, existing research has shown that Zoom is a reliable and effective tool in generating qualitative data, even on sensitive topics like mental health (Mabragana et al., 2013). Although there are some technical limitations to using this tool, this limitation can be overcome by more familiarization and training. Therefore, an amended ethical approval was given for using Zoom as a data generation tool (appendix 11).

3.12.2 Data protection

The Zoom policy outlines information about the collection and use of personal data. Personal data is collected when the application is used. It is the duty of the host (researcher) to obtain consent before recording a session. In this research, informed consent was obtained in written and oral form before recording the interviews.

Zoom as a company must follow all instructions related to personal data collected on behalf of the user. Third parties are not allowed access to any personal data. This is very important in research where the protection of highly sensitive data is required.

Data subjects may request copies of their data and have the right to erase any data used at any situation or point in time. They also have the right to stop processing their data or correct any inaccurate personal information of their data. Finally, data subjects can request for any personal data or in certain circumstances as required by law, safety, or security reasons (Zoom Video Communications Inc, 2021; Zoom Video Communications Inc, 2019b).

The Zoom policy explains that residents in the UK have legal rights concerning their data, including the EU's General Data Protection Regulation (GDPR). To ensure compliance with GDPR, Zoom has made the following updates to its platform and practice. Firstly, the platform now features an explicit consent mechanism where all new and existing users will be presented with a one-time privacy policy update which is stored for compliance purposes when signing into a desktop/ mobile app or joining a meeting.

Secondly, Zoom created 'zero-load' cookies; this means that cookies will not be placed on the user's browser until after preferences have been set. Zoom also provided a pre-signed Data Processing Addendum (DPA) for its users. This document was vetted to

comply with all GDPR requirements. The document describes how Zoom delivers its services to its customers (Zoom Video Communications; GDPR Compliance, 2018). I have attached a copy of the DPA (appendix 9).

Regarding international data protection (outside the European Union) which is the case with this study focusing on Nigeria. The reform of EU data protection legislation (2016) created a mechanism for transferring data to third countries. Furthermore, the EU Commission on the protection of personal data and privacy stipulates that 'each party recognises that protection of personal data and privacy is a fundamental right and must maintain and safeguard the safety of personal data and privacy' (EU Commission, 2018: pg. 1).

Zoom operates globally, i.e., data can be transferred and processed outside of the country of residence where data was collated, including meetings or webinars and messages received. For example, where users' data within EU or UK is moved to a user outside EU or UK, Zoom ensures that the European Commission standard contractual clause governs the transfer.

3.12.3 Data security

Session keys are created using a device's unique password ID and session recordings are stored in the host (researchers) local device. These recordings are password protected. Zoom only stores basic information such as email address, first name, last name, etc. (Zoom Privacy Policy updated Dec 31, 2019b).

Zoom updated its privacy policy, stating that all identifiable data such as account information, participant information, meetings, webinar messages, etc., have no access to

Zoom. Most especially the audio or video files, except authorised by the account holder for legal, marketing, or advert purposes (Zoom Video Communications Inc, 2021).

Zoom recently updated its features to improve its security system by allowing account users to create passwords for all meetings. It also gave the right to control meetings and remove unwanted guests. There were no security issues in this study due to the ability to invite participants, access, and record the interviews (Zoom Video Communications Inc, 2021). In addition, a major feature was the end-to-end encryption which provides access to all communication between the user and others in the meeting sessions or chats (Zoom Video Communications Inc, 2021).

A combination of industry-standard security technology, procedure, and measures are used to protect personal data. For example, credit cards are protected using TLS encryption technology; however, in this study, the free version was used, so no credit card information was exchanged.

Record security is a significant feature for researchers. Zoom does not record individual sessions unless enabled for automatic recording by the user. There is also a feature (beta) where participants are given a prompt to give consent (Zoom Video Communications Inc, 2019b).

Confidentiality was guaranteed by ensuring all data collected were transcribed and stored in a password-protected computer and Sheffield Hallam University's secured drive, with singular access to the data. Also, all recorded interview files were deleted on Zoom's application's drive and securely saved them on the local hard drive. An account was created on Zoom to help mitigate data protection issues while using Zoom specifically for the research study. After the study, the account was closed, and all data were removed.

A significant limitation of using Zoom is the lack of access to high-speed internet in some geographical regions in Nigeria. However, due to globalisation, Nigeria is rapidly improving with 98.39 million internet users. In addition, 54% of Nigerians access the internet daily while 12% have active social media accounts with an average of 3hours 17 minutes spent on social media (Clement, 2019; Udodiong, 2019). However, when internet problems were encountered during data generation, all options on the checklist were utilised to identify and resolve common technical problems (see appendix 10). Also, when internet and visual connection problems persisted, then the telephone option of the application was used for only voice recognition and recording.

3.13 Informed consent

Participants received the participant information sheet and agreed to partake in the study in a written and oral format.

They had the opportunity to ask questions and sign the consent forms (appendix 2C) before the interviews. The contents of the participant information sheets were also read out verbally before conducting the interviews.

Sometimes, while conducting qualitative interviews, it may be difficult to observe non-verbal cues in relation to obtaining informed consent from participants especially when some participants seem shy or do not want to be rude to the researcher (Robley, 1995). Therefore, I used non-verbal cues throughout the interview and took note of their emotions and behaviours, especially when they appeared upset or emotional when sharing their experiences. While using Zoom videoconferencing as a data collection tool for conducting interviews, Non-verbal characteristics were recognised due to the video and audio content shown in real-time.

3.13.1 Other ethical considerations

An ethical consideration was the potential risk of experiencing insecurity challenges such as insurgency, kidnapping etc especially in the northern region. There have been reported cases of insecurity in the region where a major part of this study was located. Therefore, using the data collection tool (Zoom videoconferencing) eliminated the risk of travelling to northern Nigeria to collect data.

Another potential risk was that mental health issues are still very sensitive in Nigeria (Onyeji, 2020; Gureje et al., 2005). Therefore, using this tool eliminates the potential risk of participants getting upset or emotional, resulting in agitation or assault when interviewing using face-to-face contact. I also avoided getting too personal with the questions to avoid upsetting the participants.

Using the data collection tool (Zoom) also eliminates environmental challenges such as weather changes, which can negatively impact the participants and me.

3.14 Data analysis

Data generated from the semi-structured interviews were analysed thematically using NVivo 11. The application was used to store, organise, and code data. The data were analysed thematically to help identify patterns relating to internal migrants concerning mental health. This approach is supported by Braun and Clarke (2006), who recommended thematic analysis to locate, scrutinise, and report repeated patterns of meaning within data. In addition, the analysis supports the use of participants' verbatim quotations and were assigned pseudonyms to ensure anonymity. The quotations were used to show the results that emerged from the study and understand the research participants' experiences, meanings, and interpretations (Eshareturi, 2016).

Thematic analysis was also used to identify themes in the textual data. After familiarisation with the data, the data was coded by brief verbal descriptions of the data. According to Braun and Clarke (2006), data generated in this study was analysed repeatedly. It should be noted that the data analysis was not done chronologically but continuously throughout the research process. The codes were assigned to specific themes in an Excel spreadsheet and written down in a draft form after each phase of the analysis process (explained further in chapter four).

This method of data analysis (thematic analysis) fits with the theoretical framework underpinning this study through the creation of study findings in a draft form after each phase of the analysis process (Serrant-Green, 2011). It should also be noted that thematic analysis is appropriate with constructionist and essentialist paradigms, which aim to report the reality and experiences of study participants by uncovering the social construction of meaning (Braun and Clarke, 2006).

The following data analysis methods were rejected. Firstly, thematic discourse analysis which is used to explore how language creates meaning (Roberts and Sarangi, 2005). This method investigates how people create a deeper understanding of a phenomena through discussions. Within this, thematic decomposition analysis examines the social meaning of the language used by research participants, focusing on exploring the role of social influences on a specific issue (Ussher and Moony-Somers, 2000). These data analysis methods were rejected because this study aims, and objectives were to explore the migration experiences and knowledge and perceptions about mental health in Nigeria. Therefore, thematic analysis was used in this study because the data analysis approach was an accessible and flexible approach to analysing qualitative data by identifying themes or patterns in the data (Braun and Clarke, 2006).

Interpretive phenomenological analysis (IPA) was considered because it studies ‘how people make sense of their life experiences’ (Smith, Flowers, and Larkin, 2009, p; 1). It was also considered because the research design used in this study was phenomenology and sought to understand and give voice to participants experiences and contextualise their reflections (Larkin et al., 2006). Finally, this analytical approach was also considered because participants were expected to share specific experiences (all participants are internal migrants in Nigeria).

IPA also aims to understand the particular experiences of participants in a specific context at a particular time. Therefore, the analysis must be thorough and systematic to represent the in-depth lived experiences of the individual (Smith, 2010b). After consideration, IPA was not used in this study because this study focused on experiences and did not explore perceptions or beliefs, which was part of the study's aim. This study also aimed to explore the knowledge and perception of participants about mental health in Nigeria. It was difficult to transfer the findings of the sample to a topic. Therefore, it was advisable to conduct studies concerning a previous study on the issue. This made it possible to create a picture for larger populations gradually.

Smith, Flowers, and Larkin (2009) recommended that Ph.D. projects using IPA as an analytical approach be divided into three separate studies. For example, first consider a single case study, secondly, a detailed examination of three cases, and thirdly examine a larger sample of about eight participants from a different location. More emphasis was on the research question and research data quality.

IPA was not used in this study because the data were analysed together. Due to time constraints, it would not be possible to divide the study into separate projects as Smith,

Flowers, and Larkin (2009) recommended. Therefore, this study used thematic analysis as a social constructionist approach that examined a group of people's lived experiences and meanings about a phenomenon. Thus, this study explored the experiences of mental health among internal migrants in Nigeria while considering perceptions, knowledge, and factors impacting their mental health. The research findings can benefit mental health policy and service delivery in Nigeria and not just internal migrants but Nigerians.

3.15 Introduction to intersectionality theoretical framework

In addition to using thematic analysis, the intersectionality theoretical framework was used in the study. This framework was used to analyse data from the findings generated in the study. The framework will be presented in the discussion chapter (chapter 6) while providing a critical reflection of the findings generated in the study. Intersectionality is a critical framework that provides knowledge for inspecting interconnections and interdependence between social categories and systems (Atewologun, 2018).

This framework is relevant for researchers because it provides theoretical explanations of how diverse members of a specific group (e.g., internal migrants in Nigeria in this study) share their experiences depending on their migration status, ethnicity, class, and other social locations (Atewologun, 2018).

The concept emerged from the racialised experiences of minority ethnic women in the United States. The framework was derived from the work of critical legal scholar Kimberly Crenshaw (1989). Her research was created to explore how African American women were treated through gender and race discrimination within the law. Intersectionality is usually associated with qualitative research by giving voice to participants through focus groups, narrative interviews, and observations. This

framework is also used as a methodological tool for qualitative analysis by utilising an intersectional reflexivity approach.

An intersection means the crossing, comparison, or confluence of two or more social categories, systems of power, etc. These categories may include social identities (woman, Nigerian, internal migrant etc.,), socio-demographic categories (gender, marital status, ethnocultural etc.,), social processes (gendering etc.,), and social systems (patriarchy, racism, colonialism etc.,).

The theory of intersectionality, therefore, means associations of how problems are concentrated on multiple positionalities and interconnecting oppressions, this led to the creation of social explanations for addressing social issues (Clarke & McCall, 2013). Intersectionality is best supported with the social constructionist epistemologies (Else-Quest and Hyde, 2016). Social constructivism ensures that our social world views are made real (constructed) through social processes and interaction (Young and Collin, 2004).

Three assumptions of intersectionality are summarized by Else-Quest and Hyde (2016). The first assumption is that people are members of multiple social categories (gender, ethnicity, religion, etc.). These categories are connected such that the experience of one social category is connected to the membership of other categories. The second assumption is that a major component of the intersectional analysis is a unique relationship between power and power interrelations with each being socially constructed. The third assumption is that all social classes have individual and contextual components. Therefore, social categories are connected to personal identities, including the whole institutional practices and structural systems.

De-Vries (2015) recommends the creation of an intersectional narrative instead of a list of identities to position oneself as a researcher. This considers the researcher's positionality by explaining all components of the research process and also explains the strengths and limitations to the research. This is similar to the Silences Framework used to structure the research process in this study. It emphasises the importance of the researcher's identity and aligns with McCall's intersectionality as a relation between diverse aspects and methods of social associations and subject constructions (Serrant-Green, 2011; McCall, 2005). This also agrees with the phenomenological approach used in this study as it emphasises the researcher's positionality by bracketing oneself through an exploration of the experiences from the researcher's perspective (Creswell, 2007).

Regarding methodology, Rodriguez et al., (2016) explained that decisions must be made regarding recruitment, data generation, and data analysis that are sensitive to the various diverse groups in the study. In addition, the nature of intersections, including an outline of the structural or associated factors while presenting the contextual aspects of intersections, is essential. This explains why the Silences Framework was used. It provides a detailed structural guide on the entire research process about a sensitive topic such as mental health to an under-researched group of internal migrants in Nigeria.

Intersectionality is usually associated with thematic analysis (Cole et al.,2012). This study investigated power and privilege and accepted social identity's fluidity and social construction more clearly in the analysis. The findings were analysed in the context of social, historical, and structural inequalities (Atewologun, 2018).

Hankivsky et al. (2010) gave reasons why it is challenging to interpret intersectionality theory into methodological practice. Firstly, there is disengagement between

intersectionality knowledge and research methodology (Hancock, 2007). Secondly, there is a lack of clarification on how the intersectionality framework can be applied (Lutz, 2002; Hankivsky and Christoffersen, 2008; Davis, 2008; Lorber, 2006). Thirdly, there are also difficulties applying intersectionality to actual designs in areas dominated by quantitative research (Ringrose, 2007). Fourthly, there is a dearth of work to ascertain if all possible intersections might be relevant (Warner, 2008; Verloo, 2006). Finally, intersectionality needs access to vital health information that may not exist, for example, data representing multiple groups showing significant associations within these groups across various social classes (Weber & Fore, 2007).

Hankivsky et al. (2010) recommended a research design that reflects thought around identity, equity, and power to address these challenges. This was the aim of this research as it explored the experiences of internal migrants' identities while exploring factors that might have impacted their mental health as a result of their migration experiences.

The researcher has a major role in the research process by being reflexive and undertaking self-examination. This is also an aim of the study using the silences framework; the study identified the researcher's role, identity, and position.

Hankivsky et al. (2010) also recommended a triangulation approach. For example, this study used the silences framework to structure and guide the entire research process. In addition, a phenomenological research design explored the lived experience of the participants. Also, thematic analysis and intersectional frameworks analysed the data generated from the study. Even though this study will explore the elements of gender and migration experiences concerning the impact on mental health, this study will proceed beyond gender to explore all identities, social categories, and systems.

The intersectionality framework makes a major and unique contribution to understanding and emancipating an under-researched group such as internal migrants about a sensitive topic like mental health in Nigeria.

3.16 Summary

This chapter identified the study's philosophical paradigm, research design, and justification for use. Details regarding the identification of this study group participants (voluntary internal migrants in Nigeria) were discussed. This chapter also explored the use of a minimally structured and one-to-one interview as a data generation method, including justification for use of Zoom videoconferencing as a data generation tool. Ethical considerations were also described. This chapter also justified the use of the intersectionality framework for data analysis. The following chapter addressed further information about the data generation and analysis process.

Chapter Four: Stage 3: Voicing ‘silences’ (Data Generation and Analysis)

4.1 Introduction

This chapter describes the process of data generation and analysis. After establishing the philosophical and theoretical approach underpinning the study, it was necessary to explain the process of data generation and analysis. This is also stage 3, called voicing ‘silences.’

4.2 Pilot study

A pilot face-to-face interview was conducted using Zoom's online application tool and was included in the main study on August 5th, 2019. This approach was adopted to gain experience and determine the eligibility of the interview questions.

Ethical approval was granted and updated. Informed consent was obtained, and a minimally structured interview was given based on the interview guide to enable the participant to provide a complete account of his experience.

The pilot interview experience was used with the literature scoping review to improve my interviewing skills for the main study (Sque & Payne, 1996). In addition, the interview guide was changed (appendix 12) as some of the questions were not self-explanatory and were a little confusing to the participant, especially about the experience of moving and mental health.

The pilot interview helped me gain and develop qualitative interview skills via an online application tool (Zoom). The first interview also helped me test and become familiar with

the Zoom online application, including recording files. The pilot interview confirmed the quality of the audio recording of the application and the suitability of the application tool.

This process also verified my ability to build rapport with the participant (Dainty et al., 2014) without the benefit of physical presence. The face-to-face element of the online application tool allowed for identifying gestures, eye contacts, and observations as if physically present. The process also allowed for familiarity with the interview questions. The participant answered a traditional, structured interview and had minimal difficulty sharing his experiences as an internal migrant in Nigeria.

The pilot interview was a trustworthy experience by making verbal summaries as a means of member checking and writing notes while maintaining active listening (Creswell, 2007). A field note and a research summary was also developed immediately after the interview to capture the initial reflections on the data generation process (Huberman and Miles, 2002; Gray, 2014). This was subsequently used in the main study interviews.

Transcribing the pilot interviews was considerably smooth and easy. It, however, confirmed the time-consuming nature of the process, which allowed for adequate preparation for the main study. The pilot interview also allowed for adequate processing and structuring to allow easy storage and retrieval of transcripts. Finally, the pilot interview data was used to practice importing and coding using NVivo 11, which was used to support data analysis in the main study.

4.3 Main study

A total of thirty participants aimed to participate in the study in the three selected states in Nigeria. However, nineteen participants were interviewed and took part in the study. A decision was made to stop conducting interviews because of data saturation as no new

information or themes were observed in the data (Saunders et al., 2018). Instead, it was found that study participants were starting to repeat the identified themes in the study. For example, most participants continuously described their migration experience to insecurity challenges, language barriers, and high cost of living. Therefore, with the advice of my supervisory team, data generation stopped at nineteen study participants. Therefore, nineteen minimally structured interviews were conducted using Zoom video conferencing as a data generation tool.

The interviews were approximately 45 minutes to one and a half hours and were completed between August 2019 and March 2020. All the interviews were conducted using Zoom, where participants were invited to partake in the study privately and confidentially. All recordings were securely saved on the Zoom's drive and deleted after securely saving these files on the secured Sheffield Hallam University's drive. The interviews were conducted in my private home to ensure confidentiality and convenience with the participants by using Zoom. The interviews were scheduled by the participants at a time convenient to them. Therefore, safeguards required to provide practical researcher safety when physically present were eliminated.

Participants were informed in the participant information sheet and at the start of the interview that they were free to opt out at any time. Participants were also debriefed at the end of the interview to ensure that the participants were happy and confident with the interview outcome. To reduce my influence and avoid monopolising the interviews, I adopted a friendly approach by welcoming them and paying attention to their responses. Furthermore, I reassured participants that they had the right to stop the interview at any time while reading their rights to participate in the study.

Providing a verbal summary of what the study was about made it easier for participants to share their experiences. I told the participants that I would mainly listen to their statements to ensure the interview flowed and would only speak to clarify or summarise their statements. Some study participants (silence dialogue) agreed to provide a review or feedback after the interviews. A summary of their responses and feedback was received via email. This allowed the participant to confirm, deny or clarify my understanding of their responses (Brinkmann and Kvale, 2015).

The potential for participants to share a traumatic or emotional experience was recognised, but none of the participants were emotional or shared any traumatic experience. However, while describing her internal migration experience, a participant explained that the experience affected her psychologically due to a lack of support. She was signposted to local support organisations, but she declined any support. Therefore, none of the participants accepted local support information or contacted afterward to request any.

4.4 Data analysis

4.4.1 Preparation for data analysis

Participants were emailed the debriefing letter (appendix 13) immediately after the interview. The letter thanked them for participating in the study and informed participants that they had the right to withdraw even after the interview, where their participation records would be destroyed. There was no penalty for withdrawal. I also wrote that they could contact me if they had any questions, enquiries, or feedback. However, none of the participants asked to withdraw from the study. Also, fourteen participants agreed to

provide feedback on the summary of the study findings. This was explained in detail in the phase two data analysis process below.

4.4.2 Data analysis process

Stage three of The Silences Framework comprises the four-phase cyclical analysis process (Serrant-Green, 2011). In addition, an inductive, data-driven thematic analysis was used based on Braun and Clarke (2006).

The figure below shows the data analysis process.

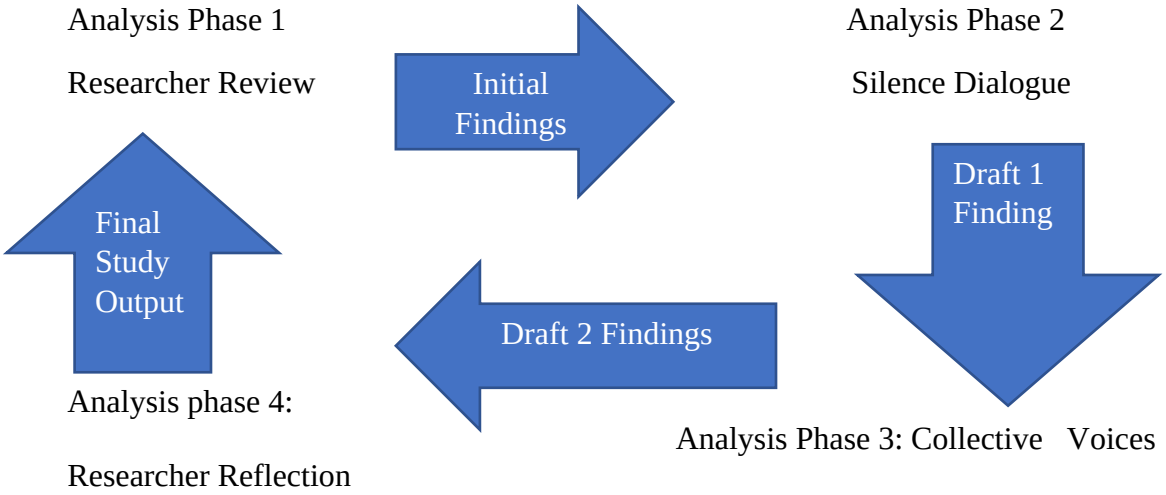


Figure 2: Figure representation of different phases of the data analysis process

The data analysis was to identify areas or 'silences' in the data or find out what was said (Serrant-Green, 2011). The data analysis focused on the meaning as described by participants (Kvale and Brinkmann, 2009; Janes, 2016). Researcher reflexivity was critical while considering the role of participant-researcher collaboration by bringing the experience and expertise of both to the research. NVivo 11 was used to store and manage data.

4.4.2A Phase one analysis (Researcher review and initial findings)

This phase involved the initial data analysis using an inductive data-driven analysis guided by Braun and Clarke (2006). The phase involved six steps, namely:

Step 1: familiarisation with the data by undertaking all interviews personally, transcribing (this involved listening to the audio recordings repeatedly) and checking the transcripts to ensure accuracy against the audio interview recordings. The audio-recorded interviews of participants' experiences were transcribed verbatim to ensure an accurate record as soon as they occurred personally (Brinkmann and Kvale, 2015). This allowed me to immerse myself in the data.

In addition, I used a natural approach to transcribing by using pauses and stutters (Janes, 2016). This agrees with the interpretive methodology and stage three of the Silences Framework (Serrant-Green, 2011), which focuses on the participants' 'voice.' Kvale and Brinkmann (2009) explained that transcribing is more than just applying notations. Still, the researcher's choice is influenced by the theoretical framework and the location in the research process. This shows the importance that the Silences Framework places on the position of researcher identity, positionality, and reflexivity in the research.

Davidson (2009), however, identified potential errors in transcribing, such as not hearing correctly and when the researcher lacked interpretation of some words. I transcribed all 19 audio recordings to immerse myself in data and this helped minimise errors undertaken during and after the interviews. Strategies adopted to minimise these errors was by listening to the audio recordings while transcribing and reviewing the completed transcripts to ensure accuracy. I also used my research notes, and a vivid recollection of the interviews helped the transcribing process. This helped complete areas that were

inaudible in the audio recordings. This transcribing process helped familiarisation with data. Interview summaries were also reviewed to ensure that participants' responses were consistent.

After reading the transcripts, I also wrote down ideas and possible themes and points (Braun and Clarke, 2006). Finally, the interview recordings were securely imported and stored in NVivo 11 software.

Step 2: Initial codes were generated to reflect data from the transcripts (Gray, 2014). After listening to recordings and reading the transcripts, I decided to use a data-driven approach as the analysis continued. A systematic open coding of each transcript of the entire words in each transcript was done to understand the meaning of each transcript. In some cases, data segments were coded to multiple codes (Braun and Clarke, 2006). To improve the coding quality, I had to be aware of the risk of over-coding leading to a lack of interpretation of data (Gray, 2014; Janes, 2016).

Some qualitative researchers (Johnson et al., 2017; Perone and Tucker, 2003) argued that employing a second data analyst is not necessary as this is appropriate for a quantitative study and not for a qualitative study that has a social phenomenon with different experiences (Kincheloe and McLaren, 2008; Janes, 2016). Therefore, a second data analyst was not employed even though the supervisory team reviewed my findings. The process of reflecting on the initial codes improved my confidence in the data generation and analysis process (Janes, 2016). The initial coding process produced 163 codes. The list of initial codes is shown in appendix 14.

When new codes came up, summaries were created to help continue coding (Green & Thorogood, 2014). This helped at the early stage of the coding process by familiarising

with the research practice and coding process. This is a crucial stage in qualitative research (Braun and Clarke, 2006).

Being familiar with the data through the interviews and transcribing all transcripts allowed me not to rely on my memory or prior knowledge but take part in a systematic coding process (Janes, 2016). I was aware of the coding process by reflecting on the themes by comparing them with my research diary after each interview and later in the coding process.

When each code was introduced, I returned to check the codes against all interviews to complete the data analysis process. Even though a grounded theory was not used in this study, the principle of a data-driven approach to the data analysis was compliant with the strategy used to complete this stage. I checked the coding of all transcripts as I was coding with the recorded audio interviews simultaneously.

After nineteen interviews, a decision was made to stop conducting additional interviews because it was observed that codes were being repeated by participants, resulting in data saturation. I rechecked the coding to ensure that the data were appropriately coded and found that few additional text segments needed further coding. The continuous process to develop the coded data involved audio recordings, interview transcripts, and field notes in this stage. NVivo 11 was particularly useful when analysing the coded data, transcripts, and interview recordings.

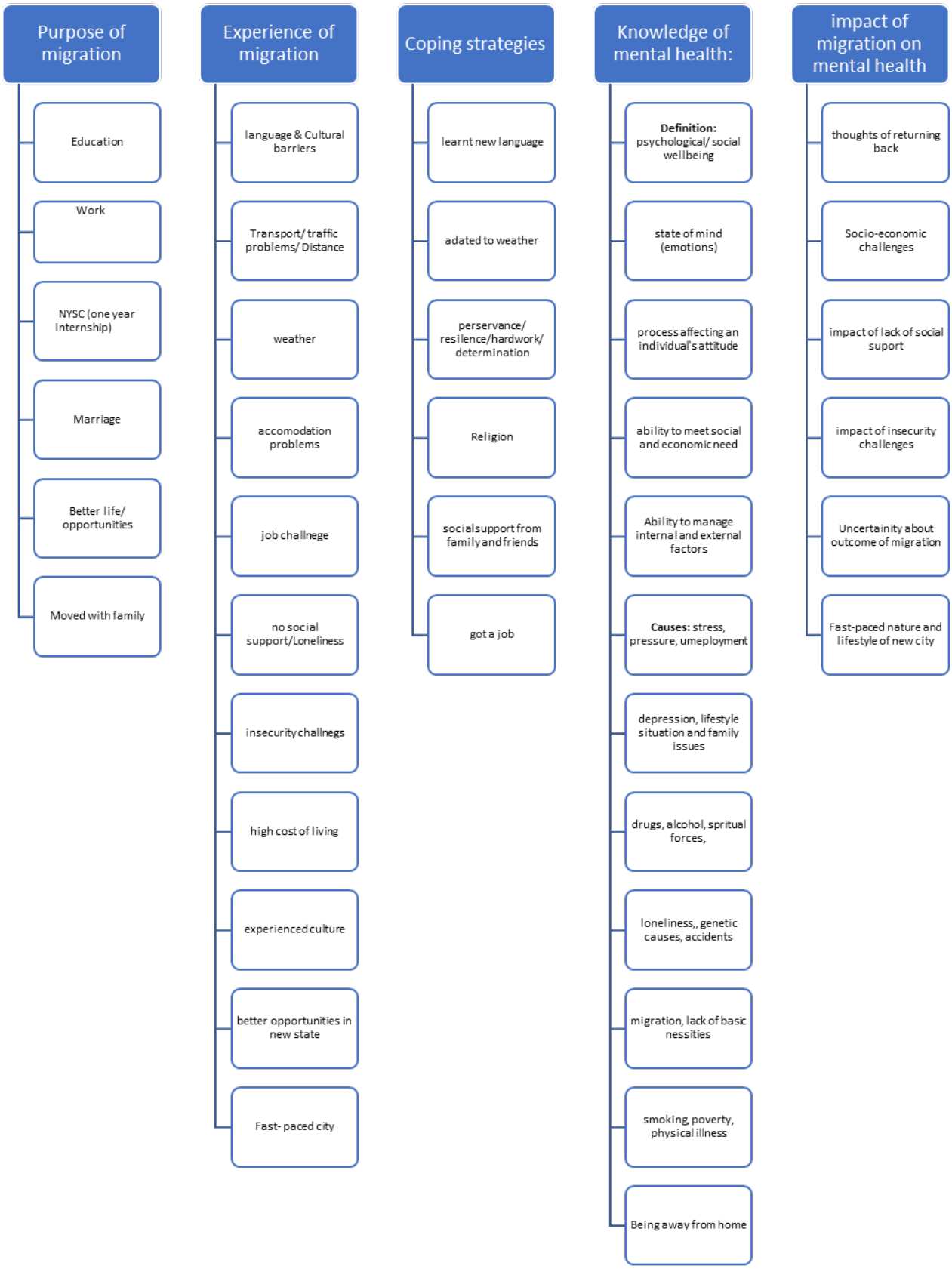
Step 3: This involved collating all the codes generated into themes and sub-themes. Appendix 15 shows how the initial codes were allotted into themes.

Step 4: Reviewing themes. All data extracted from each theme were reviewed again and checked for accuracy (Janes, 2016). This did not create problems because I had earlier

checked for codes, re-coded data, and made all necessary adjustments. Another review was undertaken by reading the entire data set again to confirm the initial themes and codes to avoid missing data.

Step 5: This was a repetitive process where minor changes were made to themes' titles (Braun and Clarke, 2006). This happened during the 'silence dialogue' and 'collective voices' phase of the analysis of the 'silences' Framework (Serrant-Green, 2011). This occurred after receiving the feedback from the 'silence dialogue' (selected study participants) and 'collective voices' (social and professional network of study participants). This analytical process will be explained more in the next section.

Figure 3 (below) shows the theme structure of the study findings. This describes an overview of all the themes and subthemes generated from the data generated from all study participants. The figure also shows the mental health experiences among internal migrants across different stages of their migration experiences.


Purpose of migration
Education
Work
NYSC (one year internship)
Marriage
Better life/ opportunities
Moved with family
Experience of migration
language & Cultural barriers
Transport/ traffic problems/ Distance
weather
accomodation problems
job challnege
no social support/Loneliness
insecurity challnegs
high cost of living
experienced culture
better opportunities in new state
Fast- paced city
Coping strategies
learnt new language
adated to weather
perservance/ resilence/hardwork/ determination
Religion
socialsupport from family and friends
got a job
Knowledge of mental health:
Definition: psychological/ social wellbeing
state of mind (emotions)
process affecting an individual's attitude
ability to meet social and economic need
Ability to manage internal and external factors
Causes: stress, pressure, umeployment
depression, lifestyle situation and family issues
drugs, alcohol, spritual forces,
loneliness,, genetic causes, accidents
migration, lack of basic nessities
smoking, poverty, physical illness
Being away from home
impact of migration on mental health
thoughts of returning back
Socio-economic challenges
impact of lack of social suport
impact of insecurity challenges
Uncertainity about outcome of migration
Fast-paced nature and lifestyle of new city

4.4.2B Phase two analysis: 'silence' dialogue and draft one findings

This summary aimed to provide an opportunity for the participants to confirm or critique the initial findings from all 19 interviews (Serrant-Green, 2011). This was important to avoid further silencing the participants in the research and ensure that the study was trustworthy. The review by the participants also acted as a member checking process. This was important as a single researcher without a second researcher or independent analyst.

Appendix 16 showed the draft summary of the initial findings after conducting the phase one analysis. This summary was generated from the coding and thematic analysis of the interview data (Braun and Clarke, 2006). It was initially challenging to summarise the broad experiences and views as described in the interviews. It was essential to ensure that the tone and format reflected the participants' experiences.

After the initial draft of the findings was analysed using thematic analysis, the initial draft report was reviewed by a selected number of participants who agreed to review and comment on the report. Five of the participants indicated that they did not wish to comment on the initial findings. Therefore, 14 summaries were sent to participants within a two-week deadline. All participants' invitations were sent by email. However, only 9 participants got back to via email after the deadline. I tried to follow up with the remaining 5 participants, but no response was received. Each participant was asked to comment on each theme if the findings described reflected their experiences as described in the interview. The initial findings were updated to reflect the changes identified by the participants to create a draft one findings summary (appendix 17).

4.4.2C Phase three analysis: 'Collective Voices' and draft two findings

This phase's goal was to explore the scope of 'collective voices': These are 'the social networks of participants whose cultural, social or professional situation may impact on the research question' (Serrant-Green, 2011, p 357). The aim of including 'collective voices' was to understand better the participants' findings and the different perspectives of the 'silences' identified in stage one of this study. The aim was also to critique or agree with the summaries of the participants' experiences by providing a different perspective on the 'silences' identified in stage one (working in silence- scoping review).

'Collective voices' are individuals from the social groups that appeared in the participants' interviews, which impacted their experiences as internal migrants in Nigeria. This study participants were recruited through the social network and contact with non-governmental organisations (NGOs) that focus on mental health and migration. Interestingly, the 'collective voice' participants also shared their own experiences as internal migrants in Nigeria.

Stage one (scoping literature review) of this study exploring the knowledge, attitudes, and treatment options of Nigerians towards mental health showed that Nigerians choose religious or spiritual coping due to the belief in supernatural causation of mental disorders. In addition, spiritual practices conducted by spiritual leaders have made patients adapt better to chronic illnesses such as mental disorders. This made them less likely to experience psychological distress leading to improved mental health outcomes (Labinjo et al., 2020; Ani, Kinanee, and Ola, 2011).

The scoping review also identified drug abuse was also recognised as a growing problem in Nigeria. About 14.3 million Nigerians aged 15-64 were described to have abused drugs

between 2017 and 2018 (United Nations on Drugs and Crime, 2018). Non-governmental organisations have been known to play a crucial role in controlling drug problems in Nigeria through regular training and rehabilitation programmes. Their role is central to drug control initiatives and subsequent reduction of mental disorders (Obot, 2004).

This shows that spiritual leaders and non-governmental organisations have a major role to play in supporting and providing awareness to persons with mental disorders in Nigeria. These factors led to selecting the 'collective voice' reviewers whose positions span from spiritual leaders, medical professionals, non-governmental officials, and community health workers.

Eight 'collective voice' participants agreed to comment on the findings and shared their experiences as internal migrants and how these experiences impacted their mental health. One of the 'collective voice' reviewers did not respond after several contacts, while two reviewers did not comment on the theme 'knowledge of mental health'. One participant was a spiritual leader (pastor), one participant was an experienced migration researcher, and one was a Chief executive officer of a mental health non-governmental organisation (NGO). In addition, four were mental health professionals, and one was a community health worker.

It is interesting to note that all 'collective voice' participants moved within Nigeria at some point in their lives. This allowed them to share their personal experiences as internal migrants and the impact these experiences had on their mental health. This observation occurred during the data analysis because the intention was to review the findings as presented and reviewed by the study participants and 'collective voice' reviewers. It was, therefore, interesting to discover that they did not only review the findings but also shared

their personal experiences as internal migrants while conducting the review. There was an instance where a 'collective voice' reviewer explained that he had little knowledge or awareness as a young migrant about mental health issues. This was noted, and the findings were updated to reflect this. Another sub-theme identified by 'collective voice' reviewers was an additional sub-theme (traffic problems) to the theme 'transportation problems.' As a result, this change was made to the finding's summary called the 'Draft two' findings report. These changes are highlighted in bold in appendix 18.

4.4.2D Phase four: Researcher reflection and final study outcome

This final phase involves a critical reflection on the findings of the three phases of the data analysis and a summary of the themes to achieve the final study outcome. The four phases ensured an iterative reviewing and continuous development of the findings of the study. This also included the integration of the broad perspectives of the social network of participants identified in the study, which is a major aspect of the Silences framework (Janes, 2016; Serrant-Green, 2011). The outcome of this final phase is presented in the following chapter.

4.5 Confidentiality and anonymity

Participants' names were changed for use in the study to protect their identities. Participants were not identified by other characteristics that were specific to them. The original list of participants was securely stored and accessible only to the supervision team (if needed) and me. According to Sheffield Hallam University policy, all study information/ materials will be kept for a minimum of five years from the end of the study.

All participants were informed of their right to withdraw at any time, and their data would be destroyed at withdrawal. This information was explained to each participant both

before and after the interview. All personal data including interview recordings and transcripts were password protected and accessible only to me and my supervision team (if required). The university IT department provided backup and IT facilities and security to protect my data.

4.6 Determining research quality

4.6.1 Trustworthiness

A major critique in qualitative research is the lack of rigour (Janes, 2016). However, there are assertions that qualitative researchers define rigour to show research quality and integrity. Therefore, the trustworthiness framework (Lincoln & Guba, 1985) was used to structure the discussion of the quality components of this study. For example, Nowell et al., (2017) explained that one way to ensure that a study is trustworthy is by undertaking a thorough thematic analysis. In this study, as described above, a thorough thematic analysis interwoven with the four-phase cyclical data analysis of the Silences framework was utilised to ensure that the study was trustworthy.

My insider position as a Black woman and a second-generation Nigerian internal migrant gave the opportunity to generate rich contextual data by using an online application tool called Zoom. The similarity in contextual backgrounds allowed the study to be more trustworthy due to the ability to reflect on personal experiences with study participants.

4.6.2 Credibility

Credibility shows the extent of confidence in the ‘truth’ as described in the research findings. Strategies used as recommended by Lincoln & Guba (1985):

1. The research findings were reviewed by some study participants (silence dialogue) with an opportunity to confirm or reject my interpretation of the interviews.

2. The participant feedback was used to adjust the initial findings to create the draft-one-finding report.

3. Feedback and verification by the ‘collective voices’ (members of the social network of participants). Their purpose was to confirm, verify, or reject the draft one-finding report. In addition, they also explored aspects of their own experiences as internal migrants. This feedback formed the generation of draft two findings report.

4. All participants (both study participants and collective voices) provided review, comment, and feedback on the final study outcomes.

The main objective of these strategies was to ensure that we do not further silence the study participants throughout the research process (Serrant-Green, 2011). Therefore, the language and terms used in this study findings were consistent with the participants' language as much as possible.

4.6.3 Triangulation

Cohen and Manion (1986) defined triangulation as an attempt to map out or explain fully the richness and complexity of human behaviour by studying it from more than one standpoint. It is also a cross-checking data process from several sources to explore quality in the research data (O’Donoghue and Punch, 2003). The benefit of triangulation is that confidence is increased in the research data. In addition, it creates new ways of

understanding a phenomenon, unique findings are revealed, and a clear understanding of the problem is provided (Thurmond, 2001).

I made use of different sources of information (literature scoping review), methods (phenomenology), theories (interpretive framework, intersectionality theoretical framework, thematic data analysis and the Silences framework) (Serrant-Green, 2011; Braun and Clarke, 2006; Miles and Huberman, 1994; Erlandson et al., 1993; Glesne and Peshkin, 1992; Ely et al., 1991; Patton, 1990; 1980; Lincoln and Guba, 1985). In addition, I used member checking from research participants and 'collective voices' (these are experienced experts in the field of study).

4.6.4 Dependability

Dependability is described as the consistency and accuracy of a qualitative research process and research findings (Guba and Lincoln, 1989). I ensured the research process was dependable by making available all necessary documents to support my decisions.

I undertook all interviews and transcribed all the interviews personally. I also confirmed all transcripts with the audio recordings and made necessary amendments.

4.6.5 Transferability

The data displayed thick descriptions to show the transferability of the research. This involved providing adequate details of an exploration of participants experiences to enable the researcher to draw a conclusion that applies to other settings, contexts, and individuals. This will be discussed in detail in chapter six.

4.6.6 Conformability

This involves the impartiality of the research by placing value on the importance of inquiry and providing a clear description of the research process. It also ensures that the reader judges the researcher's influence (Janes, 2016). This was possible by using a structural, thematic data analysis (Braun & Clarke, 2006). A detailed process of the development of initial codes and themes from the data was generated. Also, to show the reflexivity of the research, I used a reflective journal throughout the research process and identified my position in the study. These were additional strategies to help improve the research quality.

4.7 Summary

This chapter has explained the data generation and analysis processes that explored internal migration experiences and their impact or relationship with mental health in Nigeria. First, this chapter thoroughly outlined the data analysis process, which combined the thematic analysis (Braun and Clarke, 2006) with the four-stage cyclical approach to data analysis by the ‘silences’ framework (Serrant-Green, 2011). The ‘silences’ framework was created to make the reader decide on the thoroughness of the analysis process and strategies to arrive at good quality research. The next chapter shows the final study output (findings) that resulted from this data analysis process.

Chapter Five: Stage 4: Working with ‘silences’ (Findings Chapter)

5.1 Introduction

This is the final phase of the data analysis process which showed the themes generated from the data that resulted in the final report. The findings of this chapter were generated from the four-phase cyclical data analysis process as described in chapter four and used Braun and Clarke’s (2006) thematic analysis framework.

These findings were based on an analysis of nineteen semi-structured interviews of study participants from three states in Nigeria (namely, Federal Capital Territory, Kaduna, and Lagos states). In addition, eight members of the social networks to the study participants called ‘collective voice’ reviewers participated in the study. The ‘collective voices’ were included because they gave personal internal migration experiences during their feedback on the second draft report. Therefore, a total of 27 (i.e., 19 study participants and 8 ‘collective voice’ reviewers) participated in the study.

This chapter consists of two sections. The first section described the demographics and characteristics of both the study participants and collective voices. Section two presented the findings organised by the following theme: the purpose of migration, migration experience, coping strategies, knowledge of mental health, and impact of migration on mental health.

5.2 Aim and Objective of study

This study aims to identify and explore factors that impact the mental health of voluntary internal migrants in Nigeria.

The objective of this study is to:

1. Explore the experiences of selected voluntary internal migrants and the impact their internal migration experiences had on their mental health using a new theoretical framework (Serrant-Green, 2011).

2. Improve knowledge level and awareness about mental health issues in Nigeria.

3. Assist in creating further research to assist stakeholders in providing more access and delivery of mental health services in Nigeria.

4. Test the application of the 'silences' framework (Serrant-Green, 2011) for researching an under-researched group about a sensitive issue in a new context.

The research questions guiding the study are:

1. What are the views, knowledge, and experiences of voluntary internal migrants in Nigeria concerning mental health issues?

2. What are the influencing factors concerning mental health among voluntary internal migrants in Nigeria?

3. What is the impact of voluntary internal migration on mental health in Nigeria?

5.3 Section one: Study participant demographics and background information

Figure 4 showed the complete demographics of the study participants. The total number of people who participated in the study was 19. Seventeen out of 19 study participants were aged between 22 and 40 years, while 2 were over 40 years. This showed that most of the study population were youths (89%).

Seven participants moved between the year 2011 to 2019, while 5 moved between the year 2001 to 2010, 2 moved between the year 1970 to 1990, and 3 were unknown.

All participants had some level of education. Six had master's degrees; 8 had bachelor's degrees, 4 had Higher National Diplomas, while 1 had a high school certificate (WACEC).

Seven participants were residents in Federal Capital Territory (Abuja), 9 in Kaduna state, and 3 in Lagos state. Thirteen out of 19 study participants were employed; 4 were self-employed, while 1 was unemployed.

Nine out of 19 of the study participants were married, of whom 6 were females, and 3 were male. Ten were single, out of whom 3 were female, and 7 were male.

	DEMOGRAPHICS OF PARTICIPANTS							
Pseudonym	Age	State of origin	State of residence	year of relocation	Gender	Employment status	Educational level	Marital Status
Andrew	36	Edo state	FCT Abuja	2007	Male	Employed	Masters	married
Fred	31	Kwara state	FCT Abuja	2009	Male	Employed	Masters	single
Kemi	33	Kogi state	FCT Abuja	2013	Female	Employed	Undergraduate	married
Susan	35	Kogi state	Lagos state	2011	Female	Unemployed	Undergraduate	married
Philip	37	Edo state	FCT Abuja	2009	Male	self-employed	Undergraduate	single
James	37	Benue state	FCT Abuja	2008	Male	self-employed	Undergraduate	single
Chris	39	Kogi state	FCT Abuja	2014	Male	employed	Undergraduate	single
peter	30	Benue state	Kaduna State	2000	Male	employed	Diploma	single
Ayo	27	Kwara state	Kaduna State	2010	Female	employed	Diploma	married
Lilly	25	Benue state	Kaduna State	not known	Female	employed	Undergraduate	single
Ann	22	Plateau state	Kaduna State	2011	Female	Employed	High school certificate	single
Abdul	25	Kogi state	Kaduna State	2018	Male	employed	Undergraduate	single
Blessing	34	Ondo	Lagos state	1997	Female	employed	Masters	married
Joseph	28	Abia	Lagos state	not known	Male	student	Undergraduate	single
Akin	60	Kwara state	Kaduna State	1979	Male	self-employed	Masters	married
Bukky	56	Kwara state	Kaduna State	1981	Female	self-employed	Masters	married
Mathew	36	Edo state	FCT Abuja	2011	Male	Employed	Masters	married
Jane	27	Benue state	Kaduna State	not known	Female	employed	Diploma	single
Ruth	30	Cross River state	Kaduna State	2011	Female	Employed	Diploma	married

Table 3: The complete demographics of the study participants

5.3.1 Characteristics of Silence dialogue

The ‘silence dialogue’ consisted of 9 study participants who reviewed the initial findings, as shown in appendix 16.

5.3.2 Characteristics of ‘Collective voices’

Figure 5 showed the demographics of ‘collective voices.’ Eight collective voice reviewers agreed to provide their comments and feedback on the draft one-finding report (appendix 17).

S/N	Name	STATE OF ORIGIN	STATE OF RESIDENCE	Job Description
1	Richard	Kogi state	Kaduna state	Spiritual Leader (Pastor)
2	Johnson	Abia state	Kaduna state	Medical Professional
3	Mike	Edo state	Lagos state	Experienced Migration Researcher
4	Bimbo		Lagos state	mental health expert (NGO)
5	John	Lagos state	FCT Abuja	CEO of NGO
6	Ahmed		Lagos state	medical professional
7	Linda	Benue state	Lagos state	mental health nurse
8	Ade	Osun state	FCT Abuja	Community health volunteer & Pastor

Table4: The complete demographics of the collective voices.

It was observed that there was a clear consensus between the silence dialogue and ‘collective voice’ reviewers’ comments. The reviewers continuously confirmed the findings of each theme in the data analysis. It was also interesting to discover that the ‘collective voices’ did not only review the findings but also shared their personal experiences as voluntary internal migrants while conducting the review.

5.4 Section Two: Thematic analysis

The following sub-section presented the findings in five main themes from this study.

- Theme one: the purpose of migration
- Theme two: experience of migration

- Theme three: coping strategies
- Theme four: knowledge of mental health
- Theme five: impact of internal migration on mental health

The findings presented in the five themes represent the views and experiences of 19 study participants using a thematic analysis of semi-structured interviews. During a cyclical data analysis, the process was confirmed and verified by some study participants (‘silence dialogue’).

In addition, individuals (‘collective voices’) who belonged to the social, cultural, or professional network of the study participants also provided feedback and commented on the findings. In recognition of Braun and Clarke (2006), the findings in each theme were confirmed using quotations from the participant’s interviews.

Appendix 19 summarised the views and experiences of the study participants. Appendix 20 also summarised the views and experiences of the ‘collective voice’ reviewers (who belonged to the social network of the study participants).

In addition to the ‘collective voices’ providing feedback and reviewing the draft of the findings report by some study participants (silence dialogue), they also shared personal experiences as internal migrants at some particular points in their lives.

5.4.1 Theme one: Purpose of migration

All participants gave several reasons for migrating from one state to another, such as education, work, marriage, wanted a ‘better life’, moved with family, and undertook a national youth service internship. The reasons for migrating were categorised into the

following headings. However, some participants identified more than one reason for moving.

5.4.1A Education

Participants explained that the purpose of their internal migration was to pursue education, especially those in higher education, to obtain a college or bachelor's degree.

'*I will say education; education was what brought me to Kaduna state' (*Abdul- study participant).

'I did my tertiary education in Kaduna state in Zaria, […] and started working in Kaduna' (**Akin- study participant**).

In addition, 'collective voice' reviewers, while reviewing the initial findings and sharing their personal experiences as internal migrants within Nigeria, identified the reasons for migrating as educational pursuit and advancement.

'*I was a short-term migrant while in Nigeria, and the purpose was for education* (Mike- collective voice reviewer).

5.4.1B Work

Participants interviewed in the study described that the main reasons for migrating to the three identified states were to find job opportunities.

'It was work really […] After my studies, I got like an interim job in Abuja to get more experience' (Fred- study participant).

'Basically, job. A good friend […] told me that my nature of work (construction) is going on seriously in Abuja, and I am a civil engineer' (James- study participant).

‘Collective voice’ reviewers also identified the main reason for migrating to these three states was to find better job opportunities.

‘*I moved to Lagos for job opportunities’* (Bimbo- collective voice reviewer).

‘I moved for job opportunities' (Ahmed- collective voice reviewer).

5.4.1C National Youth Service Corps (NYSC- Federal government one-year internship)

Among this study participant, participants described that the reasons why they moved were to undertake their National Youth Service Corps internship placement after their tertiary education.

‘*I was posted to Kaduna town by NYSC, and I belong to federal road safety corps group’* (Abdul- study participant).

‘What brought me to Kaduna state was my National Youth Service. It is a tradition in Nigeria that when you graduate, you undertake a one-year youth call in any part of the state of the country’ (Bukky- study participant).

‘Collective voice’ participants also identified that they moved to undertake internship placements under the NYSC scheme after their tertiary education.

‘*Moved briefly to Abuja for my NYSC’* (John- collective voice reviewer).

‘I moved to Abuja for my NYSC’ (Ade- collective voice reviewer).

5.4.1D Marriage

Participants interviewed in the study identified that the primary reason for migrating to the three recognised states used in the study was for marriage i.e., to join their spouse. It is worth noting that all four participants were females. They were required to join their spouses in the new locations after their weddings.

'*I moved to Kaduna state because of marriage'* (Ayo- study participant).

The female study participants also explained that culturally, there is a belief and expectation that you must spend the rest of your life in that marriage. You accept the consequences, whether the outcome is favourable or not. Also, young women are required to get married to gain acceptance and respect in society.

'*[..] every woman tends to like work on how to get married because if you don't [..], you get this kind of treatment you would not want to. So, everyone tends to get married and all. So, we have to like to face the challenges both mentally, physically* (Kemi- study participant).

'because of the faith I practised, we were told that once you are married to your husband. The woman is meant to spend the rest of her life with such man' (Susan- study participant).

5.4.1E Better life

Participants explained that they migrated to achieve a better life due to opportunities and improved living standards in the new cities.

'I think mostly is for greener pastures and secondly for a better life and all that and to increase my standard of living' (Philip- study participant).

5.4.1F Moved with Family

Participants explained that their main reason for moving was to join family members. For example, some of the young participants moved to join their parents, uncles, or relations at the time of migration.

'*My brother invited me over to come and stay with him* (Ann- study participant).

'I came to visit my uncle […] he asked me to stay with him (Peter- study participant).

Some of this study participants also explained that they decided to settle in the state after completing their intended purpose of migration. For example, a participant explained that moving was for educational purposes and later found a job and settled in the state.

'*After my MBBS, I did my houseman ship, and then I started working'* (Akin- study participant).

Another also explained that after completing her one-year NYSC internship, she got a job and settled down in the state.

'I came here to the Kaduna state to do my youth call, but I was so fortunate that after the youth call, I was gainfully employed at the bank of Agric' (Bukky- study participant).

Also, Peter a study participant explained that he moved to join his family relations and undertook educational pursuits in the state.

'I came to visit my uncle, and he asked me to stay with him to continue my educational activities in Kaduna.'

Finally, Susan a study participant explained that she moved to undertake her tertiary education and later met her husband and decided to return to settle down in the state.

'I found myself residing in Lagos state based on the fact that I had my tertiary education, and I had the opportunity of finding my better half, who is now my husband.'

5.4.2 Theme two: Experience of Migration

All participants interviewed in the study shared several experiences as internal migrants in the three selected states in the study (Federal Capital Territory, Kaduna, and Lagos states).

Some of these experiences were both negative and positive. The participants' experiences are divided into the following sub-themes:

5.4.2A Language and cultural barriers

Participants explained that one of the challenges they encountered on arrival to the new state or city was the inability to understand and speak the native or local language in the state of relocation or destination. This impacted their ability to interact and communicate at the community level and with the local population. This resulted in feelings of withdrawal and no sense of belonging. This also led to feelings of unacceptance by the community. Participants who experienced these feelings were mostly residents in the northern region of the country.

'*I experienced um language barrier. I was not accepted because, in Kaduna, if you can speak their language, you feel more at home. You are more acceptable. and they like you more'* (Bukky- study participant).

'At first, when I came in, I couldn't relate with people because I didn't understand the language (Hausa)' (Abdul- study participant).

'Collective voice' reviewers also described experiencing language barriers as part of their personal experience while moving to the three selected states in Nigeria.

'*As a migrant, I experienced language barriers. My inability to speak the local language (Hausa) made it difficult to communicate with patients at my new job as a young doctor* (Johnson- collective voice reviewer).

Another significant experience described by the 'collective voice' reviewers was that their internal migration experiences were connected with culture and language. This

resulted in continuous cultural drift between the indigenous people in the state and the migrants.

'*I discovered that my short-term migration experience was intertwined with culture, networks, and language in a complex way. […] I had a much lower native language proficiency. There were persistent cultural barriers between the natives and those of us who were migrants'* (Mike- collective voice reviewer).

5.4.2B Transportation problems

Participants and all 'collective voice' reviewers identified transport challenges as a factor that impacted them. This theme was sub-divided into the following sub-themes:

5.4.2B(1) Distance

A major challenge the participants described was the distance to the new location. They explained that the distance between their states of origin and their states of relocation was quite far and challenging.

'*Distance was a challenge because I have not travelled a long distance before'* (Peter- study participant).

5.4.2B(2) Traffic problems

Traffic problems such as challenges moving luggage and inconvenience of the transportation system (bus and road networks problems) were identified by study participants.

For example, Fred a study participant explained that due to the high cost of living in the new city, he had to use the inconvenient transport system before he was able to afford a car.

'Transportation also was a bit steep. I was planning to get a car, but I couldn't get a car, so I had to use transportation, use the bus, and all that, so I had to cut down on my plan to survive at the initial time I got to Abuja.'

However, study participants did not identify traffic problems. This was identified by the 'collective voice' reviewers while sharing their experiences. The 'collective voice' reviewers explained that the distance between their places of accommodation and their place of work in the new cities was quite challenging.

All collective voice reviewers explained that due to the high cost of accommodation in the city centres, they had to live in the city's outskirts. They found it very challenging and distressing to travel to work daily.

'*The traffic is also very terrible with many pedestrians selling wares on the roads'* (Bimbo- collective voice reviewer).

'There was a lot of traffic from my accommodation to place of work in the city centre in Abuja. If there was no accident on the road, it could take about two hours in traffic to move from my place in Nasarawa to my workplace in Abuja' (John- collective voice reviewer).

5.4.2B(3) Transport costs

Study participants explained that the main challenge was that transportation was expensive and not conducive to use. This involved both moving to the new city and moving within the city. For example, Peter explained that the cost of moving to the new state was expensive.

'[..] *is almost 3,000 naira and at that point in time, we were struggling in the village to get a small amount of money […] to come to Kaduna'* (Peter- study participant).

‘*One, its costs, there are costs implications cos having to move’* (Kemi- study participant).

‘Collective voice’ reviewers also shared the same personal experiences. They explained that the cost of transportation was high. They also explained that the transport (bus) system was not convenient due to the debilitating nature of the bus transport system.

‘*Transportation is also a challenge and very expensive compared to my state of origin’* (Ade- collective voice reviewer).

‘I also had to use the transport (buses), and it was not convenient at all. You see people hitting each other to enter the uncomfortable (nearly damaged) buses’ (Linda- collective voice reviewer).

A study participant described leaving property behind while relocating to the new city. ‘*Some of my things, I couldn’t move along with me, and I had no option but to let go at that moment’* (Susan- study participant).

5.4.2C Weather

Study participants explained that one of the challenges they faced on arrival to the new city or state was an inability to adapt to the weather. This was more common among participants resident in the northern region of Nigeria (Kaduna state). The participants described the harmattan season (between the end of November and the middle of March every year) as very harsh and uncomfortable. It is usually dry and dusty, with the north-easterly trade wind blowing from the Sahara Desert into the Gulf of Guinea (Provost, 2013).

Study participants described that they experienced challenges adjusting due to the dry and harsh nature of the weather.

'*The main challenge that I can say is the change of weather. The harmattan is not like what we experience here, and the heat is more than in my state of origin'* (Akin- study participant).

Ann a study participant also explained that she is currently battling a medical condition (asthma) and the harsh effects of the weather made her condition challenging.

'*Right now, I am battling with asthma because of the weather.*

A 'collective voice' reviewer also explained having challenges coping and adapting to the weather. This was while sharing personal experiences as an internal migrant in Nigeria.

'*I also had a challenge coping with the harsh weather, especially during the harmattan season* (Richard- collective voice reviewer).

5.4.2D Accommodation challenges

Study participants explained that a major challenge they encountered after moving to the new city was an inability to find suitable accommodation. This was mainly due to the high cost of housing in these cities. This was more prominent among study participants resident in the Federal Capital Territory and Lagos states. The majority of the study participants said they had to squat with friends or relatives on arrival in the new city due to the high cost of the rent.

'*It was not easy at all because getting a house or accommodation in the urban area is a difficult task. [..] I was squatting with a friend; we were seven in a room'* (Andrew- study participant).

‘Collective voice’ reviewers also shared similar experiences, they shared that the city's accommodation cost was too expensive. They also explained that they had to get accommodation in the outskirts and neighbouring towns far away from the city centre due to the high cost of rent in the new cities. As a result of moving to the outskirts, they encountered traffic congestion to and from work.

‘*I had to stay in Nasarawa state (a state close to Abuja) because [..] accommodation is very high, and I could not afford to rent a flat in the city’* (John- collective voice reviewer).

‘*I found that housing was a major challenge with terrible houses being very expensive on moving to Lagos state’* (Linda- collective voice reviewer).

5.4.2E Job challenges

A major theme that came out of the experiences of both the study participants and ‘collective voice’ reviewers was the inability to get a job on arrival to the new city or state. It is worth noting that most internal migrants moved to these cities to find employment. Study participants moved to find jobs, while ‘collective voice’ reviewers also moved to find job opportunities in the three selected states used in this study. However, on arrival to these cities, these participant internal migrants struggled to find a job.

‘*It has been a bit challenging because of the level of competition and all involved in job acquisition [..] going about searching for jobs’* (Chris- study participant).

All married female participants explained that they had to leave their jobs due to moving to join their spouses. ‘*I had a job back then. But I had to move and leave the job because of these, and many sacrifices affect mentally’* (Kemi- study participant).

‘*I lost like my job because I had a job I actually had initially because I made up my mind to leave my people and move to another state entirely. ‘I found myself losing my job, and since then, picking up a new job has been very difficult’* (Susan- study participant).

5.4.2F Lack of social support

All participants explained that leaving friends, family, social gatherings, and peer groups was challenging.

*‘Moving affected me mentally due to leaving your peers, family.’ (*Kemi- study participant*).*

‘*Leaving my relations [..] I miss my brother and uncles because it is not easy to leave your loved ones to a new place like that’* (Peter- study participant).

Female married internal migrants experienced similar challenges as they struggled to form new relationships with their new families through marriage.

‘*Meeting new people […] I had issue especially because of conflict of maybe understanding’*. (Susan- study participant).

Some also experienced difficulties interacting within their new relationships due to differences in their ways of life. For example, Susan found it challenging to interact with her new family because the way they socialised differed.

‘*It affected me socially because the people I belong to are more of the socialite. They enjoy parties and maybe gatherings, [..], and I am not that kind of person’* (Susan- study participant).

Married female participants also explained that the lack of support from their husbands in the home negatively impacted them. This impacted negatively on their physical and mental health.

'*But I discovered that he is not a family person. Having to care for two children, who are not up to age 10, and having to care for them all alone without any support from anywhere was a big headache initially, and I thought I could cope with it, but I'm just trying to manage. It's having a toll on my mental and physical wellbeing'* (Susan-study participant).

One married female participant who moved to join her spouse described experiencing loneliness due to the inability to get a job and socialise with other people on arrival to the new state.

'*I was just only me, no friend, nothing' (*Ayo- study participant*).*

5.4.2G Insecurity challenges

Another theme that came up while study participants shared their experiences was the prevalent insecurity challenges in the nation. Study participants explained that they moved to their current residence because of the increased rates of insecurity in their state of origin/ previous residence. They explained that they were happy on arrival to the new city to discover that these cities were secure due to less prevalence of armed robberies, kidnappings, etc.

'*I noticed that security is better than in the Niger delta area. So, my mind was a little bit settled [..] I decided not to go back'* (James- study participant).

Some study participants also shared experiences of insecurity and riots on arrival to the new state. Naturally, this experience caused a lot of distress to the participants at that particular time.

'*When we got to Kaduna, it was at a time there was a crisis. That crisis affected me psychologically'* (Peter- study participant).

Ruth explained that she experiences fear to go about her daily and social activities due to insecurity challenges prevalent in the state.

'*You lack the confidence to go around to shop, [..] go out like to go for clubbing [..] because we are always afraid of terrorists'* (Ruth- study participant).

5.4.2H High cost of living

Study participants also explained that the costs of living in the city were expensive. These included the cost of daily items such as housing, food, healthcare, etc. Participants explained that the cost of daily commodities made it impossible to cope in the new city. '*it's [..] difficult for me paying the bills at first because I just started a job, and the money wasn't much cos Abuja is kind of high expense area, and the standard of living there is a bit high than where I was coming'* (Fred- study participant).

'Collective voice' reviewers also shared similar experiences. They also explained that the high cost of living in these cities makes it difficult to settle down properly. For example, one participant said that affordable healthcare was a major challenge. '*Housing is quite expensive and transport problems. Healthcare is not affordable'* (Ahmed- collective voice reviewer).

In addition, John explained that he had to return to his place of origin due to the high cost of living in the state of relocation. '*I could not settle in Abuja due to the high cost of living and difficulty obtaining a job to meet up with the high cost of living. So I had to return to Lagos'* (John- collective voice reviewer).

5.4.2I Fast-paced nature of the city

All participants who resided in Lagos state described how the city's fast-paced nature (i.e., hustling, and bustling) could be distressing. Participants suggested that this resulted in residents' exhibiting aggressive attributes or characters while going about their daily activities such as catching a bus to protect themselves.

'*In terms of the hustling and bustling [..] in Lagos, a little bit of you must come out, and if you do not put yourself under check, you become aggressive'* (Blessing- study participant).

'I found out that due to the hustling and bustling nature of Lagos, the people are not as 'sane' as they seem. I could hear people screaming and showing aggressive behaviour compared to my place of origin, which is quiet, calm and civil' (Bimbo- collective voice reviewer).

While sharing their personal experiences, some 'collective voice' reviewers said that their state of origin was usually calmer than that of their relocation (Lagos state) due to the fast-paced and busy lifestyle.

'My place of origin is quiet and calm, but I found out that people never minded their business on relocation to Lagos (Bimbo- collective voice reviewer).

I found that Lagos is not very accommodating, and the hustling life is very intense compared to my state of origin, which is quiet and accommodating (Ahmed- collective voice reviewer).

However, all participants resident in Lagos (including collective voice reviewers) shared that the fast-paced nature of the city made them independent and lively on arrival to the new city. The city is regarded as a city of opportunities. Young people moved to this city to establish a career or make a living. It is also considered to be a fun place for social life.

'*Living in Lagos has made me social, smart, independent, and lively'* (Linda- collective voice reviewer).

'Life in Lagos is good when you have the available resource. I enjoyed my experience socially and culturally. I also discovered that there are a lot of opportunities here compared to my state of origin' (Ahmed-collective voice reviewer).

5.4.2J Experienced culture

A positive theme that came out of the experiences of the participants was the opportunity to experience the culture of the new city. The participants shared that the language, food, lifestyle, and dressing were aspects of the culture that they enjoyed.

'*Moving down to the north helped me to know more about the northerners'* (Lily- study participant).

Some of the study participants shared that before moving to the new state, they had some negative perceptions of the people in the state. However, on arrival to the new state, they experienced the lifestyle of the people, and these perceptions changed. For example, Ruth

(a study participant) said that she feared the north due to the belief that Islam was synonymous with violence, but on arrival, these beliefs changed.

'*I will have never known some of the cultures that I have been able to experience here in the north. [..] whether a Christian or Muslim we still worship the same God'* (Ruth- study participant).

'Collective voice' reviewers also explained that they enjoyed the city life in the new states, such as big houses, expressways, etc., compared to their small and less developed states of origin. Furthermore, they also shared that they enjoyed the social and night life in the new states. They compared these states to their states of origin, which had no social or night life. Therefore, they concluded that the states of relocation or destination were fun and social life was better.

'*When I moved to my state of relocation, I loved the express roads, big cars, and city life. I also saw many people from the north who spoke the Hausa language'* (Ade-collective voice reviewer).

'Abuja is livelier than my place of origin. I became more of an outgoing person and enjoyed social life' (Ade-collective voice reviewer).

5.4.2K Better opportunities in the new state

Another positive theme described by both study participants and 'collective voice' reviewers was that they moved because of better opportunities in their respective new states.

'*It is better in terms of economy, in terms of job opportunity, in terms of um so many facilities that enhance a better living'* (Bukky- study participant).

Study participants also explained that the new states were commercially buoyant, and they decided to stay back irrespective of the insecurity challenges faced at that time.

'*I find this place more economically viable [..] there was a crisis in this place, and almost everybody was running to their state of origin, but I resisted going because I knew if I run to my state of origin, I may not experience economic status that I plan for myself'* (Akin- study participant).

5.4.3 Theme three: Coping Strategies

Participants shared several ways in which they were able to cope with their experiences of internal migration to the new states. One coping strategy was to learn the language of their new state to enable them to communicate at the community or local level. They also managed by adapting to the weather.

Perseverance and determination were terms used by participants as coping strategies. In addition, religion, obtaining social support, and getting a job were also strategies that helped the participants cope.

These are explained in detail below:

5.4.3A Learnt the new language

The main challenge faced by new migrants was the inability to speak the new language (Hausa). This language difficulty was more prominent among internal migrants who moved to the north (Kaduna and Federal Capital Territory). However, participants coped with this challenge by learning the local language to communicate at the community and local levels. Understanding the new language gave them the confidence to communicate and adapt with the native residents in the new state.

'*With time, I started learning the language, and I was able to overcome'* (Bukky- study participant).

'*With time I got to know people there, [..] I started learning. I started telling people to teach me'* (Fred- study participant).

'Collective voice' reviewers also shared similar experiences of learning the local language to communicate better with the residents in the new state.

'*I learnt the new language to cope and discharge my duties properly'* (Johnson- collective voice reviewer).

5.4.3B Adapted to the weather

Participants explained that with time they were able to adapt to the harsh weather. This was prominent among internal migrants' resident in the northern region (Kaduna state), One participant, who battles a health condition (asthma), said she tries to protect herself from the harsh effects of the weather.

'I try to avoid the weather as much as possible. At least I am coping now I can go out normal and with my cardigan and everything' (Ann- study participant).

Study participants explained that they were able to adapt to the weather over time. For example, Akin a study participant noted that '*with time I was able to adapt without any problem.'*

5.4.3C Perseverance and determination

Study participants said that attributes such as perseverance, persistence, and determination were used to cope as a new internal migrant. They shared that they refused to give up during tough times.

'*[..] were able to persevere, and we were somehow able to live above floating water'* (Andrew- study participant).

Participants also used terms such as resilience and hard work as terms they used to describe coping. They explained that the fast-paced and stressful nature of the new city, with issues such as traffic, transport, and insecurity problems, made them resilient or tough.

'*I became very resilient. You see, not giving up, not taking, or accepting no for an answer* (Blessing- study participant).

They also shared that hard work was an attribute that helped them cope.

'*I learnt to be smart and hardworking to survive in this busy city* (Linda- collective voice reviewer).

'Collective voice' reviewers also shared similar experiences and used terms such as resilience and hard work as ways that helped them cope as new internal migrants in the new state. '*I also became resilient to adapt to the hustle and bustle life of Lagos'* (Bimbo-collective voice reviewer).

5.4.3D Religion

Study participants explained that religion played a vital role in coping. Participants shared that they had a strong belief that kept them going during difficult times. '*I am a religious person. I am a Christian, so I always have this motto or belief that it will be better [..] hope kept me going even through the toughest times'* (Andrew- study participant).

They explained that prayers and strong belief in God gave them hope that things would get better. This also gave them the strength to keep moving on. They explained that religion played a major role in their migration experience.

'*Religion played a vital role in my journey'* (Andrew- study participant).

'Am kind of like a religious person. I pray, and I mean I think God helped me [..] If we are in any tight situation I mean, God came through for me' (Fred- study participant).

5.4.3E Social support

Participants described obtaining social support from family and friends on arrival to the new city. They explained that family members and friends were very supportive. This support was obtained by providing housing and other necessities. This helped them settle down after arrival.

'*I had good friends who were good to me [..] This helped me settle down, and that helped me a lot* (James- study participant).

'*I put up with friends, and they were supportive, they helped'* (Chris- study participant).

A participant explained that another way to obtain social support was by talking to people, asking questions, and seeking advice.

'*Talking to people and them giving me advice on the easiest way to do stuff [..] was able to overcome and adapt faster'* (Fred- study participant).

Participants also shared that they made friends who became like family and adapted well by visiting new friends on arrival to the new city.

'*With the help of friends, colleagues and church members [..] make me feel I have a family'* (Mathew- study participant).

However, Susan a study participant described that lack of support following relocation was a factor that impacted negatively on her wellbeing.

'*Having to care for two children, [..] all alone without any support [..] It's really taking a toll on my mental and physical well-being.*

In contrast, Philip a study participant expressed disappointment by being dependent on the family for all basic needs on arrival. This made him experience feelings of inadequacy.

'*The experience was not like when I was in the village. I was independent, but when I got to FCT, I became dependent on my sister on everything; soap, food, everything. I think that's the experience. That's something I would not like to happen to anyone.'*

'Collective voice' reviewers also shared similar experiences of obtaining support from friends due to the high cost of living and having a good network of friends to help cope and adapt better.

'*Due to the high accommodation cost, I had to stay with a friend for a year. But unfortunately, it was not in the city centre as it was too expensive'* (Ade- collective voice reviewer).

5.4.3F Secured Employment

Participants shared that after a while and after moving to the new state, they were able to get a job. However, some of the participants shared that the jobs were not to their expectations.

'*I secured a job in 2011, and I have been able to move on with life'* (Ayo- study participant).

'I got a small firm, and that helped take care of me financially' (Chris- study participant).

A participant shared that she had to engage in menial jobs below her status to take care of her family due to the inability to get a befitting job.

'*I [..] pick up some menial jobs that are really not up to my qualification just in a bid to put body and soul together* (Susan- study participant).

One 'collective voice' reviewer also shared that while undertaking her NYSC internship, she got a job that allowed her to pay rent and made a living.

'*I got a job and was able to pay rent and make a living'* (Ade-collective voice reviewer).

However, another 'collective voice' reviewer shared that due to the high cost of living and inability to get a job, he could not stay and had to return to his state of origin.

I could not settle in Abuja due to the 'high cost of living and difficulty obtaining a job. So I had to return to Lagos. Finally, I got a job and currently run an NGO' (John-collective voice reviewer).

5.4.4 Theme four: Knowledge of mental health

This theme is divided into two sub-themes: participants' definition of mental health and perceived causes of mental disorders. These sub-themes are explained in detail below:

5.4.4A Definition of mental health

Participants interviewed gave several definitions of their knowledge and views about mental health. Participants defined mental health as psychological or social wellbeing.

'*it's a state of emotional or social or psychological wellbeing'* (Ann- study participant).

Participants defined mental health as a state of mind (emotion).

'It's all about a state of mind, a degree of your emotions being happiness or sadness' (Andrew- study participant).

Mental health was also defined as a process affecting someone's attitude and the ability to meet social and economic needs. They explained that moving to the new state with economic and social opportunities and having a job helped settle their social and economic needs.

'*I was a bit mentally stable because I was able to meet some of my social needs, economic needs [.] if you don't have a job, emotionally you can't be stable'* (Bukky- study participant).

Participants described mental health as how an individual perceives situations and how these situations make a person behave or talk.

'*Mental health to me means the state of health in which you talk about the feelings, behaviour, emotions of people'* (Blessing- study participant).

All 'collective voice' reviewers agreed with the findings. They explained that mental health is connected to a person's psychological and emotional well-being.

'*Mental health is when an individual is able to adapt physically, mentally, and socially* (John-collective voice reviewer).

One 'collective voice' reviewer shared that as a young temporary migrant, he associated mental health issues with distress due to being away from home. '*Young migrants who move temporarily may sometimes associate mental health issues with distress caused by being away from home'* (Mike-collective voice reviewer).

Most participants defined mental health as adapting and handling life issues physically, mentally, socially, emotionally, and psychologically.

5.4.4B Causes of mental disorders

The most-reported causation of mental disorders described by participants was unemployment, followed by stress, depression, lifestyle situation, and family issues such as divorce and drug abuse.

They said unemployment and economic pressure resulted in crime and begging among youths, negatively impacted their mental health.

'*Generally gross unemployment which has caused a lot of vices in the society. [..] People then resort to begging. The streets are polluted, and they resort to arm robbery, kidnapping'* (Bukky- study participant).

Unemployment also led to increased drug addiction due to frustration with the inability to gain a job. James also explained this. *'People are coming to look for menial jobs [..] indulge themselves in drugs [..] resort to stealing or even kidnapping.'*

Some study participants also explained that the inability to achieve the necessities of life due to economic hardship and unemployment affected them mentally.

'*Necessity of man if he can't make it affects someone mentally'* (Peter- study participant).

Another major cause of mental disorders that study participants identified was drug abuse. Participants explained that youths, especially in rural communities consumed toxic and harmful substances to gain excitement. This can subsequently lead to cases of mental disorders.

'Well, I think maybe drugs [..] like hard drugs. Some use crack cocaine. Some do, hmm! What's it called codeine and other sort of hard drugs. There is one local one they call solution. Most people who take it back in the village are not normal. They look like mad people. Drugs are a very big factor' (Philip- study participant).

'*Majority of them indulge themselves in drugs and since they are they are coming from a local area compared to town. So, it is difficult for them to cope, especially due to drugs'* (James- study participant).

Additionally, participants explained that some people, especially youths, used illegal drugs as a coping mechanism due to stress, resulting in mental disorders.

'*Sometimes, these people take these illegal drugs in reaction to other things. For example, [..] sometimes when someone is frustrated and disappointed'* (Blessing- study participant).

Some participants also attributed factors such as spiritual attack and possession of evil spirits as causes of mental disorders.

'*We are also in Africa; we cannot rule out the powers of black magic, voodoo, and all that. You watched African movies where people attack through powers of darkness to target their enemies and cause spiritual madness. It's real. In fact, in the rural areas, most mentally unstable people are usually due to attacks by evil people or powers of darkness'* (Chris- study participant).

Loneliness and genetic factors were also described as causes of mental disorders in an individual. This was reported by three participants.

'You feel lonely, and you will feel idle [..] in fact I was depressed' (Ayo- study participant).

It was also explained that an individual's mental capacity determines how they cope with stress or pressures.

'*It is the level at which you can cope with those stress that determines your mental capacity [..] able to react appropriately to those pressures [..] determine the level of your mental status or mental health'* (Akin- study participant).

They further explained that mental disorders could be caused by internal (within the individual) factors and external (outside the individual) factors.

'*Mental health problems can be caused by internal factors with that individual or external factors'* (Blessing- study participant).

Susan explained that another possible cause of mental disorders was migration. Moving to a different land to adopt a new lifestyle, culture, and attitude with people of varying mentality or belief systems could cause mental disorders.

'*Moving to a different land entirely where you now have to adopt a new style, new culture, new attitude […] affects mentally* (Susan- study participant).

Ann a study participant explained that traumatic situations could lead to mental disorders among children. For example, she explained that children who experienced the loss of their parents, separated from their families, or being treated badly by their guardians could negatively impact their mental state. She further explained that this could cause a ripple effect where they tend to treat other children negatively when they grow up.

'When a parent dies., even children know this and tend to separate the children to maybe another relative or another uncle. [..] It depends on how your guardian is also treating you. some guardians don't treat their wards nicely at all. [..], it affects the children, and when they grow with that in their head, they tend to do the same thing to other children. and that how it goes on and on.'

A few participants attributed the cause of mental disorders to accidents, lack of basic amenities, smoking, and poverty.

'Another is accidents, it may not be common, but it also causes mental instability resulting in head injuries by accidents. Their state of mental capacity changes immediately, and this depends on the degree and all that (Chris- study participant).

'Inadequate Hmm! Facilities to make life better. You know! Poverty, you know! (Andrew- study participant).

Participants also described people with mental disorders to show erratic behaviours, thereby displaying signs of 'madness.' Study participants described people with mental disorders using derogatory terms like 'mad' or 'mental.'

'*Someone that is imbalanced, maybe when you are discussing with him [..] the next minute he will just walk [..] and start destroying properties'* (Jane- study participant).

Fred a study participant also said, 'we *kind of relate it to like someone going 'mad' […] and when I say 'we' I mean like people I've around and myself [..] sometimes we relate it to like spiritual issues […] English people call it 'voodoo.'*

These statements confirmed that these perceptions result in stigma towards persons with mental disorders in Nigeria.

All ‘collective voice’ reviewers agreed with the findings from the study participants. They decided that the inability to handle stress within an individual was known as internal variables, while external variables such as poverty, physical illness, and even spiritual problems (for example, being possessed by an evil spirit) could lead to mental disorders.

‘Mental health is a growing problem especially among young people due to stress, unemployment, drug abuse and even spiritual problems’ (Richard-collective voice reviewer).

‘*The ability of an individual to manage stress (internal variables) and various external factors mainly focused on poverty* (Johnson- collective voice reviewer).

They also agreed that drug abuse was a major cause of mental disorders, especially among youths.

’*I also agree that drug abuse is a major cause of mental issues, especially among youths in Nigeria’* (John-collective voice reviewer).

5.4.5 Theme five: Impact of internal migration on mental health

This theme identified and explored issues relating to the migration experiences of selected participants (internal migrants). Participants shared various experiences about the impact moving to a new state had on their mental health. However, some participants shared that irrespective of the challenges they encountered, they decided to stay back due to opportunities present in the new state.

5.4.5A Thoughts of returning on arrival.

Some study participants explained that due to several challenges such as insecurity, lack of support, high cost of living etc., these led to thoughts of relocating back to their places of origin which led to psychological distress thereby impacting negatively on their mental

health. For example, Susan a study participant explained that she experienced a lack of support from her family after relocating post marriage; she became distressed and considered returning to her place of origin.

'I should move again from where I am now back to my people. It's like migrating back again, you know! I have signed my life to belong to these new people. So, thinking of moving back to my place of origin with my children is not going to be easy (Susan- study participant).

Blessing another study participant also shared that she had initial thoughts of returning due to the hustling and bustling nature as well as high level of insecurity in the city but changed her mind due to the opportunities present in the new state.

'At first, I was actually put off at first, and I was thinking of relocating. But the truth of the matter is things happen in Lagos. Commercially it's very good. So at the end of the day, I was thinking, well, these things are here. What I actually need is here, why would I think of moving'.

Philip a study participant also explained that he thought of returning to his state of origin due to hardship on arrival at the Federal Capital Territory (Abuja).

'There were times when I felt okay. Unfortunately, I have to like to go back to my state because of the hardship at that point.'

Fred a study participant shared that he encountered armed robbers while transporting his luggage to the new state. This put him in a state of distress, and he began to question his motive for relocation if he was making the right decision.

‘*I had to use public transport, and then on the road, we were attacked by armed robbers [..] my kind of person where we are from, we kind of think that if you want to do something and bad things start to happen in the beginning. So we tend to say, ‘that’s like a bad omen.’ Are you sure you are making the right move?’*

Finally, Akin a study participant explained that although other internal migrants moved to their states of origin during the crisis. He refused to return due to the opportunities present in the state. He also explained that those who moved had to return after the crisis and had their properties sold for scrap on leaving.

‘*There was a time there was a crisis in this place, and almost everybody was running to their state of origin, but I resisted going because I knew if I ran to my state of origin, I might not experience the economic status that I plan for myself. So I didn’t go, and I decided to stay with my family, and the crisis subsided. However, those people who ran to their villages or their states of origin had to come back months after the crisis settled, and unfortunately, some of their properties were looted, some sold their properties at giveaway, and it was a loss; for them.’*

However, John (a ‘collective voice’ reviewer) explained that he had to return to his place of origin (Lagos) due to the high cost of living on relocation to Abuja.

‘I had to leave Abuja due to the high cost of living, which made me distressed at that time (John-collective voice reviewer).

5.4.5B Socio-economic challenges

Socioeconomic challenges caused distress to internal migrants after arrival at their destination places which negatively impacted their mental health. Some of these socioeconomic challenges were unemployment, accommodation, and infrastructural

challenges, etc. For example, the poor state of roads and the expensive cost of moving negatively affected participants. A study participant said she expressed fear during her journey by road to the new state because of the risk of accidents on the road while moving.

'*When I was moving, […] our roads are not so secured. [..] There were some accident scenes I saw while moving [..] Risk of moving affects mentally as well cos everyone is scared.'* (Kemi- study participant)

In addition, the poor state of roads attracted kidnappers and armed robbers to road travellers (Ali et al., 2015). This made the decision to travel and travelling very challenging for internal migrants. For example, Fred explained that he encountered armed robbers on his journey while migrating to Abuja which led to psychological distress.

'I had to use public transport, and then we were attacked by armed robbers on the road, which was a downside [..] So that was how the whole stress and panic started' (Fred- study participant).

Andrew a study participant also explained that lack of necessities like accommodation, food, etc., was emotionally draining and sometimes led to suicidal thoughts.

'*To be honest, it was emotionally draining. Hmm! And sometimes, you feel like giving up. Imagine a situation where you have not eaten, probably for two days. You have not had a proper shower because you don't even have a place to stay. No food, and that alone caused a lot of sometimes suicidal thoughts. Thoughts of failure, you can't succeed, disappointments, and all that. It actually puts a toll on my mental health, my total wellbeing'.*

James (a study participant) shared a similar experience that he had to squat with friends with no social amenities such as electricity, or pipe-borne water on initial arrival to the new state. This had a severe impact on his wellbeing because this was not a life, he was accustomed to.

'When I got to Abuja, the environment I was staying in was no electricity, no pipe-borne water, no good road, all because I don't have money to afford a place for myself. I had to manage with my friends' where they got because I was not working. It had a serious impact on me because I was not used to that type of life.'

Fred another study participant also explained that the cost of living in the new state (Federal Capital Territory) was very high on arrival, and he found it difficult to cope.

'I didn't know the standard of living was that high cos I didn't think I would be that it will be that high like I said. So, when I got there, it was difficult for me to cope.'

Also, the nation's situation, such as corruption, insecurity, poverty, poor infrastructure, bureaucracy, unfair treatment, etc., could lead to depression and a negative state of mind.

'*The state of affairs of the country must have had an impact […] the level of disappointment, […] the rate of kidnapping; all these things contribute to depression and negative state of mind'* (Chris- study participant).

'*There are so many factors that I should say could be the cause of mental health problems [..] we can talk about unemployment, inadequate Hmm! Facilities to make life better. You know! Poverty, you know!'* (Andrew- study participant).

Finally, Lily (a study participant) shared that her family had to move out of their apartment as a higher authority official wanted it, made her distressed.

‘*We moved to the place they gave him as part of accommodation [..] some people that were higher than him in his place of work wanted to stay in the same apartment, so they asked us to move out* (Lily- study participant).

Unemployment has also led to psychological distress and impact negatively on mental health. The dream is to secure an excellent job after spending years in school and spending vast amounts on tuition and other fees. Having to wait for years before getting a job impacted self-esteem and led to psychological distress. For example, Ayo shared that the first year was challenging and lonely due to unemployment on arrival to the new state which led to depression.

‘*I didn't even know anyone. I did not have family or relatives in Kaduna [….] I find myself to be sitting idle for a whole year[..] in fact I wanted to have something like mental health problem* (Ayo- study participant).

*'You know, children so many children graduated even masters they don't have jobs [..] There is nothing more frustrating than somebody graduating and not getting a job.' (*Bukky- study participant).

‘Every morning, we go out to look for a job, and it wasn’t that easy at all.’ (Andrew- study participant).

Unemployment is regarded as the cause of many vices such as kidnapping, crime, etc., and this has made life unsafe and a major social problem in the country. This is also a major cause of psychological distress to Nigerians.

‘*Generally gross unemployment which has caused a lot of vices in the society. [..] has caused social problems. There is a lot of vices because there are no job people then resort*

to begging. The streets are polluted, and they resort to arm robbery, kidnapping. So those are some of the problems we face in these parts of the country because of the lack of job opportunities. So it is a great social problem. And the poverty level is increasing daily. And life is not safe. People cannot go to hospitals, and it is a very terrible situation. And we are praying for God's intervention' (Bukky- study participant).

Finally, participants who moved with their families when they were younger described that their parent's lack of jobs affected their relationship with their parents. Some also explained that the inability of their parents to pay their school fees and seeing their schoolmates go to school made them unhappy, isolated, and angry.

'*Seeing my mates going to school, I am not happy. Like I was hiding, and I did not like coming out'* (Jane- study participant).

'Collective voice' reviewers agreed that negative factors affect mental health but focused on the positive effects of migration, academic advancement, and job opportunities.

'*I also discovered that negative factors [..] affect mental health but decided to focus on the purpose of migration which was for academic advancement and job opportunities'* (Johnson-collective voice reviewer).

Another 'collective voice' reviewer explained that educational-related pressure might impact the state of mind based on a personal experience as a temporary migrant.

'My temporary migration was for an educational purpose, so related educational pressures probably reflect my experience' (Mike-collective voice reviewer).

5.4.5C Unfulfilled expectations on arrival

Participants explained that unfulfilled expectations after relocation could lead to distress and negatively impact mental health. For example, Susan (a study participant) shared that she was confused if she should relocate back to her place of origin due to the unachievable expectation on arrival to the new state after marriage. She discovered that her husband had a different view and mentality about family. The participant's expectation of a supportive spouse was not achieved after migrating to join her spouse. This led to significant distress to the participant.

'*I believe family is key, but [...] my husband is […] not so committed'*. [..] *thinking of moving back to my place of origin with my children* (Susan- study participant).

However, she changed her mind because she believed marriage was a decision to remain in the new family irrespective of the outcome or consequences.

'*If I should move again from where I am now back to my people […] Because to me I have signed my life to belong to this new people'* (Susan- study participant).

Fred (a study participant) also shared that he did not receive the outcome he had planned. He planned to rent an apartment on arrival but could not afford one because he did not have the available funds, making him sad and depressed.

'I was a bit depressed because it was not how I planned it to be. Sometimes when you plan stuff, it is not always how it goes. But I was a bit depressed because initially, I had not found who I wanted to rent a flat with and wanted to rent a flat for myself, but the money wasn't enough, so I was depressed. I was confused. Hmm! I had to think a lot, and I was sad, so it affected me negatively initially'. [..] *I was checking it anyway to see if it's the right thing to do* (Fred- study participant).

A ‘collective voice’ reviewer agreed that an individual could move to a place and not experience the expected outcome on arrival. This can make a person depressed.

‘*When an individual moves to a place and does not experience the expected outcome on arrival. This can make one depressed’* (Richard-collective voice reviewer).

5.4.5D Fast-paced nature and hurried lifestyle of the new state

Participants shared that the hurried lifestyle of residents in Lagos state can lead to stress and subsequently psychological distress. Participants explained that due to the new city's fast-paced nature and hurried lifestyle, people did not seem as ‘sane’ as they looked. They seemed to show more aggressive behaviours than their counterparts in their state of origin, calm and civil. They also agreed that the fast-paced nature of the new city could sometimes be mentally draining.

‘*Due to Lagos's hustling and bustling nature, the people are not as ‘sane’ as they seem. [..] people [..] showing aggressive behaviour compared to my place of origin, which is quiet, calm, and civil’* (Bimbo- collective voice reviewer).

‘*Lagos is a fast-paced town, and it can sometimes be mentally draining’* (Linda-collective voice reviewer).

Participants also explained that surviving in an unconducive environment with difficult situations impacted mental health. Participants gave scenarios where they became aggressive on occasions due to the hostile environment. These changes greatly influenced their mood and feelings and also their mental state.

‘*How it impacted me was even my mode of communication, my manner of speech, not that I became rude or vulgar but then a little bit of being outspoken because in Lagos you*

just have to talk. You have to talk. I found myself being aggressive on many occasions with a bus driver, with someone in the compound, with someone in the market' (Blessing- study participant).

5.4.5E Impact of lack of social support

Participants also explained that lack of adequate support from family or friends led to psychological distress and greatly impacted their mental health. For example, Susan (a study participant) explained that having to care for two children alone without any support put a toll on her physical and mental health.

'*Without any support from anywhere [….] It's really having a toll on my mental and physical well-being.*

She explained further that she experienced psychological and emotional problems after leaving her family to join her husband.

Yes, psychological problems, yeah! Even at a point emotional problem because at a point because you find out that leaving your family behind and then coming down to another state entirely affected me' (Susan- study participant).

Ruth (a study participant) also described her experience as not easy because her husband, who was military personnel, was constantly posted out of state. She explained that she struggled to cope with his absence.

'*I am not finding it funny […] will not be able to put myself together because my husband is not with me.*

Some participants also explained that moving to the new state felt different and they had difficulties fitting in due to leaving family and friends behind.

'*Leaving from the old place to the new place kind of felt odd. I felt like I did not fit in at the beginning'* (Lily- study participant).

5.4.5F Impact of insecurity challenges

Some participants explained that they experienced constant fear before relocating due to the high level of crime and insecurity in their state of origin. However, they described that moving to the new state served as an escape route for them, and they felt comfortable and safe in the new state.

'*My relocation to Abuja coincides with the time of political crisis or violence in the country. So [...] saw a lot of attacks, burning of churches [..] It was an escape means or route for me'* (Chris- study participant).

'There was no disappointment because my experience here (FCT) is better compared to Niger delta because of security challenges [..] *in Warri those days we hide inside the room hearing gunshots on a daily basis. Once it's dark, you can't even go out with friends. You would be scared of people attacking you to collect your phones. That alone has effects on mental health.*' (James- study participant).

Some other participants shared that they encountered insecurity crisis that affected them psychologically, resulting in feelings of isolation and rejection on arrival to the new state.

'*We got to Kaduna; it was when there was crisis [...] affected me psychologically'* (Peter- study participant).

However, some participants refused to relocate during the crisis due to opportunities in the new state. Unfortunately, those who left during the crisis had their property looted or sold for scrap.

‘*There was a time there was a crisis in this place, and almost everybody was running to their state of origin, but I resisted going because […] I may not experience economic status’* (Akin- study participant).

Fred (a study participant) also shared an experience of experiencing armed robbers on his way while transporting his property to the new state. This experience made him distressed.

‘The moving, I had a bit of luggage, so it was not easy transporting all of it to Abuja where I was going to, and then, I had to use public transport and then on the road we were attacked by armed robbers which was a downside. that was how the whole stress and panic started.

5.5 Summary

This chapter describes the findings of this study. In addition to the ‘collective voice’ reviewers providing feedback on the findings draft report, they shared their personal experiences as internal migrants in Nigeria. This meant that all ‘collective voice’ reviewers were internal migrants in Nigeria. This was not intentional but was discovered while conducting the data analysis.

The findings showed that internal migrants in Nigeria mainly migrate within Nigeria for educational, marriage, work, and NYSC purposes. The study also found that all the married female participants moved to join their husbands. Many times, young women experienced social pressures to get married to gain acceptance.

Challenges to internal migrants' experience in Nigeria were language and cultural barriers, insecurity challenges, infrastructural challenges such as unemployment, transport problems, accommodation problems, and high cost of living. In addition, on

arrival to the new state, a lack of social support and weather challenges were faced by internal migrants.

However, there were some positive experiences as described by study participants. They explained that they enjoyed the culture of the new state, such as food, language, dressing, etc. They also explained that the opportunities present in the state made them stay irrespective of the challenges they were experiencing. In addition, participants described various ways that they coped, including learning the language, adapting to the weather, perseverance, religion, obtaining social support, and finally getting a job.

Study participants also gave their definitions of mental health. They defined mental health as psychological or social wellbeing and state of mind. They also described their perceived causes of mental disorders as stress, unemployment, family problems, drug misuse, supernatural causes, loneliness, and genetic causes.

Finally, participants explained how these migration experiences impacted their mental health. Participants shared both negative and positive experiences. The negative experiences were that they had thoughts of returning due to economic problems, lack of basic amenities such as insecurity, unemployment, accommodation problems, poor infrastructure, leaving family and friends, and high cost of living. In addition, the fast-paced nature of some cities and unfulfilled expectations on arrival due to lack of support, insecurity and high cost of living can be very distressing. These factors led to psychological distress and impacted negatively on their mental health. On the other hand, some participants also explained that they decided to stay back due to opportunities present in the new state.

The next chapter discusses the study's findings in relation to the broader literature on the topic and methodological issues relating to the study

Chapter Six: Stage Four: Working with ‘silences’ (Discussion)

6.1 Introduction

This chapter consists of two sections. The first section presents a quick summary of the findings as shown in chapter five and discussed the findings within the contextual setting and historical background identified in stage one of this study. In addition, ‘silences’ were determined in relation to the study’s aim. This allows the readers to ascertain how appropriate the recommendations shown later in this chapter were relevant for further research and policy in the context of internal migration and mental health in Nigeria.

The second section of this chapter discussed the methodological issues that arose within the study. This included the application of the intersectionality framework to the study, ‘silences’ uncovered and not expected in the study, managing power influences, my positionality in the research, the unintended consequences of the study, study constraints and limitations, and a review of my experience using the silences framework and its critique within the context of the current study.

Finally, this chapter provides recommendations for future research and policy implementation in Nigeria.

This study aims to identify and explore factors that impact the mental health of voluntary internal migrants in Nigeria.

The objective of this study is to:

1. Explore the experiences of selected voluntary internal migrants and the impact their internal migration experiences had on their mental health using a new theoretical framework (Serrant-Green, 2011).

2. Improve knowledge level and awareness about mental health issues in Nigeria.
3. Assist in creating further research to assist stakeholders in providing more access and delivery of mental health services in Nigeria.
4. Test the application of the 'silences' framework (Serrant-Green,2011) for researching an under-researched group about a sensitive issue in a new context.

The research questions guiding the study are:

1. What are the views, knowledge, and experiences of voluntary internal migrants in Nigeria concerning mental health issues?
2. What are the influencing factors concerning mental health among voluntary internal migrants in Nigeria?
3. What is the impact of voluntary internal migration on mental health in Nigeria?

Before moving to discuss the findings, please see below a quick overview of the summary of this study findings.

Theme one- (**purpose of migration**): the main reason for migrating was for work, education, undertake national youth service corps, marriage, have a better life, and to join families.

Theme two (**experience of migration**): challenges such as language and cultural barriers made participants feel unaccepted and isolated. Another was transportation issues such as distance, cost of transport and traffic problems. Weather challenges due to the inability to cope with the harsh weather on arrival were also identified by participants. Another challenge was the inability to get accommodation on arrival. Participants also described a lack of support due to leaving families, friends, and peers, this led to feelings of loneliness and isolation.

Another challenge was insecurity both before and after internal migration. The fear of insecurity made them constantly distressed, vulnerable to harm, and agitated. Another challenge was the high cost of living, mainly identified by participants resident in FCT (Abuja) and Lagos states. This massive rise in the cost of living resulted in distress and poor mental health. Another challenge, as described by participants resident in Lagos state, was the fast-paced nature of the city. The hustle and bustling lifestyle were very stressful and challenging and affected them psychologically. On the other hand, participants also shared better opportunities in the state they relocated to. Finally, some participants explained that they enjoyed the culture on arrival to these cities.

Theme three (**coping strategies**): strategies included learning the language. Participant residents in Kaduna and FCT decided to learn the local language (Hausa) to feel accepted. For example, Kaduna state is located in the north-central region, and the most popular language spoken by both educated and non-educated people is the Hausa language. Participants explained that they could adapt to the harsh weather conditions by getting used to it after some time. Terms such as persistence, perseverance, determination, and resilience were used to describe how they managed to cope after arrival at their place of destination. Religion was also a major coping strategy that participants disclosed. Social support from family and friends was another way they coped on arrival. They obtained support in the form of housing, feeding, and other necessities. Finally, they coped by getting a job after arrival at the place of destination.

Theme four (**knowledge of mental health**): participants defined mental health as psychological or social wellbeing, a state of mind (emotions), a process that affects one's attitude, and ability to meet social and economic needs. They attributed the causes of mental disorders to stress, pressure, unemployment, depression, lifestyle situation/ family

issues, drugs, alcohol abuse, loneliness, genetic causes, accidents, migration, lack of basic amenities, smoking, poverty, physical illness, and spiritual forces.

Theme five (**impact of internal migration on mental health**). a high level of insecurity in their place of origin made participants afraid and distressed and led to their subsequent relocation. Also, on arrival, insecurity led to distress and feelings of isolation. Having no support from family and friends puts a toll on their mental health. However, relying on family for help led to feelings of dependence and being a 'burden.' Economic challenges, unemployment, insecurity, etc., led to thoughts of returning to the place of origin.

Unfulfilled expectations post-migration due to a lack of support and insecurity led to thoughts of returning and negatively impacted mental health. The lifestyle and fast-paced nature of life for participants resident in Lagos negatively impacted their mental health. Finally, the low socioeconomic status and lack of infrastructural amenities such as constant electricity, good roads, etc., led to psychological distress and sometimes suicidal thoughts.

6.2 Section one: Discussion of key findings

This section discusses the key findings arising from exploring the experiences of mental health among internal migrants in Nigeria. The scoping review concentrated on the knowledge, attitudes, risk factors, and impact of mental health in Nigeria. Particular focus was given to internal migrants. This study sought to give voice to internal migrants concerning mental health in Nigeria.

Internal migrants in Nigeria account for 40% of the population in Nigeria (NBS-survey report on migration, 2020). Previous research has linked internal migrants to sexual health and early mortality in Nigeria (Odimegwu, and Adewoyin, 2020; Mberu and Mutua,

2015; Mberu and White, 2011; Mberu, 2008). Generally, internal migration research has been limited to rural and urban development and population (Oyeniyi, 2013; Oucho, 1988; Adepoju, 2008; 1998; 1976). After an extensive scoping review, there were no published and unpublished studies focused on voluntary internal migrants and their mental health in Nigeria. These individuals have been missing from research regarding health outcomes, especially mental health. There was no evidence of voluntary internal migrants concerning a sensitive topic like mental health in Nigeria in the existing literature.

However, recent papers focused on internally displaced persons (IDPs) (Mukhtar et al., 2020; Ogechi and Ezadueyan, 2020; Taru et al., 2018) who were forced from their homes by Boko Haram insurgents in the northeast region to reside in other communities and formal or informal camps (Mukhtar et al., 2020). Most of these residents who fled due to the insurgency by Boko Haram were primarily farmers. They had to become IDPs to survive, making them physically and psychologically vulnerable (Ogechi and Ezadueyan, 2020). Unfortunately, these individuals were primarily unemployed, had low education, and had no income.

As a result, most of these IDPs were diagnosed with depression and post-traumatic stress disorder (PTSD) (Aluh et al., 2019; Taru et al., 2018). It was reported that only private care initiatives (non-governmental organisations) were the primary source of rehabilitation for these IDPs (Okwuwa, 2016).

Even though there is no existing literature on voluntary internal migration in Nigeria concerning mental health, it is worth noting that insecurity challenges did not only significantly impact internally displaced persons who are a direct consequence of these

challenges. They also greatly influenced voluntary internal migrants who also moved to places they believed were more secure and less prone to the effects of insecurity. This study participants shared that the impact of insecurity led to constant thoughts of fear and anxiety. Participants who experienced insecurity challenges such as Boko Haram insurgency, armed robbery and ethnoreligious crisis described having experiences of distress and isolation.

Socioeconomic challenges such as unemployment were a significant challenge the participants shared. This negatively impacted their ability to settle and their mental health. As shared by the participants, one of the primary reasons for moving was for work purposes or to find job opportunities. According to the quarterly report by NBS (2020), about 23.20 million Nigerians are unemployed. The quest for better job opportunities dates to pre-colonial, colonial, and post-colonial times.

In the pre-colonial era, the movement of slaves by colonial administrators was done by captured slaves being sold to major cities and countries within Africa and internationally (Davidson, 1965). This was a significant driver of movement both within the country but also outside. In addition, people moved from different ethnic groups to urban cities for academic and work purposes in this era (Lovejoy, 1980).

In the colonial era, Coleman (1971) and Oyeniyi (2013) reported that the two major religions (Islam and Christianity) paved the way for urban-rural migration. For example, Christian missionaries were sent to rural areas to preach the gospel of Christianity, especially in the rural areas of southern and eastern regions of Nigeria. As a result, clergypersons, Islamic clerics, and teachers moved mainly to rural areas. Furthermore, western education paved the way for rural-urban migration due to the development of

early educational institutions situated in the urban centres. This led to the movement of youths to metropolitan cities to pursue education (Coleman, 1971).

Agriculture was also a major driver of internal migration in the colonial era in Nigeria. This was due to the exportation of crops such as cocoa, cotton, rubber, etc. This led to European traders opening businesses in cities to encourage the exportation of these crops. Furthermore, the introduction of tin mining in Jos and coal mining in Enugu was also a significant factor influencing migration to urban centres.

The development of infrastructures led to the mass migration of people within Nigeria (Falola, 1989). In addition, it was reported that males moved more due to the nature of the work, which was physically intensive, for example, construction of roads, rails, etc. (Okojie et al., 2013; Adepoju, 1998). In summary, the development of infrastructure and the introduction of educational institutions paved the way for movement from rural-urban centres in Nigeria.

In the post-colonial era, industries and infrastructures continued to attract Nigerian youths from rural areas. As a result, internal migration increased in this era, especially after the country's independence and in the 1980s, due to the desire for higher education, investment, better life, economic advancement, and job opportunities (Okojie, 2013). This has continued until today, as this study found that the majority of the participants migrated from their rural communities to larger urban cities to find job opportunities.

The lack of social amenities/infrastructures such as constant electricity, pipe-borne water, bad roads, and the high cost of living (including accommodation), etc., led to psychological distress among this study participants. For example, a similar study conducted in Africa (Sudan) found that the lack of basic social amenities such as water,

sanitation, and hygiene negatively impacted internal migrant workers' mental health (Fadallah et al., 2020). Another study conducted in a developed country (UK) also found that people with common mental disorders were more likely to move to areas of lower deprivation which made them prone to poor physical health (Greene et al., 2020).

In Nigeria, several studies among different population groups identified unemployment, lack of social amenities, and low income to be risk factors impacting poor mental health (Adewuya et al., 2021; Adewuya et al., 2018; Olagunju et al., 2015; Abiodun and Ogunremi, 1990). A study participant in this study, Andrew confirmed that socioeconomic challenges significantly impact the mental health of internal migrants in Nigeria.

This study also found that having no support and leaving family and friends impacted the participants' mental health. Several studies have emphasised the importance of social support on mental health among internal migrants (Ajaero et al., 2017; Mulcahy and Kollamparambil, 2016; de Brauw et al., 2013). This study finding agreed with studies that addressed risk factors of mental disorders among several population groups, which found that lack of social support increased the chances of developing mental disorders (John-Akinola et al., 2020; Adewuya et al., 2021; Olagunju et al., 2018; Nwedu, 2019).

The loss of social relations on arrival at the destination can create loneliness (Madsen et al., 2016; Koelet and de Valk, 2016). Therefore, an extensive network of family relations or partners and frequent friends help reduce feelings of loneliness in internal migrants (Koelet and de Valke, 2016). This study participants, Ayo and Kemi shared that they experienced loneliness due to leaving their families behind and moving to join their spouses. This led to significant distress.

An essential aspect of social support involves providing a specific form of assistance (Zaleska et al., 2014). For example, some participants explained that family members and friends provided housing, food, and other necessities on arrival. Social support was also provided in the form of emotional assistance through the creation of strong bonds. Another way to provide emotional support is by giving advice or sharing experiences. This may include disclosing important information. This allowed the new internal migrant to understand the situation and obtain available resources. For example, a study participant (Fred) shared that he obtained support through advice and guidance from local residents in the community.

Weak bonds can have a detrimental effect, especially on arrival at the place of destination (Zaleska et al., 2014). For example, a study participant (Susan) had a negative experience with her new family (in-laws) on her relocation after marriage. This experience negatively impacted her ability to settle, leading to psychological distress. On the other hand, sometimes, the actual presence of the supporting individual helps the internal migrant's adaptation (Hombrados-Mendieta et al., 2019).

In developing countries like Nigeria, family disruption usually arises through rural-urban migration. The focus is generally on the economic benefit of remittance (Oyeniyi, 2013). Therefore, loss of support from family and friends creates stress both to the individual migrating and the families left behind. This loss can lead to psychological distress such as depression, especially when close relations such as spouse or children are involved (Olurinola et al., 2014). For example, study participants (Susan and Ruth) explained that the absence of their spouses impacted negatively on them.

Internal migrants who have adequate social support are usually empowered, less stressed, less anxious, and have good overall well-being psychologically (Ajaero et al., 2017; Lu et al., 2012). However, sometimes social support can have some negative consequences where some may prefer to cope with the stress on their own. They feel that social support makes them feel like failures, dependent or redundant (Záleská et al., 2014). A study participant (Philip) agreed that the inability to be independent at the place of destination led to distress. Therefore, the level of social support provided to the internal migrant can impact how they cope during difficult times, thereby impacting their mental health (Wen and Hanley, 2016; Hombrados-Mendieta et al., 2019; Lu, 2012).

Another experience described by study participants was language and cultural barriers in the state of destination. The participants (internal migrants) complained that the inability to speak the local language in the new state made them feel unaccepted and isolated. Nigeria is a country with over 500 languages and over 250 ethnic groups (Danladi, 2013). Internal migrants in Nigeria usually lose some aspects of their culture, such as language on arrival at the new state in an attempt to adapt (Sibiri et al., 2014).

Sociocultural factors such as language, social status, food, dress etc., influences an internal migrant's decision to migrate. For example, most participants in this study and resident in Kaduna state and FCT explained that the inability to speak the local language (Hausa) made them feel unaccepted and unwelcomed in the community. Therefore, to adapt and feel accepted, they had to learn the language (Hausa).

In Nigeria, when an individual speaks the local language such as Hausa in northern Nigeria, the person feels part of the community and enjoys the associated privileges such as easy access to resources, jobs, and even little things like discounts while shopping

(Lambu, 2000). This is because the unequal socio-cultural environment has led to uneven development in the distribution of infrastructure, socio amenities, and allocation of revenue, job opportunities, and scholarships (Igbafe, 2021).

For example, an internal migrant (non-indigene) from Kaduna state may not receive some state government job opportunities or scholarship programmes due to being a non-indigene or internal migrant. As a result, internal migrants struggled to adapt to the new culture in the place of destination. This led to feelings of unacceptance and isolation. Sometimes, non-indigenes or internal migrants felt marginalised or discriminated against due to a lack of available opportunities in their states of destination.

However, internal migration has played a significant role in expanding diverse cultures and ethnic identities. Some participants explained that they enjoyed the culture, such as language, food, attires, etc., in the place of destination. Therefore, sociocultural factors such as language, food, etc., significantly affects an internal migrant's ability to adapt to the new culture of the state.

The lifestyle and fast-paced nature of life experienced by study participants resident in Lagos state impacted negatively on them. They shared that the stressful hustle and bustling experience made them distressed and sometimes depressed. Lagos is regarded as one of the most stressful cities globally (Igbo-anugo, 2017; O'Hare, 2017). It is estimated that the population in Lagos is approximately 21-25 million due to the high number of internal migrants from other states (NBS- Social Statistics Report, 2020; Leithead, 2017). It is also estimated that about two thousand people move to Lagos daily due to opportunities available in the state ((NBS- Social Statistics Report, 2020; Leithead, 2017).

Lagos is regarded as the economic centre of West Africa, with many youths moving into the state with promises of promoting careers and opportunities (De Gramont, 2015; Olurinola et al., 2014). However, the vast population has led to traffic congestion, housing problems, overcrowding, rising insecurity, pollution problems, and transport problems resulting in psychological distress of its occupants. These issues are experienced daily. To cope and survive these stressful daily events, participants had to be intelligent, resilient, and tough to adapt to and survive the stressful circumstances.

Participants moved for marriage reasons to join their spouses. It is interesting to note that all married participants who moved to join their spouses were females. None of the male married participants moved to join their spouses. The male participants moved mainly for work or educational purposes. This highlights the importance of marriage on female internal migration in Nigeria, especially because marriage is an essential part of the Nigerian society especially among women (Ogbe, 2020; Enfield, 2019).

In Nigeria, women are more likely to join their husbands after their weddings in another state regardless of their qualification, achievement, or societal reputation (Ogbe, 2020; Enfield, 2019). In this study, all married female participants explained that the primary purpose of moving was to join their spouse, leaving behind their good jobs, family, friends, and peers. They expressed that this was a sacrifice on their part as this was expected of them from society. The inability to get a job after arrival at their destination after their weddings, and a lack of support, resulted in loneliness, distress, and even depression. For example, a study participant (Susan) shared that lack of support from family led to thoughts of returning to the place of origin accompanied by feelings of loneliness and psychological distress.

This study participants shared that the cultural norm was that young women need to get married to be accepted in society. They, therefore, explained that sometimes young women experience pressure from families and friends to get married to gain acceptance (Ogbe, 2020). Sometimes, young women are forced into arranged marriages due to desperation, leading to domestic abuse and often human trafficking (Dogo, 2014).

These situations are worse for young women and girls in northern Nigeria due to experiences of inequalities in healthcare access to reproductive care and education (Ogbe, 2020; Abegunde, 2014). In addition, the general level of insecurity and poverty negatively impacts these women being victims of rape, arranged in forced marriages, and sometimes used as suicide bombers (WHO, 2019b; Ibrahim, 2016; British Council Nigeria, 2012; 2014). These experiences affect their mental, physical, and reproductive health (Ogbe, 2020).

A study participant (Bukky), during her interview, defined mental health as the ability to meet social and economic needs. She explained that the inability to meet basic socio-economic needs could lead to poor mental health. This study participants gave several definitions of their knowledge and perceptions about mental health. First, they defined mental health as psychological or social wellbeing, a state of mind (emotions), a process affecting one's attitudes and ability to meet social and economic needs. This showed that participants in the study had some knowledge of mental health.

This study explored the positive aspects of mental health by exploring and understanding knowledge and perceptions of mental health. This is because positive mental health involves achieving personal potential, working productively, and coping with daily stresses (Galderisi et al., 2017). Mental health is not just the absence of mental disorders

(Keyes, 2014; WHO, 2001). However, previous studies had focused on mental illness and mental disorders thereby ignoring the positive elements of mental health (Omolayo et al., 2020; Pederson, et al., 2020; Adeyemi, Abiola and Solomon, 2016; Gureje et al., 2005).

Among recent existing studies focused on the general population, it is interesting that people in the southwest region, especially Lagos state, had better knowledge of mental health and mental disorders (Adewuya et al., 2021; Adewumi, Oladipo and Adewuya, 2020; Mojiminiyi, 2020; Coker et al., 2019). Kuyinu et al. (2020) suggested that the frequent use of the media, the internet, the English language, and obtaining a higher education helped improved the knowledge about mental health in south-west Nigeria. This is possibly a reason why all participants in this study had some knowledge of mental health. All participants were educated, spoke good English, and could use the internet (used an online tool-Zoom as a data generation tool). This led to some positive attitudes and good health-seeking behaviours (Afolayan, Onasoga and Ademiloye, 2019; Egwuonwu et al., 2019).

However, many still recommended spiritual treatments followed by traditional treatment before resorting to medical help. Few preferred a combination of all because of the strong belief in supernatural causation and stigma towards persons with mental disorders in Nigeria (Olawande et al., 2020; Coker et al., 2019).

In the northern region, there was still poor knowledge and stigmatising attitudes towards persons with mental disorders in Nigeria (Abdullahi, Farouk and Imam, 2021; Anyebe et al., 2019; Zever, 2017). It was therefore found that poor knowledge or beliefs led to stigma which impacted help-seeking behaviours. It was observed that there were no

formal mental health services and all participants preferred spiritual treatment (Anyebe et al., 2019; Zever, 2017). In the southeast region, patient medicine stores (known as chemists) were commonly used after the onset of symptoms of mental disorders before medical treatment (Onyeonoro et al., 2016; Ikwuka et al., 2016).

In addition, existing studies in northern Nigeria reported the primary causation of mental disorders to be evil spirit possession, which greatly influenced the preferred spiritual treatment option (Argungu, Ahmed & Sa'idu, 2020; Zever, 2017). Similar studies focused on adolescents also found a strong attribution to the spiritual causation of mental disorders. However, females had better knowledge and showed greater compassion (Aluh et al., 2018 and Olawande et al., 2018). Studies focused on individuals in the southwest region found less emphasis on the supernatural causation of mental disorders (Adewumi, Oladipo and Adewuya, 2020; Mojiminiyi, 2020; Coker et al., 2018; Olatunji et al., 2020).

In agreement with stage one (scoping review), a few of this study participants also attributed the causes of mental disorders to spiritual issues. According to Lasebikan (2016) and Orngu et al. (2015), culture and religion in Nigeria tend to attribute mental disorders to spiritual forces. In addition, there is a widespread belief that mental disorders run in the family. This has led to continuous stigmatising attitudes and poor help-seeking behaviour in Nigeria and especially in the country's northern region. Therefore, Nwedu (2019) reported that persons with mental disorders preferred treatment in their homes and preferred to be isolated.

A study participant (Chris) shared during his interview that we could not ignore the place of supernatural forces in an African society. Leavey and King (2007) confirmed that spirituality was vital in Nigerian culture and embedded in the cultural fabric of Nigeria.

Culture is defined as belief, custom and other characteristics acquired by an individual as a member of a community (Tylor, 1871). For example, a survey conducted by the Africa Polling institute found that Nigerians still had widespread belief in supernatural causes such as witchcraft, demonic possession, and even punishment from God. Over 5,000 adults were interviewed in September 2019 in all states, including the Federal Capital Territory of the country. More than half of the participants in the rural areas viewed mental disorders as being possessed by evil spirits (Onyeji, 2020).

Amadi et al. (2016) explained that Nigerians are more likely to resort to religious or spiritual help for challenging situations. Therefore, it is not surprising that this study participants described religion as a coping mechanism during challenging times after migrating to their states of destination. They explained that their strong beliefs and prayers gave hope and determination to keep moving on.

Several studies found that religion helped individuals in stressful situations such as migration, with cultural background playing a significant role, where religious beliefs are central (Sanchez et al., 2012 and Bhugra et al., 1999). Studies also found a positive relationship between religion and chronic illnesses including mental disorders. This made participants in these studies less likely to develop psychological distress (Ani, Kinanee and Ola, 2011).

The scoping review (stage one) also found that Nigerians preferred traditional spiritual healers due to their strong belief in supernatural factors (Aina et al., 2020; Aina, Otakpor, and Israel-Aina, 2016; Akinsulore et al., 2014). For example, patients derived some psychological satisfaction from spiritual practices due to providing spiritual explanations (Uyanga, 1979). These are possible reasons why some Nigerians continued to attribute

the causation of mental disorders to spiritual/ supernatural factors. Therefore, regardless of the type of illness, Nigerians combined traditional or spiritual with medical treatment options (Aina et al., 2020; Labinjo et al., 2020; James et al., 2018).

Leavey and King (2007) also explained that it might be difficult for traditional/ spiritual healers to collaborate with medical professionals. Even though they provide support to emotionally distressed people, they may not want to refer people under their guidance to medical centres. Patel (2011) suggests that medical and traditional, and spiritual healers should collaborate. However, for this to work, abusive practices towards persons with mental disorders should be eliminated. Therefore, mental health policy, educational programmes focused on medical professionals, traditional healers, and spiritual healers should be employed (Labinjo et al., 2020).

Another popular causation of mental disorders as described by study participants was drug abuse. This was also shown in the scoping review (Agofure et al., 2019 and Adewuya et al., 2017; Gureje et al., 2005). Due to their low cost, drugs like Tramadol, Codeine, cough syrup, and laxatives are used mainly by youths, especially in the rural areas in northern Nigeria (BBC News, 2018). For example, in October 2017, it was estimated that about 3 million bottles of Codeine were consumed daily in Kano and Jigawa states in northern Nigeria (National Drug Law Enforcement Agency, 2018). A study participant (Philip) confirmed in his interview that many young people use these drugs, especially in rural communities. Another study participant (James) also shared that the prevailing economic situation of unemployment and poverty could make youths indulge in drugs leading to mental disorders.

Therefore, this study participants attributed the causes of mental disorders to stress, pressure, unemployment, depression, lifestyle situation/ family issues, drugs, alcohol abuse, loneliness, genetic causes, accidents, migration, lack of basic amenities, smoking, poverty, physical illness, and spiritual forces. There was some consistency in this study with the scoping review attributing the causes of mental disorders to unemployment or financial difficulties, brain injury, evil spirit possession/witchcraft, genetic causation, heredity, drug abuse, trauma, and head injury (Adewumi, Oladipo and Adewuya, 2020; Habib, 2020 Aluh et al., 2019a; Anosike et al., 2019; Chukwujekwu, 2018; Jombo et al., 2019).

Medical professionals, health workers, and nurses in the scoping review had better knowledge of mental disorders and mental health issues (Olatunji et al., 2020; Oderinde et al., 2018; Coker et al., 2018 and Omoniyi et al., 2016). However, previous literature identified health workers had poor knowledge levels, but this improved after trainings (Ekwueme and Aghaji, 2006; Abiodun, 1991; Ogunlesi and Adelekan, 1988).

The scoping review (stage one) reported students, adolescents, teachers, religious leaders, parents, and the movie industry in Nigeria. These studies found that there was still poor knowledge about mental disorders. Many could not identify the labelled mental disorder example (Aluh et al., 2019a; Anosike et al., 2019; Chukwujekwu, 2018; Olawande et al., 2018; Jack-Ide et al., 2016b). However, some studies reported that participants' knowledge levels improved after training or seminars (Isa et al., 2018; Omolayo et al., 2020; Dangana et al., 2020).

The scoping review also found a negative perception was portrayed in the media and movie industry. Movies represented mental disorders poorly with scenes of violence and

exhibiting psychotic modes. For example, some movie scenes portrayed people with mental disorders with nakedness and violent or erratic behaviours (Aroyewuo-Adekomaiya and Aroyewuo, 2019).

The scoping review also found that stigmatising terms such as ‘crazy’ ‘nuisance’ and ‘mad’ were often used across several population groups in Nigeria. This was a result of negative and stigmatising attitudes portrayed by participants in existing studies (Anosike et al., 2019; Jombo and Idung, 2018; Jyothi et al., 2015; Jidda et al., 2013). It was, however, found that social support from family and friends with religion was associated with lower levels of stigma (Pederson et al., 2020).

Therefore, in this study, although there was an improvement in knowledge of mental health, there was still persistent negative attitude towards persons with mental disorders. Study participants used terms such as ‘madness’ to describe persons with mental disorders. They also explained that persons with mental disorders displayed erratic and violent behaviours leading to stigma towards persons with mental disorders in Nigeria. These negative perceptions led to stigma towards people with mental disorders in Nigeria. This study showed that irrespective of the improvement in knowledge about mental health among study participants with less emphasis on supernatural causes, there was still some widespread stigma towards persons with mental disorders. This finding was consistent with previous literature attributing negative terms to describe persons with mental disorders in Nigeria.

The scoping review (stage one) also identified risk factors of mental disorders among different population groups in Nigeria. Risk factors such as unemployment, poor physical health, low income, low education, no social support, alcohol abuse, lack of social

amenities, family abuse, stress, marital status (separation/ divorce), polygamous family settings, age, and loneliness impacted negatively on mental health status (Adewuya et al., 2021; Nwachukwu et al., 2021a; Sanni et al., 2020; Adewuya et al., 2018; Olagunju et al., 2015; Abiodun and Ogunremi, 1990).

In this study, the study participants' perceived causes of mental disorders were similar to the risk factors of mental disorders identified in the scoping review. They identified factors such as poor support, economic challenges, family problems etc. This meant that to a large extent the current socio-economic situation such as unemployment, insecurity etc. in the country dramatically impacted the mental health status of Nigerians irrespective of internal migration status. However, internal migrants without any form of social support are more likely to experience worse mental health outcomes. For example, a study found that crude oil exploration in a community in the south-south region greatly impacted the inhabitants' health status (Okwuezolu et al., 2020). This is because the exploration caused their water, land, and other resources to be polluted, which negatively impacted the lives of the communities (Ejiba et al., 2016; Kadafa, 2012).

Some of this study participants became distressed due to the inability to achieve the outcome they expected on arrival to their places of destination. The failure to agree between their pre-migration expectation and post-migration realities led to significant distress, (Berry et al., 1987; Fozdar, 2009), impacted their mental health and considered moving back to their places of origin. For example, Susan found out on arrival at her destination after marriage that her husband was not supportive. This impacted negatively on her, and she thought of returning or leaving the marriage. Akin also shared that the insecurity challenges forced many internal migrants to return to their places of origin on arrival in Kaduna. Many had to sell their goods for scrap prices. He decided to stay back

due to opportunities present in the state. However, John shared that due to the high costof living and lack of a job in his destination (Abuja), he had to return to his place of origin (Lagos).

Wang et al. (2010) explored the experiences of rural-urban migrants in China; Wang's study found that the association between achievement and unfulfilled expectations led to poor self-esteem and mental health. Studies also found that a highly unrealistic expectation post-migration could lead to psychological distress and mental disorders (McKelvey and Webb, 1996; Williams & Berry, 1991). However, in this study, the expectation of having a good life free from insecurity or the expectation to build a supportive family and afford the basic amenities should not seem unrealistic to achieve. Therefore, the unfulfilled outcome of an internal migrant's expectation after migrating could lead to stress and negatively impact mental health.

There is a clear consensus between stage one (literature scoping review), contextual and historical background, and this study's findings. However, as no specific studies focused on voluntary internal migration and mental health in Nigeria, studies on other population groups such as natives, internally displaced persons, health professionals, young people, patients with mental disorders, etcetera were explored. This study participants lived internal migration experiences included insecurity, unemployment, and infrastructural challenges (lack of constant electricity, roads' poor state of roads, etcetera). Additional factors of a lack of social support, high cost of living, and language and cultural barriers significantly affected the ability to settle in the new state.

In addition, stage one (scoping review) found that irrespective of the migrant's status (internal or international), a complex mix of interrelated economic and social factors is

primarily significant to the migrant's wellbeing. Factors such as lack of support, low socioeconomic factors, etc., were significant to poor mental health status, low life satisfaction, and low self-esteem.

In summary, in addition to the internal migration process, factors such as lack of social support, socio-cultural factors (language and cultural barriers), unfulfilled post-migration expectations, a fast-paced or hurried lifestyle of the city, and insecurity can negatively impact internal migrants' mental health status. Also, socioeconomic factors such as unemployment, high cost of living and infrastructural challenges (lack of constant electricity, the poor state of roads, etc.) can result in significant stress, ultimately leading to poor mental health.

6.3 Section two: Methodological issues

This section discussed the methodological issues concerning the study, such as application of the intersectionality framework, and managing the power influences between my role as a researcher and the study participants. The section also discussed my positionality in the research, silences uncovered, a review of the 'silences' framework and application to the study, limitations of the study, and a summary of the study.

6.3.1 Uncovered 'silences'

This phase of the analysis presented the 'silences' uncovered as a result of conducting this study. This study did not set to explore these silences. However, these silences emerged from issues when data was generated, analysed, and reported.

A 'silence' that came up when data was generated was the impact of gender on internal migration and its impact on mental health in Nigeria. All-female married participants explained that the expectation from society was that young women must be married to

gain acceptance, recognition, and respect. This ‘silence’ outcome was not part of the aim of this study. The result emerged when participants (all married females) shared their experiences of moving to join their husbands in their states of destination. Therefore, this study showed that women are discriminated against and marginalised due to society's expectations.

In the northern region, several studies reported that young women and girls experienced inequalities in healthcare access regarding reproductive care and education. The prevailing level of insecurity negatively impacts young women resident in northern Nigeria due to cases of rape, forced marriages and sometimes used as suicide bombers (Ogbe, 2020; Ogu et al., 2016; Abegunde, 2014). However, these experiences affect not only internal migrant women but natives in general in this region (Abubakar, and Dano, 2018; Ibrahim, 2016; Ewetan and Ese, 2014; Obi, 2015. This has a tremendous negative impact on their mental health.

The ‘collective voices’ in this study identified another uncovered silence. They identified a sub-theme of ‘traffic gridlock among residents in Lagos state. They explained that the traffic gridlock was very stressful and negatively impacted the mental health of residents daily while undergoing their daily activities. This sub-theme was placed in the transportation theme as identified by the study participants. This sub-theme was created when the collective voices shared their personal experiences while providing feedback on the draft-one report.

6.3.2 The unintended outcome from the study

Nineteen participants shared their internal migration experiences on arrival to three states in Nigeria, namely Kaduna, FCT (Abuja), and Lagos states. The intention was to collect

data from thirty internal migrants in the three selected states in Nigeria. However, the interview process was stopped after conducting nineteen participants because data saturation was reached. It was found that participants in this study repeated the identified themes. For example, a code of 'work,' 'family,' and education was identified as a purpose of migration. Participants also shared their similar experiences of internal migration to unemployment, insecurity, language and cultural barriers, high cost of living, etc. However, it was found that these experiences of unemployment, insecurity etc., affected all Nigerians and not only internal migrants (Abubakar and Dano, 2018; Aliyu and Amadu, 2017).

Using the 'silences' framework, phase three of the data analysis process involved the use of 'collective voices. These were a group of people in the social network of the study participants (internal migrants), whose social, cultural, professional, or family situations impact their lived experiences. The aim was to add, agree or disagree with the issues disclosed during the interview. This helped ascertain the transferability of the research findings and identified 'silences' that still exist. These individuals' cultural, social, or professional circumstances impacted the experiences of internal migrants (study participants) in Nigeria (Serrant-Green, 2011).

Stage one (scoping review) found that spiritual leaders, medical professionals, and non-governmental organisations (NGOs) play a significant role in shaping the experiences of mental health in Nigeria (Labinjo et al., 2020). Therefore, the 'collective voice' reviewers were spiritual leaders (pastors), medical professionals, mental health experts, a community health volunteer, a chief executive officer of a non-governmental organisation (NGO), and an experienced migration researcher.

This study findings were analysed thematically and reviewed by some study participants (silence dialogue). After this, the reviewed draft one findings report by the 'silence dialogue' was reviewed by the 'collective voice' reviewers as a member checking process. The 'silences' framework used the 'collective voice' reviewers to agree or critique the disclosed silences. The intention was for the 'collective voices' to review and provide feedback on the findings by the study participants. However, it was discovered that the 'collective voice' reviewers shared personal internal migration experiences during their review and feedback which agreed with the silences identified in the interviews. This process confirmed the trustworthiness of the research process.

The 'collective voice' reviewers also added to the findings in the study under the code 'transport problems' by describing 'traffic problems' in addition to the transport problems identified by the study participants. They explained that the constant traffic gridlock in Lagos affected their daily lives and state of wellbeing (as described above).

6.3.3 Application of phenomenology in study

Hermeneutic phenomenology is a methodological approach in analysing an issue or topic (i.e., a phenomenon) by linking experiences and giving them meaning (Rodriguez and Smith, 2014). Upon reflection, it was observed that the study did not just focus on the practical knowledge but focused on the internal migration experiences of study participants in a natural way. The study also showed that internal migration identities are dynamic and depend not only on macrosocial factors but on activities performed by the individuals as a social characteristic. Therefore, the process by which internal migrants assimilate the meanings of experiences is personal and represents their lifestyle. However, even though these experiences were unique to the study participants, their

experiences and perceptions were similar due to social categories (gender), social inequalities (language barriers, unemployment, etc.), and internal migration being visible from the perspective of internal migrant participants (Tezcan, 2014).

Identity is defined as the outcome of linguistic or other semiotic processes, and it is regarded as a social and cultural process rather than an internally psychological problem (Rodriguez and Smith, 2014). Therefore, the interaction of the internal migrant with the social environment is regarded as the foundation for identity. Therefore, it is not surprising that study participants shared that they felt alienated and isolated due to the inability to communicate in the local language (Hausa), which sometimes led to discrimination.

A vital aspect of phenomenology is called the 'epoche.' The researcher brackets any personal opinions or prejudices about the phenomenon or study. Instead, the aim is to identify the phenomena or experiences as it appears to participants, i.e., how events are experienced, to reduce bias and ensure the study is executed in an honest way (Rodriguez and Smith, 2014).

The phenomenological attitude (epoche) is synonymous with stage two of the silences' theoretical framework, which identifies the researcher with this study. First, I identify myself in the study (also known as positionality) by examining own social identity in the study population (Serrant-Green, 2011), as explained in chapter two and further below. Second, it is essential to dig deep into the internal migration issue using the internal migrants' experiences and the existing evidence base (Rodriguez and Smith, 2014; Tezcan ,2014). Therefore, the epoche was necessary for this study as it helps identify unique and dynamic social actors (participants) on their internal migration journeys and experiences.

6.3.4 Application of Intersectionality Framework

New feminist research has focused on race, class, and gender as closely related. It has been argued that these concepts need to be studied closely either as a matrix of dominion (Collins, 1990), complex inequality (McCall, 2005), intersectional (Crenshaw, 1991) or as a race-class or gender approach (Pascale, 2007). Several feminist researchers have accepted the intersectional analysis.

Choo & Ferree (2010) explained that this typical type of intersectionality research involves the perspective of marginalised and under-researched participants, and these groups are the centre of the analysis. They emphasised that this helps 'give voice' to these participants. Furthermore, an individual's social position is linked to one's identity because social positioning and identity moved from one social context to another, making them fluid and constantly changing. Therefore, intersectionality relates to social groups, a person's identity, and the association between them (van Mens- Verhulst and Radtke, 2008).

Using an intersectional approach to explore the inequalities among internal migrants in Nigeria, it could be seen that rural underdevelopment and thriving urban cities have led to the massive movement of internal migrants to large urban cities. These movements started in colonial times when the British administration developed huge industries in the urban cities (Adepoju, 1977; Oyeniyi, 2013). However, lack of adequate social amenities such as electricity, clean water, sanitation, unemployment, poverty, rising insecurity, and even corruption by government officials have deprived internal migrants of the satisfaction of a better life in these urban cities.

Equity means when individuals have equal opportunities to make a living. It does not necessarily mean that the outcome will be the same for everyone. Inequalities among individuals are when fundamental requirements like food, education, security, etc., are lacking. It should not be determined by gender, ethnicity, or place of birth. These inequalities are group-based where policies are less sensitive and encourages discrimination thereby ignoring human development. These group-based inequalities are described in the intersectionality framework as known categories of gender, age, ethnicity, or religion. However, low socioeconomic status has also been associated with inequalities for these individuals.

Group-based inequalities, as described by Kabeer (2010), are called ‘intersecting inequalities.’ Kabeer described four types of inequalities which are cultural, spatial, economic, and political. Kabeer (2010) argued that the ‘intersecting’ nature of these inequalities encourages the continuation of social exclusion. It was concluded that we could identify the impact of these inequalities at this group through the intersections of gender, ethnicity, class, and location.

In addition to experiencing socioeconomic challenges such as unemployment, high cost of living, and lack of basic social amenities. They also experienced insecurity challenges. Every individual expects to achieve basic requirements such as security, basic social amenities including food, water, infrastructure, etc., irrespective of class, ethnicity, or gender. According to Bhorat, H., and Initiative (2014, p 17) on the UN High-level panel of eminent persons on the post-2015 development agenda, ‘we should ensure that no person regardless of ethnicity, gender, geography, disability, race or other status be denied universal human rights and essential economic opportunities.’

Watkins- Hayes (2014) suggested that efforts should target vulnerable groups by focusing on disadvantaged groups and eliminating disparities. Internal migrants face similar challenges with international migrants, such as language barriers, finding a job, and lack of social support to adapt to the new environment (Ma et al., 2020; Ajaero et al., 2017; Mulcahy & Kollamparumbil, 2016; Waage, 2015; Pheko et al., 2014; Lu, 2010). However, internal migrants in Nigeria faced more challenges such as socioeconomic challenges, for example, lack of constant electricity, water, insecurity, high cost of living, etcetera.

Internal migrants in this study, especially those residents in northern Nigeria, explained that they faced discrimination due to the inability to speak the local language (Hausa), making them feel unaccepted. They expressed that they were treated as 'second class citizens' and sometimes as 'non-citizens' due to the inability to speak the language. This impacted on association or communication with the native residents. This sometimes led to feelings of isolation, rejection, and discrimination.

Sometimes internal migrants are deprived of their rights and privileges due to not being from the major ethnic group. It can be said that every state and local government area in Nigeria is divided into two categories of citizens, i.e., indigenes (natives) and non-indigenes (internal migrants). Indigenes are those who can place their ethnicity and historical notes in the community where they settled, while non-indigenes are those who do not have their ethnicity placed in the community. It does not matter how long they have been resident in the place (Human Rights Watch, 2006).

The state and local government policies do not help matters but further discriminate and exclude non-indigenes (internal migrants). For example, many states do not employ non-

indigenes (internal migrants) in the state civil service, and most state universities refuse academic scholarships to non-indigenes (internal migrants). Even some state universities refuse to admit non-indigenes. If they do, the cost is very high. Recently, Kaduna state announced that tuition fees to the state university have increased from 26,000 naira (approximately £50) to 500,000 naira (about £1,000) for non-indigenes (internal migrants) (Egbas, 2021).

Internal migrants are also discriminated against in political participation. This has, unfortunately, made them appear as 'second class citizens' to places they call home (Human Rights Watch, 2006). For example, study participants (Bukky and Akin) have been residents in Kaduna state for about 40 years and regard the state as their home. But unfortunately, they still face discrimination and non-acceptance being non-indigenes (internal migrants) in the state.

Among married female participants in this study, marriage was a significant status for women in Nigeria. All female married study participants shared marriage was an indication for recognition and respect. Unmarried women are shown less respect in society, often leading to pressures from family and society (Abegunde, 2014; Salaam, 2003). Therefore, irrespective of accomplishment or achievement, a woman is less accepted and respected unless she is married. Nigeria is deeply rooted in a patriarchal system categorised by rigid culture and power differences based on gender (Salaam, 2003). For example, empowering men with violent tendencies can make them ascribe dominance on their wives. This may sometimes make these women vulnerable to violence or domestic abuse (Makama, 2013; Salaam, 2003).

In Nigeria, it is a norm for women to join their husbands after marriage (Smith, 2010a; Isiugo-Abanihe, 1995). All-female married participants in this study shared the same experiences of joining their husbands, leaving their good jobs, families, and friends behind. They also complained of lack of support on arrival to their states of destination after marriage. They also expressed psychological distress due to loneliness and missing their family and peers. Therefore, female married internal migrants in this study are 'at the intersection' of being isolated in the new city due to loneliness, socioeconomic factors (such as poverty, insecurity, unemployment), socio-cultural factors (such as religion, ethnic disparity), and even in the new family as a wife.

The societal norms and practices also encourage inequalities towards women. For example, in some ethnic groups, some cultures do not recognise or respect anyone who has only female children. It is believed that a male child carries on the family name while a female child would be married off and accept her husband's identity (Isiugo-Abanihe, 1995). Sometimes, women cannot attend or make decisions at family meetings, town hall meetings, or community meetings in some families or communities. This is evident at the government level, where few women are represented in politics and decision-making (Makama, 2013).

Feminists distinguish between gender and sex. Sex is described as biological, while gender is cultural and sociological. The concepts of 'masculinity and 'femininity' were outcomes of society's expectations in Nigeria. For example, boys are brought up to exhibit manliness, thereby showing authority and strength, while girls are brought up to be delicate, sensitive, and nurturing (Makama, 2013; Salaam, 2003). These refer to cultural differences in gender roles with an emphasis on how gender norms are socially interpretated (Olonade and Adetunde, 2021).

When young women do not follow these expectations, they are seen as rebels. From birth, these gender expectations have been placed on them by society, and they are required to follow them, growing up with the mindset of these expectations. For example, the chores in the home are different for boys and girls. The male child can go out to play while the female child is expected to be at home helping her mother with the chores, cooking, and helping her younger ones (Ogbe, 2020). The male child is taught to be in control by going around on errands, while the female child is taught to stay home, and if going out, her movement is monitored. As these children grow, their mindsets are fixed on these rules and expectations.

A female is taught from childhood to take care of her home when she has one. When a young Nigerian woman is unmarried, she is seen as a failure to herself and sometimes to her family (Dogo, 2014). Nigerian societies expect women to either be married, have children, or have both. When she cannot achieve any of these expectations, she is seen as unfit and usually discriminated against (Makama, 2013).

In northern Nigeria, the inequality towards women is worse. In many northern communities, women are not allowed to interact with males without their husbands' presence (WHO, 2019b). A recent study by Ogbe (2020) on gender inequality of women in northern Nigeria showed that socio-cultural, economic, and religious norms, including early marriages and insecurity, have led to a negative impact on health, including mental health, reproductive rights, and literacy of women and girls in the northern region of Nigeria (Ogbe, 2020). In addition, religion strongly influences women's lives in northern Nigeria (Ogu et al., 2016). However, studies found that women from southern states fared better than those in northern states due to reduced poverty and gender development (British Council Nigeria, 2012; Ibrahim, 2016).

The patriarchal system also has a strong regard for the 'male child,' which has greatly affected the education of the girl child in northern Nigeria. The belief is that girls will be married off, and it is a waste of money sending the girl to school as she has no direct benefit to her own family but the one, she is married into (Alabi and Alabi, 2014). Other reasons affecting the education of girls in northern Nigeria are that girls will lose their morals if they go to school (Bakwai et al., 2014; Ogbe, 2020). Therefore, it was assumed that sending girls to school was seen as discouraging traditional norms, encouraging pre-marital sex, and unwanted pregnancies. Therefore, early marriages were recommended in these traditional societies (Alabi and Alabi, 2014; Ogbe, 2020).

Many of these girls in northern Nigeria aged about 12 years or less are married off to benefactors or strangers who are most times older (Alabi and Alabi, 2014). However, the Federal Child's rights Act (2003) prohibits under 18-year marriage in Nigeria. But not all states in northern Nigeria have accepted the Act, with many under 18 girls being married off. Moreover, these practices are encouraged by religious-cultural norms and rules (Ogbe, 2020).

In addition, the rising insurgency and conflict in northern Nigeria, especially in the northeast region, have significantly impacted the health and rights of women and girls. For example, these women and girls can often not assess health facilities, markets, sanitation (toilet access), etc. (Dunn, 2018). Usually, during conflicts, the most significant impact falls on the girl and woman. They are usually victims, many are taken as child brides or brides to members of the insurgents, trafficked or kidnapped, sold as slaves, raped, and sometimes used as weapons of war (Ogbe, 2020). For example, from January – July 2017, Boko Haram used 145 girls as suicide bombers across the northeast region

(Dunn, 2018). These had a severe impact on the mental health of these girls and their families.

Internal migrants face some similar challenges as international migrants to adapt and adjust to their new location. Factors such as language barrier, challenges finding a job, and lack of social support are responsible for these challenges (Bhugra and Gupta 2011; Wojcik and Bhugra 2010; Bhugra et al., 1999). In addition, internal migrants in Nigeria faced socioeconomic difficulties such as lack of constant electricity, pipe-borne water, insecurity, and high cost of living.

Unfortunately, existing research (stage one-scoping review) hardly focused on internal migrants and their mental health. Only a few researchers studied the impact of internal migration on human development, determinants, remittances, socio-cultural factors, early life mortality, and sexual behaviour (Odimegwu, & Adewoyin, 2020; Mberu and White, 2011; Sibiri et al., 2014; Oyeniyi, 2013; Olowa & Awoyemi, 2012; Akinyemi et al., 2005; Mberu, 2005; Anyanwu, 1992; Adepoju, 1979). More research and policy should focus on these group of people (internal migrants) who constitute a large proportion of the population in Nigeria and contribute significantly to rural development through regular remittances (Adepoju, 1979; Akinyemi et al., 2005; Oyeniyi, 2013).

Chanter (2006) suggests that applying intersectionality in a person's life experience can help address the structural elements of inequality including elements of ethnicity, gender and socioeconomic inequalities as identified in this study. However, as recommended by Carter, Sellers and Squire (2002) and Stewart and McDermott (2004), to encourage further use of the intersectionality framework, a considerably large heterogeneous sample of gender, race/ethnicity, and social class should be included. Furthermore, the measures

of a social class should clearly show the relationship between power relations and inequalities and not just traditional demographic data.

6.3.5 Managing power influences between researcher and participants

Using a minimally structured interview as a data generation method helped the participants gain control of the conversation, which helped minimise my power influences in the study. As explained in chapter three, the Zoom video conferencing tool for data generation was helpful due to its convenience, ease of use, flexibility, and cost-effectiveness (Archibald et al., 2019; Mabragana, Carbello-Dieguez and Giguere, 2013).

The use of jargon was avoided both before and during the interviews. These were some of the strategies used to help reduce the inherent power influences in the study. Also, the data analysis and generation of the findings involved the study participants (known as ‘silence dialogue’-phase two of the data analysis) and social/professional networks of study participants (known as ‘collective voices’-phase three of data analysis).

My influence and power were significantly reduced as an initiator of the study because I focused on the experiences of the study participants. In addition, ‘collective voices’ reviewers commented on the feedback of the summary of the study findings. ‘Collective voices’ also shared their personal experiences as internal migrants in Nigeria by confirming the issues disclosed or ‘silences’ identified while conducting the interviews. These strategies helped minimise my power and influence in the study.

6.3.6 Positionality in the research study

Positionality in research is a central and controversial issue as it involves the researcher's position in the study. The researcher must declare their status and position in the study to

allow others decide on the effects on the findings (Alasuutari et al., 2008). ‘Emic’ or insider positionality relates to a study where the researcher is deeply connected with the study (Kahuna, 2000). Throughout the research process, I was constantly aware of my position as a second-generation internal migrant (born in place of relocation) and a primary or first-generation internal migrant (moved to Federal Capital Territory after first degree for NYSC and work purposes).

I also reflected on my position and relationship with this study (this was explained in detail in chapter 2 of this thesis). This reflection impacted on the design, implementation, and reporting of this study by attempting to push my personal experiences aside and reflect on the experiences of the study participants. It was also helpful that there were some similarities between my personal experiences and the study participants.

An example of challenges a researcher faces while stating a position in research is when interacting with participants during the interview. For example, when participants shared that they grew up in Kaduna state. I tried to avoid bringing in my personal experience as I also grew up in Kaduna state. This will help build rapport but will tend to shift the focus from the participant to me. I was constantly aware of remaining in the researcher role to avoid stepping into the role as a fellow internal migrant with shared or similar experiences.

The participants' similarities in my background as a second-generation internal migrant and a Nigerian helped the data generation process. In addition, the use of the data generation tool (Zoom) was helpful during the interviews due to its ease of use, cost effective and convenient application. This was also helpful when participants shared their

internal migration experiences due to similar backgrounds and an understanding of the participants contextual background and settings.

I decided to introduce myself as a student researcher without expert knowledge in the research study. Fine (1994) described this challenge removes the focus from the researcher to the participants. This was accomplished using dialogue during the interviews, which depended on continuous reflexivity (reflection) to identify these issues as they came up. I also took note of emotions and gestures to capture all experiences of participants (Arber, 2006) and helped manage practical reflexivity (Asselin, 2003).

I developed a strategy of answering any questions with regards to my interest or knowledge of the topic. This came up with one participant. After the interview, she asked if I could help with the definition of mental health, as this was part of the interview questions. I reassured her that her answers were not wrong and gave a standard WHO definition of mental health. She was happy and left the interview feeling confident.

It could be argued that some interviews could have been improved by adopting an open emic or insider position, thereby enhancing the possibility of better rapport with participants. However, I decided to depend on the interpersonal skills of attentive, active listening, observation, and reporting. I actively listened to help build rapport while limiting any identified influence that could have been created by adopting an open emic position during the interviews. The peculiar nature of positionality can differ from an interaction from emic (insider) to etic (outsider) and vice versa (Janes, 2016).

To remain reflexive throughout the research process, I also adopted an etic/ outsider approach when conducting interviews and data analysis. I noticed that my positionality and reflection are continuously changing. It also requires a conscious balance of

participation and exclusion throughout the research process (Arber 2006; Kahuna, 2000; Janes, 2016). Even though I focused on attentive listening to participants while adopting a neutral position in the study, I constantly reflected on my personal experiences. I also maintained continuous reflexivity during interviews and record-keeping of these experiences. The strategies I used to help manage this issue were to keep a record of my personal experiences, which I also discussed in chapter two, and the potential impact on the study in my reflective diary.

Sometimes, I struggled with whether to ignore my experiences and any similarities to the participants. My focus was on the participants' stories and experiences. Despite my insider knowledge as an internal migrant, I was very aware as a researcher of my role in influencing the data generation or analysis process. Therefore, I decided to view the participant's perspective by entering 'inside' their experiences during the data generation, analysis, and reporting processes.

6.3.7 Review of the 'silences' Framework

The 'silences' framework attempts to relate theory with daily practice at a specified point in time (Serrant, 2020). This aligns with McCall's idea of intersectionality as 'relationships between multiple dimensions and modalities of social relations and subject formations' (McCall, 2005, p, 1771). Therefore, the 'silences' framework is created to suit health-related studies. The framework explores topics that are regarded as 'sensitive,' and the people (participants) at the centre of the study are members of a marginalised group (Serrant-Green, 2011). This was the case with this study as there is currently an under-researched group of internal migrants (Oyeniyi, 2013), especially about a sensitive

topic like mental health, which is hardly talked about in Nigeria (Aluh et al., 2019a; Okpalauwaekwe et al., 2017; Pederson et al., 2020).

Furthermore, the ‘silences’ framework examined individual experiences by ascribing personal interpretations of events (Serrant-Green, 2011). Therefore, this study focused on research participants individually by arriving at group findings generalised to internal migrants residing in Nigeria.

The framework has been successfully used in aspects of marginalised perspectives of experiences of health provision for newly released offenders (Eshareturi et al., 2015; 2014), exploration of HIV stigma within Black sub-Saharan African communities in the UK (Nyashanu and Serrant, 2016), comorbidities of HIV and Tuberculosis in Brazil (Rossetto et al., 2018) and recovery experiences of young adults after proximal fracture of the femur after a fall velocity fall (Janes et al., 2018).

Overall, the ‘silences’ framework guided the entire study and research process. The framework suitably supported this study, especially with marginalised and under-researched individuals such as internal migrants in Nigeria. However, terms regarding marginalisation had some limitations, especially regarding individuals such as internal migrants in Nigeria. Internal migrants in Nigeria experienced similar challenges as Nigerians except maybe for language or cultural barriers on arrival to the new state or city (Abubakar, and Dano, 2018; Ewetan and Ese, 2014; Obi, 2015).

Challenges such as socioeconomic challenges, insecurity challenges, unemployment, high cost of living, e.g., accommodation, etc., are experienced by all Nigerians. Even though these challenges may be worse for internal migrants who are new arrivals to these cities without any social support, it is essential to identify the potential significance of

marginalisation in this framework. This will potentially benefit researchers focused on migration, especially on sensitive topics such as mental health.

The cyclical data analysis process of the 'silences' framework using the 'silence dialogue' and 'collective voices' was very useful in preventing further silencing of the participants. Furthermore, the 'collective voice' reviewers became study participants after sharing their personal experiences as internal migrants at some particular point in their lives. The process also helped with member checking, especially as the research was independently done by me (Connelly and Yoder, 2000) by verifying the findings by individuals and groups external to the participants but sharing similar experiences of internal migration (Groleau et al., 2009). Finally, the framework allowed the study to be trustworthy by allowing a lone researcher like me, work independently (Guba and Lincoln, 1989).

'Collective voices' feedback was helpful as they confirmed the findings as reported by participants and 'silence dialogue' and created a sub-theme of traffic congestion under the theme 'transportation.' This was discussed in the findings chapter and highlighted at the beginning of this chapter.

The 'silences' framework was considerably flexible and easy to use. As explained by Denzin and Lincoln (2011), the traditional research process involves phases 1 to 5. Phase one describes the personal background/identification with study, phase two describes the identification of research paradigms and philosophical and theoretical frameworks. Phase three describes the research approach, phase four describes the data collection and analysis, and phase five describes the interpretation and evaluation of data. This study's research process was synonymous with the 'silences' framework of stages one-four,

including its relevance to a sensitive topic of mental health in Nigeria among an under-researched group (internal migrants in Nigeria).

However, the framework's structure was difficult to understand initially. However, after constant reading and its application to the research process, I got accustomed to the framework's structure. A difficult phase was the cyclical data analysis phase and its application to the study. This was further compounded by combining Braun and Clarke's (2006) thematic analysis framework with the phase four cyclical data analysis process (figure 2 shown in chapter four). However, the use of the framework became easier after frequent use and application in research practice.

Janes, Serrant & Sque (2019) emphasised that it was vital for researchers to know that when planning their research, the volunteer reviewers ('silence dialogue') and 'collective voices' are part of data analysis and not data generation process. However, this seems very confusing for both the researcher and the readers. For example, in this study, 'collective voices' turned into study participants as they shared their personal experiences as internal migrants in Nigeria. This outcome has not been reported by previous use of the framework in another research. This is possible because this is the first study to use the framework out of the usual nursing context and is used for the first time in a migration research context. It is, therefore, essential to consider allowing 'collective voice' reviewers share their personal stories in addition to providing feedback and comment. This may be vital for migration studies and exploring sensitive issues such as mental health.

Researchers must outline how the 'collective voices' will be recruited in their ethical report and their feedback or comment on the findings reported. It should be known that

the participants' social networks (collective voices) were recruited when conducting the research. It is not straightforward for the researcher to plan these groups at the beginning of the study. Finally, the researcher must explain this concept of ‘collective voices’ to other researchers and readers unfamiliar with the framework because it is quite different from the traditional research process.

Applying the ‘silences’ framework in a different context like internal migration and in a different set of developing countries like Nigeria shows that the ‘silences’ framework suitably guides this study’s research process. The ‘silences’ framework was adequately suited due to its flexibility and ability to structure and guide the research process from inception to completion.

The framework's limitations are the potential confusion of the data generation and data analysis processes. It was also difficult for an early researcher to understand the ‘silences’ framework. The concept of marginalisation may appear different in different contexts and can result in poor awareness of individuals or groups thought to be marginalised. For example, similar experiences or inequalities between groups may question how truly marginalised they seem. In the case of this study, internal migrants reported similar experiences of unemployment, high costs of living, infrastructural challenges, etc., with Nigerians as a whole (Abubakar and Dano, 2018; Ewetan and Ese, 2014; Obi, 2015). Although internal migrants were still regarded as marginalised due to being non-existent in stage one (existing scoping literature review), the similarity in experiences still questions the level of their marginalisation.

Finally, using ‘collective voice’ for data analysis, i.e., providing feedback or comments, is superficial. In this study, ‘collective voices’ reviewers turned out to be participants by

sharing their personal stories or experiences. Therefore, this phase should be revised to allow for participation in the study as study participants.

6.4 Study constraints

Study participants were selected from three states out of the thirty states in the country to take part in this study. Therefore, these experiences may not reflect the experiences of all internal migrants in all the other states of the country. However, this study found that socioeconomic factors were reasons for internal migration and the challenges participants experienced on arrival to their states of destination.

In addition, the existing internal migration research that focused on drivers and experiences in the southwest region showed that socioeconomic factors such as social infrastructure and neglect of the rural community were reasons for internal migration (Ogunmakinde et al., 2015). Similar studies in the southern region found that youths moved to other states to escape the harsh economy in Nigeria (Ikuteyijo, 2020). Previous studies have found that internal migrants from the southeast region moved to other areas due to poor environmental and economic conditions, with 80% moving for economic reasons while 10% for educational purposes (Mberu and Pongou, 2010). On the other hand, the northern region has been less attractive due to its proximity to the Saharan desert in urban cities of Kano, Sokoto, and Katsina states. In addition, insecurity, socio-economic challenges have made these destination states less attractive (Garga, 2015; Osumah, 2013).

Even though this study's findings do not reflect the experiences of internal migrants in all the states of the country, stage one (literature scoping review) and stage 3 (findings) identified that the reasons for internal migration in Nigeria were for socioeconomic

reasons. Therefore, even though the study's findings may not be generalised to all internal migrants in Nigeria, the results are consistent with existing research that socioeconomic factors are both drivers and challenges internal migrants face on arrival to their destinations.

Another constraint was that all the study participants were educated and employed, with the least having a West African Education Certificate (WAEC), i.e., high school certificate. Less formally skilled and unemployed people are less likely to move from rural communities (Adepoju, 1979; Adetoro and Fadayomi, 2012; Mberu, 2005). Adepoju (1976) agreed that young, educated people were more likely to migrate than people without formal educational qualification.

However, people without formal educational qualification who moved to urban cities were more likely to work in the informal sector and be self-employed by selling goods or wares in marketplaces, having small-scale shops, and engaging in street trading. These jobs cost less and are labour intensive (Adepoju, 1976; Olurinola et al., 2014). Most reside in slums, especially residents in Lagos (Olurinola et al., 2014). Therefore, the findings of this study cannot be generalised to people without formal educational qualification and unemployed internal migrants. It would be imperative to explore the experiences of people without formal educational qualification and unemployed migrants and the impact on their mental health.

Zoom video conferencing was used as a data generation tool to interview study participants. The tool has been successfully used in qualitative and sensitive research (Mabragana, Carbello-Dieguez and Giguere, 2013). The tool helped limit geographical boundaries and widen the sample of participants from diverse locations while eliminating

barriers of time and space. Due to time and financial constraints, the tool was used to allow greater flexibility as I did not have to travel to Nigeria from the UK to generate data. It also allowed participants to choose an interview location and time at their convenience (Archibald et al., 2019; Lo Iocono et al., 2016).

However, while using the tool, I experienced challenges with some participants struggling to join the meeting and staying connected due to the low internet connection. There were also issues of poor video and audio quality. These issues occurred even after a checklist for common technical difficulties was created and familiarisation with the tool was made when demographic questions were collected. This was a major limitation due to the lack of access to high-speed internet in many regions in Nigeria. In addition, about five participant interviews had to be rescheduled due to poor internet connection. Two had to opt for the telephone option of the interview due to poor internet connection using voice recognition and recording.

Another constraint was that the 'silence dialogue' and 'collective voice' reviewers feedback form appeared to be 'survey' like in nature. Even though the collective voice reviewers shared their personal internal migration experiences, they did not critique the study participants' responses. However, they gave an additional sub-code of 'traffic problems' by confirming the transport problems identified by participants.

It would be helpful to identify other in-depth methods to generate data from the collective voice reviewers about the study. For example, a one-to-one interview would be beneficial to provide an in-depth discussion of their relationship or association with study participants. This will possibly help share personal experiences either on themselves or their association or relationship with study participants.

Finally, only one method of data generation was used (one-to-one interviews). However, several procedures of data analysis were used as outlined in the methodology chapter on chapter three as follows:

- Transparent interviewing, transcribing, and data analysis process.
- A structural approach to data analysis (Braun and Clarke, 2006)
- A cyclical data analysis using ‘silence dialogue’ and ‘collective voice’ reviewers of the ‘silences’ framework.
- Used language and terms used by study participants as much as possible during analysis and findings report.
- Availability of documents transparently
- Demonstrate researcher reflexivity throughout the research process.
- Used additional intersectionality framework to explore the intersections around gender, social identities, ethnicities, social categories, and systems.

Therefore, this study is a major contribution to existing knowledge in Nigeria by studying an under-researched group of internal migrants (Oyeniyi, 2013), especially about a sensitive topic like mental health, which is hardly talked about in Nigeria (Aluh et al., 2019a; Okpalauwaekwe et al., 2017; Pederson et al., 2020).

6.5 Summary

The study identified and explored factors that impacted the mental health of internal migrants in Nigeria. The study also identified and explored the intersection of gender, ethnicity, and internal migrants' socioeconomic status and its impact on their mental health.

The research questions are:

1. What are the views, knowledge, and experiences of internal migrants in Nigeria concerning mental health issues?
2. What are the influencing factors concerning mental health among internal migrants?
3. What is the impact of internal migration on mental health?

The study achieved its aim that internal migration experiences such as socioeconomic factors (unemployment, high cost of living, poverty, insecurity, and unavailability of basic infrastructural facilities such as constant electricity) negatively impact internal migrants in Nigeria. In addition, socio-cultural factors (such as language and cultural barriers results in ethnic discrimination) and lack of social support negatively impacted the internal migrant's ability to adapt and settle in these new urban cities, which affected their mental health.

Based on the study findings, recommendations were made for future research and policy implementation. Using the 'silences' framework, 'screaming silences' were identified from an exploration of the participants internal migration experiences and the impact this had on their mental health. The hope is that these identified 'silences' will be further explored in research and subsequently answered by government policy implementation and practice.

Firstly, this is a unique contribution to knowledge as this, to the best of my knowledge, is the first study to explore the experiences of internal migrants concerning mental health in Nigeria and one of the few studies in Africa about internal migration and mental health (Ajaero et al.,2017; Mulcahy & Kollamparambil, 2016; Tuller, 2013). It also contributed to 'silences' research by identifying the current gap in the body of knowledge regarding

the experiences of internal migrants concerning mental health in Nigeria. This study identified internal migrants in Nigeria as silenced and largely missing from the academic literature about sensitive topics such as mental health (Labinjo et al., 2020).

Secondly, this study has contributed to the silences research by exploring the experiences of a marginalised and under-researched group of people called 'internal migrants' in Nigeria. Internal migration is hardly researched in Nigeria, and few studies focused on internal migration were based on human development, remittances, and drivers of internal migration (Oyeniyi, 2013; Anyanwu, 1992; Adepoju, 1976). Moreover, no study has looked at the link between internal migration and health outcomes, especially mental health, even though mental health issues in Nigeria are still associated with stigma, discrimination, and negative attitudes (Argungu, Ahmed and Sa'idu, 2020; Jyothi et al., 2015; Pederson et al., 2020).

Thirdly, in addition to using a minimally structured in-depth interview, a cyclical approach to data analysis of the 'silences' framework was also used to 'give voice' to these marginalised and under-researched study participants about their experiences. As part of member checking, phase three of data analysis involved the use of 'collective voice' reviewers who are social networks associated with the experiences of study participants.

'Collective voices' used in this study were experts or professionals in both migration and mental health fields. In data analysis, these individuals provided feedback and comments on the experiences reported by this study participants. They also shared personal experiences as they coincidentally happen to be internal migrants at some point in their lives.

Finally, the study was guided using the ‘silences’ framework (Serrant-Green, 2011). The ‘silences’ framework was useful for guiding and structuring this study. A student researcher undertook the study. Some minor recommendations were made for future use of the framework, and these recommendations were made on reflection of the data analysis process.

6.6 Research Recommendations

This section answers the ‘silences’ uncovered in all the stages of this study and provided recommendations to resolve them. In addition, this section provided recommendations for future research and for policies to address internal migration and mental health in Nigeria. Recommendations were made to avoid further silencing the participants' voices. The recommendations were divided into two: recommendation for research and recommendation for policy.

Recommendation for research

Internal migrants in Nigeria account for about 40% of the general population of Nigeria (NBS- Annual Abstracts of Statistics, 2017). For example, in Lagos state, about 2,000 migrants move in daily (NBS- Survey Report on Migration, 2020). In addition, existing research has linked internal migrants to sexual health and early mortality in Nigeria (Odimegwu, and Adewoyin, 2020; Mberu and Mutua, 2015; Mberu and White, 2011; Mberu, 2008).

The scoping review (stage one) did not identify any study linking voluntary internal migration with mental health in Nigeria. Moreover, only a few recent papers focused on internally displaced persons (IDPs) and mental health (Mukhtar et al., 2020; Ogechi and

Ezadueyan, 2020; Taru et al., 2018). Therefore, more research linking voluntary internal migration with health outcomes, especially mental health in Nigeria, is necessary.

More research needs to be focused on northern Nigeria. Recent studies have linked internally displaced persons and mental health in the northeast region due to insurgency and in Federal Capital Territory (Abuja) because of the concentration of camps where these internally displaced persons (IDPs) are located (Adofu and Alhassan, 2018; Aluh et al., 2019b).

The northern region has the highest rate of poverty, youth unemployment with a low level of education. Furthermore, the region has the highest rate of insecurity, infrastructural challenges such as lack of constant electricity, the poor state of roads, etc. In addition to the weak status of women in northern society, the northern region of Nigeria is three times in poverty than in southern region of Nigeria (Abubakar and Dano, 2018; Aliyu and Amadu, 2017).

In terms of education, the northern region of Nigeria has millions of ‘out of school children on the streets called ‘almagiri’ (Abubakar, and Dano, 2018; Adofu and Alhassan, 2018; Aliyu and Amadu, 2017; Makanju and Uriri, 2018). There is also an increase in drug abuse among youths in the northern region, primarily due to hopelessness resulting from youth unemployment (Moghalu, 2019). Therefore, more research on the northern region, especially among an under-researched group of internal migrants, is needed concerning mental health.

In comparison with stage one (scoping review), this study found an improvement in the knowledge level of mental health among study participants. On the other hand, the

improvement in knowledge in the southern region in the scoping review, especially the southwest region of Nigeria, could result from education. For example, all this study participants were educated, and, in the literature, the southwest had higher educated people than in the northern region (British Council Nigeria, 2014; Varrella, 2020).

However, the reported causation of mental disorders among this study participants remained the same. The reported causation was stress, drug abuse, supernatural factors, etc. The scoping review observed that health professionals and residents in the southwest region had improved knowledge of mental health (Nwedu, 2019; Akinsulore et al., 2018; Coker et al., 2018; Odinka et al., 2014). However, residents in northern Nigeria still had a poor knowledge of mental health (Argungu, Ahmed and Sa'idu, 2020). The socio-economic and socio-cultural challenges noted above, and high levels of illiteracy could be possible reasons for this poor knowledge level and inherent supernatural belief in the northern population (Kuyinu et al., 2020; Mojiminiyi, 2020; Omolayo et al., 2020; Agofure et al., 2019; Isa et al., 2018; Jack-Ide et al., 2016). Therefore, more research, awareness, and education about mental health are necessary in Nigeria, emphasising the northern region.

More research is needed on strategies to improve delivery of mental health services in Nigeria, especially in the rural communities and primary health centres. Research has found that poor funding, lack of access to care led to considerable gaps in treatment, and payment out of pocket have led to poor mental health (Ugochukwu et al., 2020; Gureje and Saxena, 2006). Therefore, one of the key strategies is incorporating health insurance to allow more coverage of treatment of mental disorders.

In addition, the integration of mental health in primary health centres, the adaptation of performance-based financing, and continuous engagement with stakeholders, including donor organisations is relevant to improve delivery of mental health services in Nigeria (Abdulmalik et al., 2019). Some community mental health services were recently introduced at community levels in Nigeria but received low turnout due to insufficient mental health knowledge at community levels (Eaton et al., 2017). Therefore, more training, awareness, and performance-based research are necessary, especially at community levels.

It is necessary to explore the experiences of second-generation internal migrants, i.e., individuals who were born in the place where their parents migrated (Oyeniyi, 2013). Existing studies showed that factors such as social integration, personal autonomy, and life satisfaction were positively linked with good mental health among second-generation internal migrants (Chen et al., 2019). Also, second-generation internal migrants constantly face social exclusion, which negatively impacts these internal migrants' mental health, where experiences of social stigma and discrimination were significant (Li and Rose, 2017). This proposed study will identify and explore the experiences of second-generation internal migrants and the impact of being born in the place their parents migrated, and how these experiences impacted their mental health. The overall aim is to identify and explore their experiences while growing up in a different state from their parents.

A limitation in the study was the exclusion of people without formal educational qualification and low-skill individuals as study participants. Most of the study participants were educated, employed, self-employed and skilled individuals. It will be essential to

explore the experiences of people without formal educational qualification and low-skilled individuals and how these experiences impact their mental health.

More research should be conducted on the impact of gender on internal migration and mental health in Nigeria. An uncovered silence was Nigerian women and girls faced immense pressure to get married due to societal expectations. Therefore, it would be necessary to explore the experiences of internal migrant women and the impact on their mental health, incorporating socioeconomic and sociocultural factors. Specific focus should be given to women in the northern region of Nigeria as it has been found that women in the north experience more disadvantage and social exclusion (British Council Nigeria, 2012; Makama, 2013; Ogbe, 2020; Smith, 2010a).

Future studies should determine the degree of consensus or dissent about the merits or demerits of using Zoom video conferencing among both researchers and study participants. Therefore, future research should examine future applications of video conferencing technology in context, user satisfaction, data quality, and integrity (Archibald et al., 2019).

This study (stage one-literature scoping review) found that internal and international migration drivers are similar as all migrants moved to improve their wellbeing. They also experienced some similar experiences such as job challenges and lack of social support. Internal and international migration reduced poverty through regular remittances to families and households for various reasons such as education and health purposes. These remittances have assisted in human capital formation and poverty alleviation (Oyeniyi, 2013). However, even though there are similarities between the two, the effects, cost, and policies may differ (Oyeniyi, 2013).

Research and surveys conducted within the country ascribed internal migration to have adverse effects leading to an increase in population, environmental degradation, pollution, increased waste, growing slums, etc. (Adepoju, 1976; Oucho, 1988; Oyeniyi, 2013). The negative perceptions of internal migration may be due to difficulties capturing and processing quality data and studies related to internal migration in Nigeria (Oucho, 1988; Oyeniyi, 2013). In addition, the complex nature of Nigerian society makes data collection on internal migration complicated (Oyeniyi, 2013). For example, Nigeria lacks comprehensive and verifiable population data (NBS- Annual Abstracts, 2019; Akanbi, 2016).

Therefore, more efforts should be made to study internal migration in all aspects, including health outcomes. Internal migration is an essential part of the interventions taken to ensure social inclusion and economic development (Oyeniyi, 2013). Therefore, more research are required to enhance understanding of the socioeconomic impacts of internal migration and urbanisation in developing countries like Nigeria (Anyanwu, 1991).

Finally, using the ‘silences’ framework, the ‘collective voice’ reviewers were required to provide feedback about the experiences of the study participants to either agree or critique the initial findings (Serrant-Green, 2011). However, in the process of providing their feedback, they also shared personal experiences as internal migrants. This was not expected as an outcome in the study. It is, therefore, essential to note that since this group of individuals (‘collective reviewers’) had some personal or professional relationship due to having social networks or relations with the study participants. Therefore, it would be

helpful to allow these reviewers to share personal experiences using one to one interview or focus groups.

Recommendation for policy

Even though there was an improvement in knowledge of mental health among this study participants, the strong belief in supernatural causation, especially in the rural communities, impacts the traditional/ spiritual health-seeking decisions. This is part of the culture of Nigerians, and religion was an essential coping strategy (Lasebikan, 2016). Therefore, the concept of spirituality should be reviewed and included in mental health care management in Nigeria. Also, collaboration between religious institutions and mental health professionals is necessary to improve knowledge and awareness to help reduce stigma towards persons with mental disorders in Nigeria (Labinjo et al., 2020).

The National assembly reintroduced a Mental Health Bill in 2013. The bill was created to protect the rights of people with mental disorders, ensure equal access to treatment and care, and discourage stigma and discrimination. It also provides access to mental health care services, ensures law enforcement and judicial issues for people with mental disorders, and oversees involuntary admission to implement the provision of mental health legislation (Federal Ministry of Health, 2016).

Unfortunately, after the Bill was introduced, this is yet to be implemented, and the bill is yet to be passed into law. Several psychiatrists have pleaded to Nigerian lawmakers to ensure urgent implementation of the mental health bill because Nigerians still perceive mental health as an undiscussed topic due to the focus on the Lunatic Act (1958)

(Abdulmalik et al., 2016). For example, a recent study by Akanni et al. (2020) found that very few attorneys knew about Nigeria's existing mental health law.

There is also a lack of in-depth information on mental health services in Nigeria. The service is usually hospital-based, primarily provided in eight federal psychiatric hospitals, a few states psychiatric hospitals, a few teaching hospitals, and very few private psychiatric hospitals/ clinics (Federal Ministry of Health, 2016; Gureje et al., 2015; 2005; Gureje and Saxena, 2006). About 20 million Nigerians suffer from mental disorders, and many do not seek professional help, with only 30% of the government's health budget being allocated to mental health (Federal Ministry of Health, 2016; Gureje et al., 2015; Gureje and Saxena, 2006).

It is, therefore, crucial for the government to focus on implementing the mental health policy in Nigeria to increase funding, improve access to mental health care, treatment, and service. This also includes the movement from hospital-based care to community-based care, which is less restrictive. This, in the long run, will help eliminate stigma and discrimination towards persons with mental disorders.

Internal migrants in this study described experiences of discrimination by native residents due to their inability to speak the local language or adapt to the culture and lifestyle of the native residents. As a result, no matter how long internal migrants lived in a state or city, they were still seen as outcasts even though they are citizens of the country. Unfortunately, the government is not doing anything to stop or discourage these practices of discrimination. Even though the Nigerian constitution ensures freedom from discrimination, the direct impact of tribalism on internal migrants can result in inter-communal clashes (Smith, 2006).

The federal government should sponsor, publicise, and enforce legislation to eliminate differences between indigenes (natives) and non-indigenes (internal migrants). These harmful, discriminatory practices based on ethnicity should be prohibited. In addition, legal charges should be given to any sort of discrimination against internal migrants both at the state and local government levels. Public education and awareness campaigns should be created to focus on the rights of Nigerians to end all forms of discrimination against internal migrants (non-indigenes) in Nigeria. In addition, all state government laws that deny internal migrants access to educational opportunities, job opportunities, scholarships, and other benefits should be eliminated. These changes should be reflected and enforced at the federal, state, and local government levels.

Finally, all study participants (internal migrants) described that the socio-economic challenges such as lack of constant electricity, unemployment, insecurity challenges, the poor state of roads, and high cost of living impacted their internal migration experiences and mental health status. Therefore, a better job market where youths can get jobs or open businesses will improve the economic situation and, in the long run, lead to a reduction in crime rate and insecurity.

Also, basic infrastructures such as constant electricity, good and accessible roads, efficient rail networks, security, affordable housing, and a better standard of living should be available to all Nigerians. The provision and access to these facilities and infrastructure will make these cities more attractive to internal migrants while improving their quality of life (Wang et al., 2019).

Chapter Seven: Summary

7.1 Introduction

This final chapter discussed a reflection of my experience undertaking the study, a summary of the study findings, and the study's contribution to knowledge.

7.2 Reflection on learning experience

While conducting the study, I acknowledged my contribution to the research process and realised that positioning 'outside' the study was very challenging. For example, with regards to my reflexivity, I discovered my position as the knowledge creation agent. I identified how my values, experiences, interests, and social identity had shaped the study. Additionally, my position as a second-generation and first-generation internal migrant helped give some context to the study.

Regarding using the 'silences' framework, I was aware of my position in this study by recording my experiences, beliefs, and views. This enabled me to accurately report the research process. However, I encountered a few challenges while using the framework as an early researcher, such as recognising the place of 'collective voices' in the data analysis process instead of data generation. This is because they shared personal experiences while providing feedback. This could be reviewed in the future because this is the first study to use the framework in a migration context. Nevertheless, the framework was very flexible and allowed me to reflect on every stage of the research process.

Also, combining the thematic analysis framework (Braun and Clarke, 2006) with the cyclical phase data analysis of the 'silences' framework (Serrant-Green, 2011) was initially problematic. However, I got used to it after studying and applying both frameworks to the research process.

I have realised as a researcher that the analysis of the narratives as shared by the participants could not give a straightforward answer to the research questions. Instead, it offered a deep understanding of factors that created the need for the study.

I found out that exploring lived experiences is quite challenging. It is necessary to understand how these experiences are represented or interpreted.

Finally, this study has improved my knowledge about mental health and internal migration in Nigeria. This has also helped improve my research skills as an early career researcher. While undertaking this study, three peer-reviewed papers were published, namely:

- Labinjo, T., Serrant, L., Ashmore, R., & Turner, J. (2020). Perceptions, attitudes, and cultural understandings of mental health in Nigeria: a scoping review of published literature. *Mental Health, Religion & Culture*, *23*(7), 606–624. [This paper is one of the most read papers on Research Gate platform with over 1,700 reads and 6 citations].
- Labinjo, T., Ashmore, R., Serrant, L., & Turner, J. (2020). A Pilot study exploring the experiences of mental health among internal migrants in Nigeria. *Journal of mental health and substance abuse*, *1*(1), 109.
- Labinjo, T., Ashmore, R., Serrant, L., and Turner, J (2021) The use of Zoom Videoconferencing for Qualitative Data Generation: A Reflective Account of a Research Study. *Open Access Journal of Biogeneric Science and Research*. 10(1).

I also presented relevant papers at The Migration Conference as follows:

- Labinjo, T. O. Exploring the Experiences of Mental Health Among Internal Migrants in Nigeria (A Pilot Study). In *The Migration Conference 2020 Proceedings: Migration and Politics* (pp. 239-242). Transnational Press London.
- Labinjo, T.O. Perceptions, Attitudes and Cultural Understandings of Mental health in Nigeria: A scoping review of published literature. *The Migration Conference 2019 Proceedings: Migration and Wellbeing*. Transnational Press London.

7.3 Summary of study

All study participants (internal migrants) shared similar internal migration experiences after arrival to these three urban cities. They explained the continual and prevailing level of unemployment, insecurity, high cost of living, transport costs, and traffic problems affected them. In addition, lack of social amenities such as constant electricity, road networks, etc., have impacted their adaptability to the new environment and resulted in significant distress, thereby negatively impacting their mental health. Unfortunately, not much has been done by the government to alleviate these challenges, not only on internal migrants but Nigerians as a whole (Abubakar and Dano, 2018).

Study participants also described that the nation's insecurity negatively impacted them. Insecurity is increasing at an alarming rate (Ewetan and Ese, 2014; Obi, 2015), especially in the northeast region due to insurgency attacks by Boko Haram. Recent research has focused on internally displaced persons displaced by insecurity. However, the majority of study participants (internal migrants) also reported that insecurity challenges impacted their migration experiences.

In terms of ethnicity, internal migrants, especially residents in the northern states of Kaduna and FCT (Abuja), shared that they experienced non-acceptance and discrimination due to their inability to speak the local language (Hausa). Internal migrants said they had to learn the language (Hausa) before communicating and feeling accepted. The non-acceptance of internal migrants in these states made them feel isolated. In addition, they sometimes experienced discrimination by not being given civil service jobs or academic scholarships due to being internal migrants in the state.

In terms of gender, married female migrants shared that they all moved from their current state of origin to join their husbands in the urban cities of Kaduna, Abuja, and Lagos. They had to leave their jobs and family networks, and support behind. It was an expectation from society that young women must be married to gain acceptance, recognition, and respect in society.

Other studies in the northern region found that young women and girls experienced inequalities in healthcare access, reproductive care, and education. In addition, the prevailing level of insecurity negatively impacts their lives due to cases of rape, forced marriages and sometimes used as suicide bombers. However, these experiences affected not just internal migrant women but natives in general except for lack of support and language and cultural barriers.

7.4 Contribution to knowledge

This study aims to identify and explore factors that impact the mental health of voluntary internal migrants in Nigeria.

The objective of this study is to:

1. Explore the experiences of selected voluntary internal migrants and the impact their internal migration experiences had on their mental health using a new theoretical framework (Serrant-Green, 2011).
2. Improve knowledge level and awareness about mental health issues in Nigeria.
3. Assist in creating further research to assist stakeholders in providing more access and delivery of mental health services in Nigeria.
4. Test the application of the 'silences' framework (Serrant-Green, 2011) for researching an under-researched group about a sensitive issue in a new context.

The research questions guiding the study are:

1. What are the views, knowledge, and experiences of voluntary internal migrants in Nigeria concerning mental health issues?
2. What are the influencing factors concerning mental health among voluntary internal migrants in Nigeria?
3. What is the impact of voluntary internal migration on mental health in Nigeria?

The study achieved its aims and objectives and made a unique contribution to knowledge. It contributed to the silences research by exploring the gaps in the body of knowledge regarding the experiences of internal migrants concerning mental health in Nigeria. After a thorough and systematic search of the literature (scoping review), internal migrants' views, and experiences regarding mental health in Nigeria had been silenced and largely missing from academic literature.

Minimally structured in-depth interviews and an inductive cyclical approach to data analysis were used to give voice to these groups of people (internal Nigerian migrants) by obtaining, exploring, and reporting the situated views of nineteen study participants

about their internal migration experiences and impact on their mental health. Thus, to the best of my knowledge, this is the first study to explore the experiences of mental health among internal migrants in Nigeria.

Mental health in existing literature was regarded as a condition and completely ignored the positive aspects of mental health. This study therefore explored positive aspects of mental health by exploring and understanding the study participants' knowledge of mental health. Positive mental health is when an individual has the ability to work in unity with the universal values of society (Galderisi et al., 2017). Previous existing studies focused on mental illness or mental disorders by investigating its perceptions, attitudes and prevalence across different population groups in Nigeria (Omolayo et al., 2020; Pederson et al., 2020; Adeyemi, Abiola and Solomon, 2016).

As a black, Nigerian African woman, it was easy to collect data from Nigerian internal migrants' experiences due to the similarity in contextual backgrounds and settings. It would be difficult for a non- Nigerian to understand the contextual settings and backgrounds while collecting data especially when using Zoom as a data collection tool. This makes a unique contribution due to my ability to collect rich contextual data about Nigerian internal migrants' experiences and meanings in relation to mental health. This was achievable due to our similar backgrounds and settings.

The findings were verified by selected study participants and members of the social networks of the study participants. This was very helpful as 'collective voices' gave personal experiences while giving their feedback. Based on the study findings, recommendations were made for future research and policy. Therefore, the 'screaming silence' related to the migration experiences and mental health among internal migrants

in the study had been identified and explored. This included ‘silences’ that were uncovered in the study and had been identified while undertaking the study.

Finally, the study used the silences framework (Serrant-Green, 2011) and found it appropriate for guiding research into internal migrants’ migration experiences and its impact on mental health, undertaken by an early career researcher. This is the first time the framework is being used within the context of migration.

Minor suggestions have been made for future use. The framework also allowed for a reflection on my position in the study and the research process.

References

Abasiubong, F., Ekott, J. U., & Bassey, E. A. (2007). A comparative study of attitude to mental illness between journalists and nurses in Uyo, Nigeria. *African Journal of Medicine and Medical Sciences, 36*(4), 345-351.

Abayomi, O., Akinhanmi, A. O., & Adelufosi, A. O. (2015). Psychiatric morbidity and subjective burden among cares of outpatients of a psychogeriatric clinic in southwestern Nigeria. *Journal of Cross-Cultural Gerontology, 30*(4), 439-450.

Abdallah, A. R., & Gabr, H. M. (2014). Depression, anxiety, and stress among first-year medical students in an Egyptian public university *International Research Journal of Medicine and Medical Sciences, 2*(1), 11-19.

Abdul-Azeez, I. A., & Opoola, N. A. (2011). An appraisal of the factors influencing rural-urban migration in some selected local government areas of Lagos state Nigeria. *Journal of Sustainable Development, 4*(3), 136.

Abdullahi, A. T., Farouk, Z. L., & Imam, A. (2021). Common mental disorders in mothers of children attending out-patient malnutrition clinics in rural north-western Nigeria: A cross-sectional study. *BMC Public Health, 21*(1), 1-9.

Abdulmalik, J., Olayiwola, S., Docrat, S. et al. (2019) Sustainable financing mechanisms for strengthening mental health systems in Nigeria. *International Journal of Mental Health Systems* 13, 38. https://doi.org/10.1186/s13033-019-0293-8.

Abegunde, B. (2014). Gender inequality: Nigeria and international perspectives. *British Journal of Arts and Social Sciences,* 17(1), 165-191.

Abiodun, O. A. (1991). Knowledge and views on drug abuse of primary health care workers in Nigeria. *Drug and Alcohol Dependence, 28*(2), 177-182.

Abiodun, O. A. (1993). Emotional illness in a paediatric population in Nigeria. *Journal of Tropical Pediatrics, 39*(1), 49-51. doi:10.1093/tropej/39.1.49

Abiodun, O. A. (1993). A study of mental morbidity among primary care patients in Nigeria. *Comprehensive Psychiatry, 34*(1), 10-13.

Abiodun, O. A. (1995). Pathways to mental health care in Nigeria. *Psychiatric Services (Washington, D.C.), 46*(8), 823-826.

Abiodun, O. (2000). Physical morbidity in a psychiatric population in Nigeria. *General Hospital Psychiatry, 22*(3), 195-199.

Abiodun, O. (2006). Postnatal depression in primary care populations in Nigeria. *General Hospital Psychiatry, 28*(2), 133-136.

Abiodun, O., Adetoro, O., & Ogunbode, O. (1992). Psychiatric morbidity in a gynaecology clinic in Nigeria. *Journal of Psychosomatic Research, 36*(5), 485-490.

Abiodun, O., Adetoro, O., & Ogunbode, O. (1993). Psychiatric morbidity in a pregnant population in Nigeria. *General Hospital Psychiatry, 15*(2), 125-128.

Abiodun, O. A., Tunde-Ayinmode, M. F., Adegunloye, O. A., Ayinmode, B. A., Sulyman, D., Unaogu, N. N., . . . Jimba, M. K. (2011). Psychiatric morbidity in paediatric primary care clinic in Ilorin, Nigeria. *Journal of Tropical Pediatrics, 57*(3), 173-178.

Abiodun, O. A., & Ogunremi, O. O. (1990). Psychiatric morbidity in medical and surgical wards of a Nigerian general hospital. *Journal of Psychosomatic Research, 34*(4), 409-414.

Abubakar, D. (2002). The north and the Nigerian civil war. The Nigerian Civil War and its Aftermath, in Osaghae, EE, Onwudiwe, E.& Suberu, RT (Eds.) the Nigerian Civil War and its Aftermath *Ibadan: John Archers Publishers Ltd.*

Abubakar, I. R., & Dano, U. L. (2018). Socioeconomic challenges and opportunities of urbanization in Nigeria. In Urbanization and its impact on socio-economic growth in developing regions (pp. 219-240). *IGI Global.*

Achebe, C. (2012). There was a country: A memoir *Penguin.*

ACP Observatory on Migration (2011) Research Guide for research commissioned by the ACP Observatory on Migration. *ACP Observatory/IOM*: Brussels. http://www.acpmigration-obs.org/ node/168.

Adebayo, B. (2018). "Nigeria's President vows schoolgirl with Boko Haram 'will not be abandoned'". *CNN*. Retrieved 23 March 2018.

Adebiyi, A. O., Fagbola, M. A., Olakehinde, O., & Ogunniyi, A. (2016). Enacted and implied stigma for dementia in a community in south-west Nigeria. *Psychogeriatrics, 16*(4), 268-273. doi:10.1111/psyg.12156.

Adebowale, T., & Adelufosi, A. (2013). Stress and minor psychiatric morbidity among Nigerian executives: Some socio-demographic and biological correlates. *Annals of Medical and Health Sciences Research, 3*(3), 412-416.

Adebowale, T. O., & Ogunlesi, A. O. (1999). Beliefs and knowledge about aetiology of mental illness among Nigerian psychiatric patients and their relatives. *African Journal of Medicine and Medical Sciences, 28*(1-2), 35-41.

Adebowale, T., Umukoro, O. L., Gater, R., Akinhanmi, A., Ogunlesi, A., Helme, C., . . . Ibikunle, I. (2014). Evaluation of a mental health training course for primary health care workers in Ogun State, southwest Nigeria. *African Journal of Psychiatry (South Africa), 17*(5) doi:10.4172/Psychiatry.1000141

Adegunloye, O., Buhari, O., & Abiodun, O. (2018). Depression in elderly primary health care clinic attendees in Ilorin, Nigeria. *Tropical Journal of Health Sciences, 25*, 1-7.

Adejoh R. (2010), The Impact of Religious Crises on Democracy in Nigeria in Egwemi V. (eds) A Decade of Democracy in Nigeria Issues, Challenges and Prospects of Consolidation. Makurdi: *Aboki Publishers*. Pp. 84-107.

Adelekan, M. L., Makanjuola, A. B., & Ndom, R. J. (2001). Traditional mental health practitioners in Kwara state, Nigeria. *East African Medical Journal, 78*(4), 190-196.

Adeleke, W., (2020, April 15) Kaduna State Festival of Arts and Culture. *Kaduna state.*

Adeolu, J. O., Yussuf, O. B., & Popoola, O. A. (2016). Prevalence and correlates of job stress among junior doctors in the university college hospital, Ibadan. *Annals of Ibadan Postgraduate Medicine, 14*(2), 92-98.

Adeosun, I. I., Adegbohun, A. A., Jeje, O. O., & Adewumi, T. A. (2014). Experiences of discrimination by people with schizophrenia in Lagos, Nigeria. *Journal of Public Mental Health, 13(4) 189-196. ISSN: 1746-5729. DOI 10.1108/JPMH-06-2013-0038.*

Adepoju, A. (1974). Migration and socio-economic links between urban migrants and their home communities in Nigeria1. *Africa, 44*(4), 383-396.

Adepoju, A. (1976). Migration and development in Nigeria. *Manpower and Unemployment Research,* 9(2), 65-76.

Adepoju, A. (1977). Migration and development in tropical Africa: Some research priorities. *African Affairs, 76*(303), 210-225.

Adepoju, A. (1979). Migration and socio-economic change in Africa. *International Social Science Journal, 31*(2), 207-225.

Adepoju, A. (1981). Migration and socio-economic change in tropical Africa: Policy and research. *Why People Move, UNESCO, Paris,* 317-336.

Adepoju, A. (1998). Linkages between internal and international migration: The African situation. *International Social Science Journal, 50*(157), 387-395.

Adepoju, A. (2000). Issues and recent trends in international migration in Sub-Saharan Africa. *International Social Science Journal, 52*(165), 383-394.

Adepoju, A. (2008). Migration in sub-Saharan Africa *Nordiska Afrikainstitutet.*

Adepoju, P., (2020, September 29) Short of mental health professionals, Nigeria tries a new approach. Retrieved from: https://www.devex.com/news/short-of-mental-health-professionals-nigeria-tries-a-new-approach-98176. Assessed 02 January 2021.

Adesoji, A. (2010) "The Boko Haram Uprising and Islamic Revivalism in Nigeria". *Africa Spectrum*. Archived from the original *on 1 March 2015. Retrieved August 2014.*

Adetoro, G. W., and Fadayomi, T.O. (2012) Migration and Youth Unemployment in Nigeria: Reflections from an Empirical Study. *Covenant University.*

Adewale, J. G. (2005). Socio-economic factors associated with urban-rural migration in Nigeria: A case study of Oyo state, Nigeria. *Journal of Human Ecology, 17*(1), 13-16.

Adewumi, T., Oladipo, E., & Adewuya, A. O. (2020). Public perception and attitude towards people living with epilepsy in Nigeria. *Epilepsy & Behavior, 106*, 107033.

Adewuya, A. O., Adewumi, T., Ola, B., Abosede, O., Oyeneyin, A., Fasawe, A., & Idris, O. (2017). Primary health care workers' knowledge and attitudes towards depression and its management in the MeHPric-P project, Lagos, Nigeria. *General Hospital Psychiatry*, 47, 1-6. doi: 10.1016/j.genhosppsych.2017.04.002

Adewuya, A. O., Coker, O. A., Atilola, O., Ola, B. A., Zachariah, M. P., Adewumi, T., . . . Idris, O. (2018). Gender difference in the point prevalence, symptoms, comorbidity, and correlates of depression: Findings from the Lagos state mental health survey (LSMHS), Nigeria. *Archives of Women's Mental Health*, doi:10.1007/s00737-018-0839-9

Adewuya, A. O., Eegunranti, A. B., & Lawal, A. M. (2005). Prevalence of postnatal depression in western Nigerian women: A controlled study. *International Journal of Psychiatry in Clinical Practice, 9*(1), 60-64. doi:10.1080/13651500510018211

Adewuya, A. O., Fatoye, F. O., Ola, B. A., Ijaodola, O. R., & Ibigbami, S. O. (2005). Sociodemographic and obstetric risk factors for postpartum depressive symptoms in Nigerian women. *Journal of Psychiatric Practice, 11*(5), 353-358.

Adewuya, A. O., & Makanjuola, R. O. A. (2008a). Lay beliefs regarding causes of mental illness in Nigeria: Pattern and correlates. *Social Psychiatry and Psychiatric Epidemiology, 43*(4), 336-341. doi:10.1007/s00127-007-0305-x

Adewuya, A. O., & Makanjuola, R. O. A. (2008b). Social distance towards people with mental illness in southwestern Nigeria. *Australasian Psychiatry, 2008, Vol.42; 42*(5; 5), 389; 389-395; 395. doi:10.1080/00048670801961115

Adewuya, A. O., & Makanjuola, R. O. A. (2009). Subjective quality of life of Nigerian schizophrenia patients: Sociodemographic and clinical correlates. *Acta Psychiatrica Scandinavica, 120*(2), 160-164. doi:10.1111/j.1600-0447.2009. 01395.x

Adewuya, A. O., & Oguntade, A. A. (2007). Doctors' attitude towards people with mental illness in western Nigeria. *Social Psychiatry and Psychiatric Epidemiology, 42*(11), 931-936.

Adewuya, A. O., Ola, B. A., & Adewumi, T. A. (2007). The 12-month prevalence of DSM-IV anxiety disorders among Nigerian secondary school adolescents aged 13-18 years. *Journal of Adolescence, 30*(6), 1071-1076.

Adewuya, A. O., Ola, B. A., Aloba, O. O., Dada, A. O., & Fasoto, O. O. (2007). Prevalence and correlates of depression in late pregnancy among Nigerian women. *Depression and Anxiety, 24*(1), 15-21.

Adewuya, A. O., Ola, B. A., Coker, O. A., Atilola, O., Zachariah, M. P., Olugbile, O., . . . Idris, O. (2016). Prevalence and associated factors for suicidal ideation in the Lagos state mental health survey, Nigeria. *BJPsych Open, 2*(6), 385-389.

Adewuya, A. O., Oladipo, O., Ajomale, T., Adewumi, T., Momodu, O., Olibamoyo, O., . . . Adegbaju, D. (2021). Epidemiology of depression in primary care: Findings from the mental health in primary care (MeHPriC) project, Lagos, Nigeria. *The International Journal of Psychiatry in Medicine*, 0091217421996089.

Adewuya, A., Ologun, Y., & Ibigbami, O. (2006). Post-traumatic stress disorder after childbirth in Nigerian women: Prevalence and risk factors. *BJOG: An International Journal of Obstetrics & Gynecology, 113*(3), 284-288.

Adewuya, A. O., & Ologun, Y. A. (2006). Factors associated with depressive symptoms in Nigerian adolescents. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine, 39*(1), 105-110.

Adewuya, A. O., & Oseni, S. B. (2005). Impact of psychiatric morbidity on parent-rated quality of life in Nigerian adolescents with epilepsy. *Epilepsy & Behavior, 7*(3), 497-501.

Adewuya, A. O., Owoeye, O. A., & Erinfolami, A. R. (2011). Psychopathology and subjective burden amongst primary caregivers of people with mental illness in south-western Nigeria. *Social Psychiatry and Psychiatric Epidemiology, 46*(12), 1251-1256.

Adeyemi EO, Waziri BA, Atere AA, Emmanuel A (2009). Economic reforms, living conditions, and urban violence: a situation analysis of metropolitan Lagos. Ethiopian *Journal of Environmental Studies and Management* 2, 36–48.

Adeyemi, S., Abiola, T., & Solomon, K. (2016). Stigma and discrimination against people with mental illness: Findings from north-central Nigeria. *Malaysian Journal of Psychiatry, 24*(2)

Adiele, S. N. (1991). Religion and Contemporary Issues: The Church and Burial Ceremony among the Igbo of Nigeria. *African Journal of Biblical Studies*, 6, 2-10.

Adofu, I., & Alhassan, A. (2018). Insecurity and economic development in Nigeria. *Journal of Economics and Sustainable Development, 9*(18), 101-112.

Adriaanse, M., Veling, W., Doreleijers, T., & van Domburgh, L. (2014). The link between ethnicity, social disadvantage, and mental health problems in a school-based multiethnic sample of children in the Netherlands. *European Child & Adolescent Psychiatry*,*23*(11),1103-13.

Adriaanse, M., Doreleijers, T., van Domburgh, L., & Veling, W. (2016). Factors associated with psychiatric symptoms and psychiatric disorders in ethnic minority youth. *European Child & Adolescent Psychiatry, 25*(10), 1067-1079.

Afe, T. O., & Ogunsemi, O. (2016). Social distancing attitudes toward the mentally ill and victims of sexual violence among college students in southwest Nigeria. *Indian Journal of Social Psychiatry, 32*(4), 320.

Afinotan, L., & Ojakorotu, V. (2009). The Niger Delta crisis: Issues, challenges, and prospects. *African Journal of Political Science and International Relations, 3*(5), 191-198.

Afinotan, L. A., & Ojakorotu, V. (2014). Threat to Nigeria since 1960: A retrospection. *Canadian Social Science, 10*(5), 210-220.

Afolabi, M. O. (2007). Rural-urban migration and productivity in the Nigerian agricultural sector (*Doctoral dissertation, Master of Public Policy Program-Simon Fraser University).*

Afolayan, J. A., Riaz, M. N., Odo, P. I., & Berefagha, L. W. (2011). Causal beliefs of mental illness and attitudes towards seeking professional help. *FWU Journal of Social Sciences, 5*(1)

Afolayan, J. A., Onasoga, O. A., & Ademiloye, H. A. (2019) Attitudinal disposition of adults toward people with mental disorders in Oke-Ose community, Ilorin East, Nigeria. *Sigma Nursing Repository.*

Agar, M. (1980). Getting better quality stuff: Methodological competition in an interdisciplinary niche. *Urban Life*, 9(1), 34-50.

Agbahowe, S. A., Ohaeri, J. U., Ogunlesi, A. O., & Osahon, R. (1998). Prevalence of psychiatric morbidity among convicted inmates in a Nigerian prison community. *East African Medical Journal, 75*(1), 19-26.

Agbonlahor, M. U., & Phillip, D. O. A. (2015). Deciding to settle: Rural-rural migration and agricultural labour supply in southwest Nigeria. *The Journal of Developing Areas, 49*(1), 267-284.

Agbigbe, W. A. (2016). The impact of transportation infrastructure on Nigeria's economic development (*Doctoral dissertation, Walden University*).

Aghukwa, N. (2009). Secondary school teachers' attitude to mental illness in Ogun state, Nigeria. *African Journal of Psychiatry, 12*(1), 59-63.

Aghukwa, C. N. (2012). Care seeking and beliefs about the cause of mental illness among Nigerian psychiatric patients and their families. *Psychiatric Services (Washington, D.C.), 63*(6), 616-618. doi: 10.1176/appi.ps.201000343

Agofure, O., Okandeji-Barry, O., & Ume, I. (2019). Knowledge and perception of mental disorders among relatives of mentally ill persons in a rural community in south-south Nigeria. *Journal of Community Medicine and Primary Health Care, 31*(2), 66-77.

Aina, F. (2001). Socio-demographic and clinical profile of patients attending a private psychiatric hospital in Lagos, Nigeria. *West African Journal of Medicine, 20*(2), 117-122.

Aina, O. F. (2004). Mental illness and cultural issues in west African films: Implications for orthodox psychiatric practice. *Medical Humanities, 30*(1), 23-26.

Aina, I. O., Otakpor, A. N., & Israel-Aina, Y. T. (2016). Pattern of care before presentation among the psychiatric emergency cases at a tertiary health care center in Nigeria. *The Primary Care Companion for CNS Disorders, 18*(2), 10.4088/PCC.15m01817. e Collection 2016. doi:10.4088/PCC.15m01817

Aina, O., Gautam, L., Simkhada, P., & Hall, S. (2020). Prevalence, determinants and knowledge about herbal medicine and non-hospital utilisation in southwest Nigeria: a cross-sectional study. *BMJ open*, 10(9), e040769.

Ajaero, C. K., Odimegwu, C. O., Chisumpa, V., & Obisie-Nmehielle, N. (2017). The influence of internal migration on mental health status in South Africa. *International Journal of Mental Health Promotion, 19*(4), 189-201.

Ajayi, J. A., Falola, T. O., Udo.,R. K and Kirk-Greene., A.H. M. (2020, December 08). Nigeria. *Encyclopedia Britannica*. https://www.britannica.com/place/Nigeria

Ajefu, J. B. (2017). Understanding the relationship between health and internal migration in the United Kingdom. *International Journal of Migration, Health, and Social Care, 13(4), 432-448, DOI 10.1108/IJMHSC-05-2016-0021.*

Ajero, C., Madu, I. A., & Mozie, A. T. (2013). Appraisal of the factors of rural-urban migration in southeastern Nigeria. *Innovare Journal of Social Sciences, 1*(2), 1-8.

Ajiboye, P. O., Abiodun, A., Tunde-Ayinmode, M., Sanya, E. O., Wahab, K. W., Buhari, O. I. N., . . . Agbabiaka, T. (2012). Psychiatric morbidity in a Nigerian neurology clinic. *East African Medical Journal, 89*(2), 64-70.

Akanbi, O.A. (2016) The Africa Data Report: A Case Study of Nigeria. *United Nations Development Programme*. www.undp.org.

Akanni, O. O., & Adayonfo, E. O. (2015). Correlates of psychoactive substance use among Nigerian adolescents. *Sahel Medical Journal, 18*(4), 192.

Akanni, O. O., Igbinomwanhia, N. G., Ogunwale, A., & Osundina, A. F. (2020). Knowledge of mental health law and attitude toward mental illness among attorneys in Nigeria. *Social Health and Behavior, 3*(3), 110.

Akerele, D., Momoh, S., Aromolaran, A. B., Oguntona, C. R., & Shittu, A. M. (2013). Food insecurity and coping strategies in south-west Nigeria. *Food Security, 5*(3), 407-414.

Akighir, A. (1982). Traditional and modern psychiatry: A survey of opinions and beliefs amongst people in plateau state, Nigeria. *International Journal of Social Psychiatry, 28*(3), 203-209.

Akinbode, O., & Tolulope, T. (2017). Factors influencing adolescents stigmatising attitudes and perception of community reaction towards mental illness in Nigeria. *Sudan Journal of Medical Sciences, 12*(4), 240-252.

Akinsulore, A., Aloba, O. O., Mapayi, B. M., Oloniniyi, I. O., Fatoye, F. O., & Makanjuola, R. O. A. (2014). Relationship between depressive symptoms and quality of life in Nigerian patients with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology, 49*(8).

Akinsulore, A., Esimai, O. A., Mapayi, B. M., & Aloba, O. O. (2018). Public awareness and attitude towards depression: A community-based study among an adult population in ile-ife south-western Nigeria. *Community Mental Health Journal,* doi:10.1007/s10597-017-0222-8

Akinwotu, E., (2021, May 05). 'Nobody is safe': Nigeria reels from nationwide wave of deadly violence. *The Guardian.*
Assessed from: https://www.theguardian.com/world/2021/may/05/nigerian-president-faces-growing-criticism-after-security-system-collapse

Akinyemi, A., Olaopa, O., & Oloruntimehi, O. (2005). Migration dynamics and changing rural-urban linkages in Nigeria. *Available at: Iussp2005princeton.edu/download.Aspx,*

Akinyemi, O. O., Owoaje, E. T., Ige, O. K., & Popoola, O. A. (2012). Comparative study of mental health and quality of life in long term refugees and host populations in oru-ijebu, southwest Nigeria. *BMC Research Notes, 5*(1), 1-9.

Akinyemi, O., Atilola, O., & Soyannwo, T. (2015). Suicidal ideation: Are refugees more at risk compared to the host population? Findings from a preliminary assessment in a refugee community in Nigeria. *Asian Journal of Psychiatry, 18,* 81-85.

Akinyemi, O. O., Owoaje, E. T., & Cadmus, E. O. (2016). In their own words: Mental health and quality of life of West African refugees in Nigeria. *Journal of International Migration and Integration, 17*(1), 273-287.

Akpunne, B. C., & Uzonwanne, F. C. (2015). Demographic determinants of public perceptions of mental illness in heterogeneous communities of Lagos State Nigeria. *Advances in Social Sciences Research Journal,* 2(1), 1-10.

Akresh, R., Bhalotra, S., Leone, M., & Osili, U. O. (2012). War and stature: Growing up during the Nigerian civil war. *American Economic Review, 102*(3), 273-277.

Alabi, T., & Alabi, O. S. (2014). Female education: A sociological analysis of girl-child education in Nigeria. *International Journal of Educational Policy Research and Review,* 1(1), 006-013.

Alasuutari, P. (2004) Social theory, and human reality. London: *Sage.*

Alasuutari, P., Bickman, L., & Brannen, J. (Eds.). (2008). The Sage handbook of social research methods. *Sage.*

Alegría, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D., ... & Meng, X. L. (2008). Prevalence of mental illness in immigrant and non-immigrant US Latino groups. *American Journal of Psychiatry., 165*(3), 359-369.

Ali, A. D. (2013). Leadership and socio-economic challenges in Nigeria. *Singaporean Journal of Business Economics, and Management Studies, 1*(9), 1-8.

Ali, R., Barra, A. F., Berg, C. N., Damania, R., Nash, J. D., Russ, J., & Russ, J. D. (2015). Transport infrastructure and welfare: an application to Nigeria. *World Bank Policy Research Working Paper*, (7271).

Aliyu, A. A., & Amadu, L. (2017). Urbanization, cities, and health: the challenges to Nigeria–a review. *Annals of African Medicine*, 16(4), 149.

Allen, N. (2016, September 22). "Charting Boko Haram's Rapid Decline". *War on the Rocks*. Retrieved 13 October 2016

Almeida-Filho, N., Mari, J. D. J., Coutinho, E., Franca, J. F., Fernandes, J., Andreoli, S. B., & Busnello, E. D. (1997). Brazilian multicentric study of psychiatric morbidity: Methodological features and prevalence estimates. *The British Journal of Psychiatry, 171*(6), 524-529.

Aluh, D. O., Anyachebelu, O. C., Anosike, C., & Anizoba, E. L. (2018). Mental health literacy: What do Nigerian adolescents know about depression? *International Journal of Mental Health Systems, 12*(1), 1-6.

Aluh, D. O., Okonta, M., & Odili, V. (2019a). A comparative study of depression literacy between pharmacy and non-pharmacy students of a Nigerian university. *The Journal of Mental Health Training, Education and Practice, 15(2). ISSN: 1755-6228*

Aluh, D. O., Okoro, R. N., & Zimboh, A. (2019b). The prevalence of depression and post-traumatic stress disorder among internally displaced persons in Maiduguri, Nigeria. *Journal of Public Mental Health, 19(2) ISSN: 1746-5729.*

Amadi, K. U., Uwakwe, R., Aguocha, C. M., Ezeme, M. S., Muomah, R. C., Ndukuba, A. C., & Odinka, P. C. (2016). Illness coping behaviour of outpatients with depression or diabetes mellitus in two tertiary hospitals in Enugu State, southeast Nigeria. *Mental Health, Religion & Culture,* 19(4), 371–378. doi:10.1080/13674676.2016.1201055

Amnesty International, (2018, February 22) Amnesty International Report 2017/18 - Nigeria, available at: *https://www.refworld.org/docid/5a993898a.html* [accessed 31 July 2021]

Amoo, G., & Ogunlesi, A. O. (2005). Financial cost of treating Nigerian in-patients with schizophrenia. *African Journal of Medicine and Medical Sciences, 34*(1), 15-23.

Amoran, O., Lawoyin, T., & Lasebikan, V. (2007). Prevalence of depression among adults in Oyo state, Nigeria: A comparative study of rural and urban communities. *Australian Journal of Rural Health, 15*(3), 211-215.

Amoran, O. E., Lawoyin, T. O., & Oni, O. O. (2005). Risk factors associated with mental illness in Oyo state, Nigeria: A community-based study. *Annals of General Psychiatry, 4*, 19-19.

Amoran, O., Ogunsemi, O., & Lasebikan, V. (2012). Assessment of mental disorders using the patient health questionnaire as a general screening tool in western Nigeria: A

community-based study. *Journal of Neurosciences in Rural Practice, 3*(1), 6-11. doi:10.4103/0976-3147.91922

Amusan, L., & Ejoke, U. P. (2017). The psychological trauma inflicted by Boko Haram insurgency in Northeastern Nigeria. *Aggression and violent behavior*, 36, 52-59.

Anbesse, B., Hanlon, C., Alem, A., Packer, S., & Whitley, R. (2009). Migration and mental health: A study of low-income Ethiopian women working in middle eastern countries. *The International Journal of Social Psychiatry*, *55*(6), 557-568.

Andrew, K., Igboanusi, C. J. -., Joshua, I. A., & Yakubu, M. (2017). Knowledge of depression in the elderly among primary health care workers in Kubau, Nigeria. *Annals of Tropical Medicine and Public Health*, *10*(1), 143-148. doi:10.4103/1755-6783.196820

Anfara V. A. and Mertz, N. T. (ed.) (2006) Theoretical Frameworks in Qualitative Research. California, USA: *Sage.*

Ango, A., Ibrahim, S., Yakubu, A., & Usman, T. (2014). Determination of socio-economic factors influencing youth rural-urban migration in Sokoto state, Nigeria. *Journal of Human Ecology, 45*(3), 223-231.

Ani, C., Kinanee, J., & Ola, B. (2011). Psychological distress among trainee teachers in Nigeria: Association with religious practice. *European Journal of Educational Studies, 3*(1), 163-172.

Anosike, C., Aluh, D. O., & Onome, O. B. (2020). Social distance towards mental illness among undergraduate pharmacy students in a Nigerian university. *East Asian Archives of Psychiatry, 30*(2), 57.

Anosike, C., Igboeli, N. U., Ukwe, C. V., & Okani, C. V. (2019). Comparative survey of beliefs about mental illness among pharmacy and non-pharmacy students of a Nigerian university. *Mental Health and Social Inclusion, 23(3) ISSN: 2042-8308.*

Anyanwu, S. O. (1991). An econometric analysis of patterns and determinants of internal migration in Nigeria (*Doctoral dissertation, School of Postgraduate Studies of the University of Lagos, Akoka).*

Anyanwu, S. O. (1992). A quantitative analysis of major determinants of rural-urban migration in Nigeria. *The Nigerian Journal of Economic and Social Studies, 34*(3), 177-194.

Anyebe, E., Olisah, V., Garba, S., & Amedu, M. (2019). Current status of mental health services at the primary healthcare level in northern Nigeria. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(5), 620-628.

Arber, A. (2006) Reflexivity: A challenge for the researcher as practitioner? *Journal of Research in Nursing*, 11:2, pp147- 157.

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods, 18*.

Archuleta, A. J. (2015). Newcomers: The contribution of social and psychological well-being on emotion regulation among first-generation acculturating Latino youth in the southern united states: C & A C & A. *Child & Adolescent Social Work Journal, 32*(3), 281-290. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1007/s10560-014-0370-4

Aremu, J. O. (2014). Ghana's role in the Nigerian war: Mediator or collaborator? *International Journal of Humanities and Cultural Studies ISSN 2356-5926*, 51.

Aremu, J. O., & Buhari, L. O. (2017). Sense and senselessness of war: Aggregating the causes, gains and losses of the Nigerian civil war, 1967-1970. *IAFOR Journal of Arts & Humanities, 4*(1), 61-79.

Arenas, E. (2008). Health selectivity of internal migrants in Mexico: Evidence from the Mexican family life survey. *UCLA CCPR Population Working Papers,*

Argungu, Z. M., Ahmed, M., & Sa'idu, A. (2020). Public attitude towards psychiatrists: A comparison between two metropolitan cities in Nigeria (Birnin-kebbi and Sokoto). *World, 3*(7), 22-30.

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International journal of social research methodology*, 8(1), 19-32.

Aromolaran, A. (2013). Assessment of benefits associated with rural-urban migration among non-migrants in odeda area, Ogun State, Nigeria. *International Journal of Pure and Applied Sciences and Technology, 14*(2), 31-38.

Aroyewun- Adekomaiya, K., & Aroyewun, F. T. (2019). Representation of mental illness in movies: A Nigerian perspective. *African Journal for the Psychological Studies of Social Issues, 22*(2), 103-117.

Asibong, U., Udonwa, N., Okokon, I., Gyuse, A., Aluka, T., & Ekpe, E. (2010). Patient characteristics that may predict the likelihood of the presence of mental health problems in patients attending the general outpatient clinic of a tertiary hospital in south-south Nigeria. *Mental Health in Family Medicine, 7*(3), 169-177.

Asiegbu, J. U. (1984). Nigeria and its British invaders, 1851-1920: a thematic documentary history. *Nok Publishers International*. ISBN 0-88357-101-3

Associated Press (16 December 2020) "Boko Haram claims abduction of students in northern Nigeria". . Retrieved 16 December 2020.

Asselin, M.E. (2003) Insider research: issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Staff Development*,19:2, pp 99- 103.

Assouline, A. A. H. (2015). Adolescents who migrate alone from the former Soviet Union to Israel: Battling the triple challenge. *Child and Adolescent Social Work Journal, 32*(2), 199-208.

Atella, V., Deb, P., & Kopinska, J. (2019). Heterogeneity in long-term health outcomes of migrants within Italy. *Journal of Health Economics, 63*, 19-33.

Atilola, O., & Olayiwola, F. (2012). The Nigerian home video boom: Should Nigerian psychiatrists be worried? Lessons from content review and views of community dwellers. *The International Journal of Social Psychiatry, 58*(5), 470-476.

Atilola, O., & Olayiwola, F. (2013). Frames of mental illness in the Yoruba genre of Nigerian movies: Implications for orthodox mental health care. *Transcultural Psychiatry, 50*(3), 442-454. doi:10.1177/1363461512443998

Atilola, O., Omigbodun, O., & Bella-Awusah, T. (2014). Post-traumatic stress symptoms among juvenile offenders in Nigeria: Implications for holistic service provisioning in juvenile justice administration. *Journal of Health Care for the Poor and Underserved, 25*(3), 991-1004. doi:10.1353/hpu.2014.0116

Atsua, T. G., Garba, C. H., & Oludi, P. (2017) Prolonged internal displacement and common mental disorders among internally displaced persons in Benue State, Nigeria. *Academia.edu.*

Atewologun, D. (2018). Intersectionality theory and practice. In Oxford Research *Encyclopedia of Business and Management.*

Audu, I. A., Idris, S. H., Olisah, V. O., & Sheikh, T. L. (2013). Stigmatization of people with mental illness among inhabitants of a rural community in northern Nigeria. *International Journal of Social Psychiatry, 59*(1), 55-60. doi:10.1177/0020764011423180

Awaritefe, A. (1988). Clinical anxiety in Nigeria. *Acta Psychiatrica Scandinavica, 77*(6), 729-735.

Awumbila, M. (2014). World Migration Report 2015: Linkages between Urbanization, Rural-Urban Migration and Poverty Outcomes in Africa. *International Organization for Migration (IOM).*

Ayandele, O., Popoola, O., Obosi, A., & Busari, A. (2019). Depression, anxiety, and smart phone addiction among young people in southwest Nigeria. *Covenant International Journal of Psychology, 4*(2)

Ayonrinde, A., & Erinosho, O. A. (1977). A pilot experiment in preventive psychiatry in a rural community: The case of Igbo-ora in Nigeria. *International Health Education., 20*(2), 120-125.

Babatunde, R. O., & Martinetti, E. C. (2010). Impact of remittances on food security and nutrition in rural Nigeria. *Unpublished Manuscript, Centre for International Cooperation and Development, University of Pavia, Italy,*

Bagley, C. (1968). Migration, race and mental health: A review of some recent research. *Race, 9*(3), 343-356.

Baiyewu, O., Yusuf, A. J., & Ogundele, A. (2015). Depression in elderly people living in rural Nigeria and its association with perceived health, poverty, and social network. *International Psychogeriatrics, 27*(12), 2009-2015. doi:10.1017/S1041610215001088

Bakare, M. O., Agomoh, A. O., Eaton, J., Ebigbo, P. O., & Onwukwe, J. U. (2011). Functional status and its associated factors in Nigerian adolescents with bipolar disorder. *African Journal of Psychiatry, 14*(5), 388-391.

Bakwai, B., Yisa, H. M., Jega, M. A., Kpae, C., & Okon, J. (2014). Insecurity in northern Nigeria and girls' participation in basic primary schools: Planning for a peace culture. *Managing and Planning Education for Peace Building in Nigeria: Themes and Perspectives*, 27-33.

Balami, A. D. (2015). Depression, anxiety, stress, and their associated factors among corps members serving in kebbi state. *Nigerian Journal of Medicine: Journal of the National Association of Resident Doctors of Nigeria, 24*(3), 223-232.

Bankole, A. (1988). Migration status and investment in rural productive activities: Evidence from Oyo state, Nigeria. *Genus, 44*(1-2), 249-264.

Barbour, K. M. (1982). Africa and the development of geography. *Geographical Journal*, 317-326.

Belizaire, L. S., & Fuertes, J. N. (2011). Attachment, coping, acculturative stress, and quality of life among Haitian immigrants. *Journal of Counselling and Development: JCD, 89*(1), 89-97.

Bella, T., Omigbodun, O., & Atilola, O. (2011). Towards school mental health in Nigeria: Baseline knowledge and attitudes of elementary school teachers. *Advances in School Mental Health Promotion, 4*(3), 55-62.

Bella-Awusah, T., Adedokun, B., Dogra, N., & Omigbodun, O. (2014). The impact of a mental health teaching programme on rural and urban secondary school students' perceptions of mental illness in southwest Nigeria. *Journal of Child and Adolescent Mental Health, 26*(3), 207-215. doi:10.2989/17280583.2014.922090

Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *International migration review*, 21(3), 491-511.

Bhorat, H., & Initiative, A. G. (2014). The Post-2015 Development Agenda: What Are the Priorities for Africa? *Foresight Africa*, 16.

Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica, 109*(4), 243-258.

Bhugra, D., Baldwin, D. S., Desai, M., & Jacob, K. (1999). Attempted suicide in west London, II. inter-group comparisons. *Psychological Medicine, 29*(5), 1131-1139.

Bhugra, D., & Gupta, S. (2011). Introduction: Setting the scene. *Migration and Mental Health*, 1-15.

Binitie, A. (1981). Psychiatric disorders in a rural practice in the Bendel state of Nigeria. *Acta Psychiatrica Scandinavica, 64*(4), 273-280.

Binitie, A., & Ofili, P. (1978). Psychiatric disorders in a rural practice, in the Bendel state of Nigeria. Paper presented at the *International Sociological Association,* Retrieved from http://lcproxy.shu.ac.uk/login?url=https://search-proquest-com.lcproxy.shu.ac.uk/docview/61761391?accountid=13827

Bisiriyu RJ. Nigerian railway (2016, February 04): A tail of failed contracts, dashed hope. *Punch Newspapers*,1-24p. [Online]. Available: https://punchng.com/nigerian-railway-a-tale-of-failed-contracts-dashed-hope/

Blair, D. (2012, February 05). "Al-Qaeda's hand in Boko Haram's deadly Nigerian attacks". *The Daily Telegraph*. Retrieved 3 August 2014.

Bloland, H. G. (1995). "Postmodernism and Higher Education." *Journal of Higher Education* 66:521-59.

Bolle, S. R., Larsen, F., Hagen, O., & Gilbert, M. (2009). Video conferencing versus telephone calls for teamwork across hospitals: A qualitative study on simulated emergencies. *BMC Emergency Medicine, 9*(1), 22.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.

Braun, V., Clarke, V., & Gray, D. (Eds.). (2017). Collecting qualitative data: A practical guide to textual, media and virtual techniques. *Cambridge University Press*.

Breslau, J., Aguilar-Gaxiola, S., Borges, G., Kendler, K. S., Su, M., & Kessler, R. C. (2007). Risk for psychiatric disorder among immigrants and their US-born descendants: Evidence from the national comorbidity survey replication. *The Journal of Nervous and Mental Disease, 195*(3), 189-195. doi: 10.1097/01.nmd.0000243779. 35541.c6.

Breslau, J., Borges, G., Tancredi, D., Saito, N., Kravitz, R., Hinton, L., ... & Aguilar-Gaxiola, S. (2011). Migration from Mexico to the United States and subsequent risk for depressive and anxiety disorders: A cross-national study. *Archives of General Psychiatry., 68*(4), 428-433.

Brinkmann, S., & Kvale, S. (2015). Interviews: Learning the craft of qualitative research interviewing (Vol. 3). Thousand Oaks, CA: *Sage.*

Brinton, M. C., Lee, Y., & Parish, W. L. (1995). Married women's employment in rapidly industrializing societies: Examples from East Asia. *American Journal of Sociology, 100*(5), 1099-1130.

British Broadcasting Corporation *(*2014, August 24). "'Islamist militants' kill 10 in northern Cameroon". *Retrieved* 8 August *2014*.

British Broadcasting Corporation News (2014, November 14) "Boko Haram militants 'seize Nigerian town of Chibok'". *Retrieved* 14 November *2014*.

British Broadcasting Corporation (2014, November 30)"Boko Haram Kano attack: Loss of life on staggering scale". *Retrieved* 12 December *2014*.

British Broadcasting Corporation News, Africa (2015, April 29) Nigerian army 'rescues nearly 300' from Sambisa Forest. *British Broadcasting Corporation News*. Retrieved 29 April 2015.

British Broadcasting Corporation NEWS. (2018, May 3). Nigeria companies raided over cough syrup addiction. *BBC News Africa*. Retrieved from https://www.bbc.co.uk/news/world-africa-43994087

British Broadcasting Corporation News. (2020, December 25) "Boko Haram kill villagers in Christmas Eve attack". *Retrieved* 26 December *2020*.

British Broadcasting Corporation News Africa (2021, March 15) Nigerian primary school teachers abducted in Kaduna state. Retrieved: https

British Council Nigeria (2012) Gender in Nigeria Report. Improving the Lives of Girls and Women in Nigeria. *Issues, Policies, and Actions*. 2nd edition.

British Council Nigeria (2014) Girls' education in Nigeria. Report 2014: Issues, influencers, and actions. *https://www.britishcouncil.org/sites/default/files/british-council-girls-education-nigeria-report.pdf*

Burkitt, I. (2004). The time and space of everyday life. *Cultural Studies, 18*(2-3), 211-227.

Cameron, M., Ray, R., & Sabesan, S. (2015). Remote supervision of medical training via videoconference in northern Australia: A qualitative study of the perspectives of supervisors and trainees. *BMJ Open, 5*(3), e006444-2014-006444. doi:10.1136/bmjopen-2014-006444.

Campbell J. (2019). Africa in Transition. Home to Over Half the Population, Nigeria's Cities Continue to Boom. Retrieved on September 9, 2020, from*: https://www.cfr.org/blog/home-over-half-population-nigerias-citiescontinue-boom*

Cardano, M., Scarinzi, C., Costa, G., & d'Errico, A. (2018). Internal migration and mental health of the second generation. The case of Turin in the age of the Italian economic miracle. *Social Science and Medicine, 208,* 142-149.

Carter, P, Sellers, SL and Squire, C. (2002). Reflections on race/ethnicity, class, and gender-inclusive research. *African American Perspectives,* 8(1): 111–124.

Cater, J. K. (2011). Skype a cost-effective method for qualitative research. *Rehabilitation Counselors & Educators Journal, 4*(2), 3.

Centre for Disease and prevention (2021) Map of Nigeria (Nigeria Traveller View). Available at *https://wwwnc.cdc.gov/travel/destinations/traveler/none/nigeria*

Chanter, T. (2006). Gender: Key concepts in philosophy. *Bloomsbury Publishing.*

Chapin H. (1991) A country study Washington: GPO for the library of congress, 1991, Retrieved Oct 11, 2014. *doi:http://countrystudies.us/Nigeria/19.htm.*

Chase, S. (2005). Chapter 25: Narrative inquiry. *The Sage Handbook of Qualitative Research* (3rd edition). *Thousand Oaks: Sage*, 651-679.

Chen, J. (2011). Internal migration and health: Re-examining the healthy migrant phenomenon in China. *Social Science & Medicine, 72*(8), 1294.

Chen, H., Xiong, P., Chen, L., & Hao, G. (2020). Childhood neighborhood quality, friendship, and risk of depressive symptoms in adults: the China health and retirement longitudinal study. *Journal of affective disorders*, 276, 732-737.

Chen, W., Zhang, Q., Renzaho, A., & Ling, L. (2019). The disparity in mental health between two generations of internal migrants (IMs) in China: Evidence from A nationwide cross-sectional study. *International Journal of Environmental Research and Public Health, 16*(14), 2608.

Chen, H., Zhu, Z., Sun, D., & Wang, X. (2016). The physical and psychological health of migrants in Guangzhou, China: How does neighborhood matter? *Inquiry: A Journal of Medical Care Organization, Provision, and Financing, 53.*

Chete, L. N., Adeoti, J. O., Adeyinka, F. M., & Ogundele, O. (2014). Industrial development and growth in Nigeria: Lessons and challenges (No. 2014/019). *WIDER working paper.*

Chikaodiri, A. N. (2009). Attitude of health workers to the care of psychiatric patients. *Annals of General Psychiatry, 8*(1), 1-7.

Chiwuzulum Odozi, J., Taiwo Awoyemi, T., & Omonona, B. T. (2010). Household poverty and inequality: The implication of migrants' remittances in Nigeria. *Journal of Economic Policy Reform, 13*(2), 191-199. doi:10.1080/17487871003700788

Cho, Y., & Haslam, N. (2010). Suicidal ideation and distress among immigrant adolescents: The role of acculturation, life stress, and social support. *Journal of Youth and Adolescence, 39*(4), 370-9.

Choo, H. Y., & Ferree, M. M. (2010). Practicing intersectionality in sociological research: A critical analysis of inclusions, interactions, and institutions in the study of inequalities. *Sociological Theory*, 28(2), 129-149.

Chou, K., Wong, W. K., F., Chow, N. W., & S. (2011). Interaction between pre-and post-migration factors on depressive symptoms in new migrants to Hong Kong from mainland China. *Community Mental Health Journal, 47*(5), 560-7.

Chukwu, J. O. (2017). Estimating inequality semi-elasticity of poverty reduction in Nigeria. *Social Indicators Research, 131*(3), 1087.

Chukwu, N. E., & Onyeneho, N. G. (2015). Sociocultural factors associated with abuse of mentally impaired persons in Imo state, Nigeria. *International Quarterly of Community Health Education, 35*(4), 349-370. doi:10.1177/0272684X15596094

Chukwuemeka, E. E., Chidiebere, O., & Okechukwu, E. (2013) Management of rural-urban migration and economic development in Nigeria: The case of Anambra state. *European Scientific Journal*, 9(34).

Chukwujekwu, C. D. (2018). Knowledge and attitude about mental illness of students in a university in southern Nigeria. *Journal of Biosciences and Medicines, 6*(6), 95-104.

Clarke, A. Y., & McCall, L. (2013). Intersectionality and social explanation in social science research. *Social Science Research on Race*, 10(2), 349-363.

Cleary, S. D., Snead, R., Dietz-Chavez, D., Rivera, I., & Edberg, M. C. (2018). Immigrant trauma and mental health outcomes among Latino youth. *Journal of Immigrant and Minority Health, 20*(5), 1053-1059.

Clement, J., (2019, Dec 02). Nigeria: Number of Internet users 2017-2023. *Statista.com/* statistics/183849/internet-users-Nigeria/

Cohen, L. and Manion, L. (1986) Research Methods in Education. *London*: *Croom Helm.*

Coker, A., Olibamoyo, O., Adewunmi, A., Osakwe, V., Taiwo, T., & Alonge, A. (2019). Help-seeking behaviour of individuals with mental illness before pursuing professional mental health care services in Lagos, Nigeria. *Communities, 1*, 5-7.

Coker, A. O., Olibamoyo, O., Adetiloye, B., & Adewunmi, N. (2018). Stigma and discrimination among individuals with mental disorders in Lagos, Nigeria: A qualitative study. *African Journal for the Psychological Studies of Social Issues, 21*(1), 114-124.

Cole, E. R., Avery, L. R., Dodson, C., & Goodman, K. D. (2012). Against nature: How arguments about the naturalness of marriage privilege heterosexuality. *Journal of Social Issues*, 68(1), 46-62.

Coleman, F. L. (1971). The northern Rhodesia Copperbelt, 1899-1962: Technological development up to the end of the central African federation *Manchester University Press.*

Collins, P. (1990). Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment. *London: Routledge.*

Connelly, L. M., & Yoder, L. H. (2000). Improving qualitative proposals: common problem areas. *Clinical Nurse Specialist*, 14(2), 69-74.

Copelj, A., & Kiropoulos, L. (2011). Knowledge of depression and depression related stigma in immigrants from former Yugoslavia. *Journal of Immigrant and Minority*

Health, 13(6), 1013-8. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1007/s10903-011-9463-8

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative sociology*, 13(1), 3-21.

Coutinho, Evandro Da Silva Freire, De Almeida Filho, N., De Jesus Mari, J., & Rodrigues, L. C. (1999). Gender and minor psychiatric morbidity: Results of a case-control study in a developing country. *The International Journal of Psychiatry in Medicine, 29*(2), 197-208.

Crain, R., Grzywacz, J. G., Schwantes, M., Isom, S., Quandt, S. A., & Arcury, T. A. (2012). Correlates of mental health among Latino farmworkers in North Carolina. *The Journal of Rural Health, 28*(3), 277-285.

Crenshaw, K. W. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine. *University of Chicago Legal Forum*, 139–168.

Crenshaw, K. (1991). "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color." *Stanford Law Review* 43: 1241–1299.

Creswell, J. W. (2007). Qualitative inquiry and research design: Choosing among five approaches. *Thousand Oaks, CA: Sage*

Creswell, J. W., and. Poth, C. N. (2016). Qualitative inquiry and research design: Choosing among five approaches. *Thousand Oaks, CA*: *Sage Press.*

Crotty, M. (1998) The foundations of social research: meaning and perspective in the research process. 1st ed. *London*: *Sage Publishers.*

Czarniawska, B. (2004). Narratives in social science research. *Sage.*

Daar, A. S., Jacobs, M., Wall, S., Groenewald, J., Eaton, J., Patel, V., ... & Ndetei, D. (2014). Declaration on mental health in Africa: Moving to implementation. *Global Health Action*, 7(1), 24589.

Dai, J., Zhong, B., Xiang, Y., Chiu, H. F. K., Chan, S. S. M., Yu, X., & Caine, E. D. (2015). Internal migration, mental health, and suicidal behaviors in young rural Chinese. *Social Psychiatry and Psychiatric Epidemiology, 50*(4), 621-631. doi:10.1007/s00127-014-0985-y

Dainty, A., Allcock, N., Cooper, J. (2014) Study of irritable bowel syndrome and co-existing psychological illness. *Nurse Researcher*, 21:4, pp 27-31.

Danladi, S. S. (2013). Language policy: Nigeria and the role of English language in the 21st century. *European Scientific Journal*, 9(17).

Dangana, J. F., Uwobuesor, R., & Soneye, O. (2020) autism spectrum disorder: Knowledge, attitudes, and perception among religious organizations in Nigeria. *Babcock Journal of Education (BUJED*). Vol. 6, No. 1, pp. xx-xx. ISSN: 1596-8823-0 (Print).

Das-Munshi, J., Clark, C., Dewey, M., Leavey, G., Stansfeld, S., & Prince, M. (2014). Born into adversity: Psychological distress in two birth cohorts of second-generation Irish children growing up in Britain. *Journal of Public Health, 36*(1), 92-103.

Davidson, B. (1965). Wanted: a library of African classics. *Africa Report,* 10(10), 24.

Davidson, C. (2009). Transcription: Imperatives for qualitative research. *International journal of qualitative methods*, *8*(2), 35-52.

Davidson, B., & Buah, F. K. (1967). The growth of African civilization: A history of West Africa 1000-1800. *(New and expanded ed.). London: Longmans.*

Davis, K. (2008). Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. *Feminist theory*, *9*(1), 67-85.

De Almeida-Filho, N. (1982). Internal migration and mental disorders: new evidence for an old hypothesis]. *Acta Psiquiatricay Psicologica De America Latina, 28*(1), 21-29.

de Almeida Vieira, A. P. T., & Serra, A. V. (2011). Vulnerability to stress in migratory contexts: a study with eastern European immigrants residing in Portugal. *Journal of immigrant and minority health,* 13(4), 690-696.

de Brauw A, Mueller V, and Woldehanna T. (2013) Does internal migration improve overall well-being in Ethiopia? *Ethiopia Strategy Support Program* II. 55.

de Castro, A. B., Gee, G. C., & Takeuchi, D. T. (2008). Job-related stress and chronic health conditions among Filipino immigrants. *Journal of Immigrant and Minority Health, 10*(6), 551-8. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1007/s10903-008-9138-2

de Freitas, M. H., & dos Santos, B. R. (2017). Religiosity and mental health among the immigrants in Brasília. *International Journal of Migration, Health, and Social Care, 13*(2), 207-219.

De Gramont, D. (2015). Governing Lagos: Unlocking the politics of reform (Vol. 12). Washington, DC: *Carnegie Endowment for international peace*.

De Haas, H. (2007). Turning the tide? Why development will not stop migration. *Development and Change,* 38(5), 819-841.

De Mola, C. L., Stanojevic, S., Ruiz, P., Gilman, R. H., Smeeth, L., & Miranda, J. J. (2012). The effect of rural-to-urban migration on social capital and common mental disorders: Peru Migrant study. *Social Psychiatry and Psychiatric Epidemiology., 47*(6), 967-973.

de Vries, K. M. (2015). Transgender people of colour at the centre: Conceptualizing a new intersectional model. *Ethnicities*, *15*(1), 3-27.

Deakin, H., & Wakefield, K. (2014). Skype interviewing: Reflections of two Ph.D. researchers. *Qualitative Research, 14*(5), 603-616.

Deci, E. L., & Ryan, R. M. (2008). Hedonia, eudaimonia, and well-being: An introduction. *Journal of happiness studies*, *9*(1), 1-11.

Delbar, V., Tzadok, L., Mergi, O., Erel, T. O., Haim, L., & Romem, P. (2010). Transcultural mental health care issues of Ethiopian immigration to Israel. *Advances in Mental Health*, *9*(3), 277-287.

Denzin, N.K. (1998) The new ethnography. *Journal of Contemporary Ethnography*, 27(3), 405-415.

Denzin, N. K., & Lincoln, Y. S. (1995). Transforming qualitative research methods: Is it a revolution? *Journal of Contemporary Ethnography*, 24(3), 349-358.

Denzin, N. K., & Lincoln, Y. S. (2002). The qualitative inquiry reader. *Sage.*

Denzin, N. K., & Lincoln, Y. S. (2008). Strategies of qualitative inquiry (Vol. 2). *Sage.*

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). The Sage handbook of qualitative research. *Sage.*

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological bulletin*, *125*(2), 276.

Dike, A. A. (1982). Urban migrants and rural development. *African Studies Review*, *25*(4), 85-94.

Diop, S., Barusseau, J. P., & Descamps, C. (Eds.). (2014). The land/ocean interactions in the coastal zone of west and central Africa. *Springer.*

Dogo, S. A. (2014). The Nigerian patriarchy: when and how. *Cultural and Religious Studies*, 2(5), 263-275.

Dogra, N., Omigbodun, O., Adedokun, T., Bella, T., Ronzoni, P., & Adesokan, A. (2012). Nigerian secondary school children's knowledge of and attitudes to mental health and illness. *Clinical Child Psychology and Psychiatry*, *17*(3), 336-353.

Dunn, G. (2018). The impact of the Boko Haram insurgency in Northeast Nigeria on childhood wasting: a double-difference study. *Conflict and health*, 12(1), 1-12.

Eaton, J., & Agomoh, A. O. (2008). Developing mental health services in Nigeria: The impact of a community-based mental health awareness programme. *Social Psychiatry and Psychiatric Epidemiology*, *43*(7), 552-558. doi:10.1007/s00127-008-0321-5

Eaton, J., Gureje, O., De Silva, M., Sheikh, T. L., Ekpe, E. E., Abdulaziz, M., . . . Onyuku, T. (2018). A structured approach to integrating mental health services into primary care: Development of the mental health scale-up Nigeria intervention (mhSUN). *International Journal of Mental Health Systems*, *12*(1), 1-12.

Eaton, J., Nwefoh, E., Okafor, G., Onyeonoro, U., Nwaubani, K., & Henderson, C. (2017). Interventions to increase use of services, mental health awareness in Nigeria. *International journal of mental health systems*, 11(1), 1-6.

Ebeigbe, P. N., & Akhigbe, K. O. (2008). Incidence and associated risk factors of postpartum depression in a tertiary hospital in Nigeria. *The Nigerian Postgraduate Medical Journal, 15*(1), 15-18.

Egbas, J., (April 26, 2021) Kaduna State University increases fees for non-indigenes from N26,000 to N500,000. *Pulse.ng*. retrieved from: https://www.pulse.ng/news/local/kaduna-state-increases-fees-for-non-indigenes-from-n26000-to-n500000/v4692cz.

Egwuonwu, C. C., Kanma-Okafor, O. J., Ogunyemi, A. O., Yusuf, H. O., & Adeyemi, J. D. (2019). Depression-related knowledge, attitude, and help-seeking behavior among residents of Surulere local government area, Lagos State, Nigeria. *Journal of Clinical Sciences, 16*(2), 49.

Ehirim, N., Onyeneke, R., Chidiebere-Mark, N., & Nnabuihe, V. (2012). Effect and prospect of rural to urban migration on the poverty status of migrants in Abia state, Nigeria. *Agricultural Science Research Journal, 2*(4), 145-153.

Ejiba, I. V., Onya, S. C., & Adams, O. K. (2016). Impact of oil pollution on livelihood: evidence from the Niger Delta region of Nigeria. *Journal of Scientific Research and Reports*, 1-12.

Ekwueme, O., & Aghaji, M. (2006). The concept and attitudes of primary health care workers towards mental illness in rural Igbo land of Nigeria. *International Journal of Medicine and Health Development, 11*(2), 125-129.

Elaigwu, J. I. (2005). Nigeria: Yesterday and today for tomorrow: Essays in governance and society *Aha Publishing House.*

Elegbeleye, A. (2014). Psycho-Social Predictors of Mental Health among Orphans in Southwest Nigeria: Efficacy of Psycho-Education Intervention *(Doctoral Dissertation, Covenant University).*

Else-Quest, N. M., & Hyde, J. S. (2016). Intersectionality in quantitative psychological research: I. Theoretical and epistemological issues. *Psychology of Women Quarterly*, *40*(2), 155-170.

Ely, M., Anzul, M., Friedman, T., & Gardner, D. (1991). Doing qualitative research: Circles within circles. Bristol, PA: *The Falmer Press.*

Emmanuel, N. O., William, F. M., Gladys, A., & Denis, Y. N. (2012). Microeconomic determinants of migrant remittances to Nigerian households. *Economics Bulletin, 32*(4), 3425-3438.

Emovon, A. C. (1976). The relationship between marital status and mental illness. *Mental Health and Society, 3*(1-2), 10-21.

Enfield, S. (2019). Gender Roles and Inequalities in the Nigerian Labour Market. *K4D Helpdesk Report. Brighton, UK: Institute of Development Studies.*

Erinosho, O. A. (1977). Belief-system and the concept of mental illness among medical students in a developing country: A Nigerian example. *Journal of Anthropological Research, 33*(2), 158-166.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). Doing naturalistic inquiry: A guide to methods. *Sage.*

Eshareturi, C. (2016). Mapping the offender health pathway: challenges and opportunities for support through community nursing. *ProQuest Dissertations Publishing*.

Eshareturi, C., & Serrant, L. (2018). Challenges and opportunities for ex-offender support through community nursing. *International journal of offender therapy and comparative criminology*, 62(14), 4642-4654.

Eshareturi, C., Serrant-Green, L., Bayliss-Pratt, L., & Galbraith, V. (2014). The case for nurses as central providers of health and social care services for ex-offenders: a discussion paper. *Journal of advanced nursing*, 70(5), 1030-1039.

Eshareturi, C., Serrant, L., Galbraith, V., & Glynn, M. (2015). Silence of a scream: application of the Silences Framework to provision of nurse-led interventions for ex-offenders. *Journal of Research in Nursing*, 20(3), 218-231.

Essang, S. M., & Mabawonku, A. F. (1974). Determinants and impact of rural-urban migration: A case study of selected communities in western Nigeria *Department of Agricultural Economics*, Michigan State University.

European Commission, (2018, July 19). EU provisions on cross-border data flow and protection of personal data and privacy in the digital trade title of EU trade agreements. *5th Round of Trade Negotiations between the EU and Indonesia*. Article 2.

Ewetan, O. O., & Ese, U. (2014). Insecurity and socio-economic development in Nigeria. *Journal of sustainable development studies*, 5(1), 40-63.

Ewhrudjakpor, C. (2009). Knowledge, beliefs, and attitudes of health care providers towards the mentally ill in delta state, Nigeria. *Studies on Ethno-Medicine, 3*(1), 19-25.

Ewhrudjakpor, C. (2010). A comparative study of knowledge and attitude of urban and rural dwellers towards vagrant sufferers of schizophrenia in delta state of Nigeria. *East African Journal of Public Health, 7*(2)

Eze, B. (2016). The underlying factors of rural-urban migration in southeastern Nigeria: A study in nsukka region of Enugu state. *IOSR Journal of Humanities and Social Science, 21*(7), 46-54.

Ezeala-Adikaibe, B., Achor, J., Onwukwe, J., Ekenze, O., Onwuekwe, I., Chukwu, O., . . . Obu, C. (2013). Knowledge, attitude, and practice towards epilepsy among secondary school students in Enugu, southeast Nigeria. *Seizure, 22*(4), 299-302.

Ezeme, M. S., Uwakwe, R., Ndukuba, A. C., Igwe, M. N., Odinka, P. C., Amadi, K., & Obayi, N. O. (2016). Socio-demographic correlates of treatment response among patients

with schizophrenia in a tertiary hospital in south-east Nigeria. *African Health Sciences, 16*(4), 1036-1044.

Fadlallah, M. M. A., Pal, I., & Chatterjee, J. S. (2020). Health Disparities: A Perspective on Internal Migration and Health Behaviour in Sudan. *Annals of global health*, 86(1).

Falavarjani, M. F., Yeh, C. J., & Brouwers, S. A. (2019). Exploring the effects of acculturative stress and social support on the acculturation-depression relationship in two countries of similar social status. *Journal of International Migration and Integration*, 1-20.

Falola, T. (1989). Politics and economy in Ibadan, *1893-1945 Modelor*.

Falola, T. (2020). Emerging democratic practices in Nigeria. Governance and leadership institutions in Nigeria (pp. 141-164) *Routledge.*

Falola, T., & Genova, A. (2009). Historical Dictionary of Nigeria-*The Scarecrow Press Inc*.

Falola, T., and Heaton, M, M. (2008). A history of Nigeria. *Cambridge UP,* (978-0-521-68157-5)

Famodu, O. O., Adebayo, A. M., & Adebayo, B. E. (2018). Child labour and mental health status of in-school adolescents in a municipal local government area of Lagos State, Nigeria. *International Journal of Adolescent Medicine and Health, 33(2), 20180075*.

Fay, B. (1987). Critical social science: Liberation and its limits. *Cornell University Press.*

Federal Ministry of Health. (2013, August). National policy for mental health services delivery. Retrievedhttps://cheld.org/wp-content/uploads/2015/02/*national_policy_for_mental_health_service_delivery__2013_.pdf* (accessed June 17, 2020).

Federal Republic of Nigeria (2003) Child Rights Act No 26. Assessed from: *https://lawsofnigeria.placng.org/laws/C50.pdf*

Federal Ministry of Nigeria (2016) Health Budget. Retrieved from: *https://www.health.gov.ng/doc/2016HealthBudget.pdf*

Federal Road Safety Corporation (2019) Annual Report 2019. https://frsc.gov.ng/wp-content/uploads/2020/12/2019-Annual-Report2.pdf

Felman, A (2020, April) What is Mental health? *Medical News Today*. https://www.medicalnewstoday.com/articles/154543.

Findley, S. (1997). Migration and family interactions in Africa. *Family, Population, and Development in Africa*, 109-138.

Fine, K. (1994). Essence and modality: The second philosophical perspectives lecture. *Philosophical perspectives*, 8, 1-16.

Fleitas, J. (1998). Spinning tales from the world wide web: Qualitative research in an electronic environment. *Qualitative Health Research, 8*(2), 283-292.

Flick, U. (2008). Managing quality in qualitative research. *Sage.*

Food and Agriculture Organisation of the United Nations (2018) Small Family Farms Country Factsheet. Nigeria. *FAO*. http://www.fao.org/3/i9930en/I9930EN.pdf

Fox News. *(*2014, June 23)"Nigeria says 219 girls in Boko Haram kidnapping still missing".. *Retrieved August 2014*.

Fozdar, F. (2009). The Golden Country': Ex-Yugoslav and African Refugee Experiences of Settlement and 'Depression. *Journal of Ethnic and Migration Studies*, 35(8), 1335-1352.

France 24 (2020, April 6) *"Suspected Boko Haram suicide bombers kill several in northern Cameroon"*. *Retrieved* 12 April *2020*.

Freshwater, D., & Cahill, J. (2013). Paradigms lost, and paradigms regained. *Journal of mixed methods research*. Volume 7, issue 1. https://doi.org/10.1177/1558689812471276.

Fritz, M. V., Chin, D., & DeMarinis, V. (2008). Stressors, anxiety, acculturation, and adjustment among international and North American students. *International Journal of Intercultural Relations, 32*(3), 244-259.

Fu Keung Wong, D., & Song, H. X. (2008). The resilience of migrant workers in Shanghai China: The roles of migration stress and meaning of migration. *International Journal of Social Psychiatry, 54*(2), 131-143.

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World psychiatry*, *14*(2), 231.

Gao, L., Penning, M. J., Wu, Z., Sterrett, S. J., & Li, S. (2020). Internal Migration and the Health of Middle-Aged and Older Persons in China: The Healthy Migrant Effect Reconsidered. *Research on Aging*, 0164027520958760.

Gao, L., Wu, Z., & z Li, S. (2019). Internal Migration and Health Changes: A longitudinal study of Chinese adults in mid and later life. *Innovation in Aging*, 3(1), S796.

Garga, E. (2015). The effects of insecurity and poverty on human development at the municipal level in the northern Nigeria. *Journal of Emerging Trends in Economics and Management Sciences, 6*(7), 268-276.

Garuba, D. S. (2006). Survival at the margins: Economic crisis and coping mechanisms in rural Nigeria. *Local Environment, 11*(1), 17-36.

Gberie, L. (2017). Mental illness: Invisible but devastating. *Africa Renewal, 30*(3), 18-19.

Gbiri, C. A., Badru, F. A., Ladapo, H. T. O., & Gbiri, A. A. (2011). Socio-economic correlates of relapsed patients admitted in a Nigerian mental health institution.

International Journal of Psychiatry in Clinical Practice, 15(1), 19-26. doi:10.3109/13651501.2010.506954

Geertz, C. (1973). The interpretation of cultures (Vol. 5019). *Basic books.*

Giles, D. (1977). Short, 'Blood and treasure the reduction of Lagos, 1851'. *ANU Historical Journal. 13*(0012068.)

Gimba, Z., & Kumshe, M. G. (2011). Causes and effects of rural-urban migration in Borno state: A case study of Maiduguri metropolis. *Asian Journal of Business and Management Sciences, 1*(1), 168-172.

Ginsburg, C., Bocquier, P., Béguy, D., Afolabi, S., Augusto, O., Derra, K., . . . Collinson, M. A. (2016). Healthy or unhealthy migrants? Identifying internal migration effects on mortality in Africa using health and demographic surveillance systems of the IN-DEPTH network. *Social Science and Medicine,* 164, 59-73.

Glesne, C. & Peshkin, A. (1992). Becoming qualitative researchers: An introduction. White Plains, *NY: Longman.*

Goglia, F. (no date) Nigerian Pidgin English. Manchester Working Group on Language Contact. *The University of Manchester.*

Govera, H., & Bayat, A. (2020). Differences in Mental Health among Migrants and Non-migrants in South Africa: Evidence from the National Income Dynamics Study. *AHMR,* 74.

Grant, B. F., Stinson, F. S., Hasin, D. S., Dawson, D. A., Chou, S. P., & Anderson, K. (2004). Immigration and lifetime prevalence of DSM-IV psychiatric disorders among Mexican Americans and non-Hispanic whites in the United States: Results from the national epidemiologic survey on alcohol and related conditions. *Archives of General Psychiatry, 61(12)., 61*(12), 1226-1233.

Gray, D.E. (2014) Doing research in the real world. London: *Sage.*
Green, M. C. (2006). Narratives and cancer communication. *Journal of communication,* 56, S163-S183.

Green, M. A., Subramanian, S. V., Vickers, D., & Dorling, D. (2015). Internal migration, area effects, and health: Does where you move to impact upon your health? *Social Science & Medicine, 136,* 27-34. doi: 10.1016/j.socscimed.2015.05.011

Green, J., and Thorogood, N. (2014). Beginning data analysis. *Qualitative methods for health research,* 3, 205-215.

Greene, G., Gartner, A., Farewell, D., Trefan, L., Davies, A. R., Bellis, M. A., & Paranjothy, S. (2020). Mental health selection: common mental disorder and migration between multiple states of deprivation in a UK cohort. *BMJ Open,* 10(2), e033238. doi:10.1136/ bmjopen-2019-033238

Greenhalgh, T., and Peacock, R. (2005) Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources. *British Medical Journal*, 331:7524.

Gregory, K. (2019). Lessons of a failed study: Lone research, media analysis and the limitations of bracketing. *International Journal of Qualitative Methods*, 18.

Grix, J. (2002). Introducing students to the generic terminology of social research. *Politics*, 22(3), 175-186.

Groleau, D., Zelkowitz, P., & Cabral, I. E. (2009). Enhancing generalizability: Moving from an intimate to a political voice. *Qualitative health research*, 19(3), 416-426.

Guan, M. (2017). Measuring the effects of socioeconomic factors on mental health among migrants in urban China: A multiple indicators multiple causes model. *International Journal of Mental Health Systems, 11*, n/a.

Gulf Times *(2018, January 19) "Six Nigerian troops killed in Boko Haram raid*". . Retrieved 19 January 2018.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *ECTJ*, 29(2), 75-91. https://doi.org/10.1007/BF02766777

Guba, E. G., & Lincoln, Y. S. (1989). Fourth generation evaluation. *Sage.*

Guba, E.(1990). The paradigm dialog. Beverly Hills, CA: *Sage.* 105-117

Guo, M., Liu, J., Xu, L., Mao, W., & Chi, I. (2018). Intergenerational relationships and psychological well-being of Chinese older adults with migrant children: Does internal or international migration make a difference? *Journal of Family Issues, 39*(3), 622-643.

Gureje, O. (2002). Psychological disorders and symptoms in primary care. *Social Psychiatry and Psychiatric Epidemiology, 37*(5), 220-224.

Gureje, O., Abdulmalik, J., Kola, L., Musa, E., Yasamy, M. T., & Adebayo, K. (2015). Integrating mental health into primary care in Nigeria: Report of a demonstration project using the mental health gap action programme intervention guide. *BMC Health Services Research, 15*(1), 1-8.

Gureje, O., & Alem, A. (2000). Mental health policy development in Africa. *Bulletin of the World Health Organization, 78*, 475-482.

Gureje, O., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *The British Journal of Psychiatry, 186*(5), 436-441.

Gureje, O., Lasebikan, V. O., Kola, L., & Makanjuola, V. A. (2006). Lifetime and 12-month prevalence of mental disorders in the Nigerian survey of mental health and well-being. *The British Journal of Psychiatry, 188*(5), 465-471.

Gureje, O., Makanjuola, V. A., & Kola, L. (2007). Insomnia and role impairment in the community: Results from the Nigerian survey of mental health and wellbeing. *Social Psychiatry and Psychiatric Epidemiology, 42*(6), 495-501.

Gureje, O., & Saxena, S. (2006). WHO-AIMS report on Mental Health System in Nigeria. *WHO and Ministry of Health, Ibadan, Nigeria,*

Gurje, O., Uwakwe, R., Udofia, O., Wakil, A., Adeyemi, O., & Enyidah, N. (2008). Common psychiatric disorders over a lifetime: Age of onset, risk, and treatment contact in the Nigerian survey of mental health and wellbeing. *African Journal of Medicine and Medical Sciences, 37*(3), 207-217.

Gureje, O., Uwakwe, R., Oladeji, B., Makanjuola, V. O., & Esan, O. (2010). Depression in adult Nigerians: Results from the Nigerian survey of mental health and well-being. *Journal of Affective Disorders, 120*(1-3), 158-164. doi: 10.1016/j.jad.2009.04.030

Habib, Z. G. (2020). Perception of parents to childhood psychiatric disorders in Nigeria. *Open Journal of Psychiatry, 10*(2), 69-82.

Hains, R., (2013). Northern Nigeria: The illo canceller and borgu mall' .*13*(3)

Hancock, A. M. (2007). Intersectionality as a normative and empirical paradigm. *Politics & Gender*, *3*(2), 248-254.

Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: a Canadian perspective. *Critical Public Health*, *18*(3), 271-283.

Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010). Exploring the promises of intersectionality for advancing women's health research. *International journal for equity in health*, *9*(1), 1-15.

Hao, Z., & Cui, L. (2015). The role of intergroup permeability on Chinese migrant children's social integration. *Social Behavior and Personality, 43*(2), 303-314.

Harris, M. (1968). The rise of anthropological theory. New York: Thomas Y. *Crowell Company.*

Hesse-Biber, S., & Griffin, A. J. (2013). Internet-mediated technologies and mixed methods research: Problems and prospects. *Journal of Mixed Methods Research, 7*(1), 43-61.

Hewson, C. (2008). Internet-mediated research as an emergent method and its potential role in facilitating mixed methods research. *Handbook of Emergent Methods,* 543-570.

Higgins, J.P.T. and Green, S. (Eds) (2011) Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0 *The Cochrane Collaboration.* (Accessed 5 January 2019).

Hoffman, S. (2013). Suicidal ideation and migration aspirations among youth in central Mexico. *Global Journal of Health Science, 6*(1), 92-98. doi:10.5539/gjhs. v6n1p92 [doi]

Hoi, C. K., Chen, W., Zhou, F., Sou, K., & Hall, B. J. (2015). The association between social resources and depressive symptoms among Chinese migrants and non-migrants living in Guangzhou, China. *Journal of Pacific Rim Psychology, 9*(2), 120-129.

Hollis, M. (1994). The philosophy of social science*:* An introduction. *Cambridge University Press.*

Hombrados-Mendieta, I., Millán-Franco, M., Gómez-Jacinto, L., Gonzalez-Castro, F., Martos-Méndez, M. J., & García-Cid, A. (2019). Positive influences of social support on sense of community, life satisfaction and the health of immigrants in Spain. *Frontiers in psychology*, 10, 2555.

Hong, Y., Li, X., Stanton, B., Lin, D., Fang, X., Rong, M., & Wang, J. (2006). Too costly to be ill: Healthcare access and health-seeking behaviors among rural-to-urban migrants in China. *World Health & Population, 8*(2), 22-34.

Hooley, T., Wellens, J., & Marriott, J. (2012). What is Online research? Using the Internet for social science research. *A&C Black.*

Hooten, W. M. (2016). Chronic pain and mental health disorders: Shared neural mechanisms, epidemiology, and treatment. Paper presented at the *Mayo Clinic Proceedings, 91*(7) 955-970.

Horrell, B., Stephens, C., & Breheny, M. (2015). Online research with informal caregivers: Opportunities and challenges. *Qualitative Research in Psychology, 12*(3), 258-271.

Hou, B., Nazroo, J., Banks, J., & Marshall, A. (2019). Impacts of migration on health and well-being in later life in China: Evidence from the China health and retirement longitudinal study (CHARLS). *Health and Place*, doi: 10.1016/j.healthplace.2019.01.003

Hounkpatin, H. O., Wood, A. M., Brown, G. D., & Dunn, G. (2015). Why does income relate to depressive symptoms? Testing the income rank hypothesis longitudinally. *Social Indicators Research, 124*(2), 637-655.

Hovey, J. D., & Magaña, C. G. (2002). Exploring the mental health of Mexican migrant farmworkers in the Midwest: Psychosocial predictors of psychological distress and suggestions for prevention and treatment. *The Journal of Psychology, 136*(5), 493-513.

Huberman, M., & Miles, M. B. (2002). The qualitative researcher's companion. *Sage.*

Human Rights Watch (2006). They do not own this place – government discrimination against non-indigenes in Nigeria, [online] Available at: *https://www.hrw.org/report/2006/04/25/they-do-not-own-place/government-discrimination-against-nonindigenes-nigeria* [Accessed 30 September 2018].

Human Rights Watch. (2013). Nigeria: Turning a blind eye to mass killings. *Human Rights Watch.* Available at: *https://www.hrw.org/news/2013/12/12/nigeria-turning-blind-eye-mass-killings*

Human Rights Watch USA (2015, January 12). *: Nigeria | Human Rights Watch". Hrw.org. Retrieved* 21 May *2016.*

Hummel, D. (2016). Inter-state internal migration: State-level wellbeing as a cause. *Journal of Happiness Studies, 17*(5), 2149-2165.

Ibaba, I. S. (2011). Local government and the failure of rural development in Nigeria: Exploring the role of political participation. *Journal of Social Development in Africa, 26*(2), 93-115.

Ibeziako, P., Bella, T., Omigbodun, O., & Belfer, M. (2009). Teachers' perspectives of mental health needs in Nigerian schools. *Journal of Child & Adolescent Mental Health,* 21(2), 147-156.

Ibrahim, A.N. (2016) Influence of socio-cultural values on girl-child education in Yobe state, Nigeria. *Doctoral Dissertation, Universiti, Putra Malaysia*.

Idemudia, E. S. (2014). Associations between demographic factors and perceived acculturative stress among African migrants in Germany. *African Population Studies, 28*(1), 449-462.

Idowu, A. A. (2013). Security laws and challenges in Nigeria: The Boko haram insurgency. *Journal of Applied Security Research, 8*(1), 118-134.

Igbafe, E. C. (2021). Exploring Ethnic Marginalisation and Indigene-Settler Problems in University Life in Nigeria. *Education Research International*, 2021.

Igberase, O., & Okogbenin, E. (2017). Beliefs about the cause of schizophrenia among caregivers in midwestern Nigeria. *Mental Illness, 9(1) ISSN: 2036-7465.*

Igbo-Anugo, A., (Sep 20, 2017) Lagos is the 'third most stressful city in the world. *The Cable* Lifestyle. Available at: *https://lifestyle.thecable.ng/lagos-third-stressful-cities-world/#:~:text=A%20new%20study%20has%20said,stressful%20cities%20in%20the%20world.&text=500%20locations%20were%20taken%20into,least%20stressful%20cities%20of%202017.*

Ighodaro, A. A. (2017). Analysis of attitudes toward mental illness among medical professionals in Ibadan, Nigeria. *Yale Medicine Thesis Digital Library.* 2132. https://elischolar.library.yale.edu/ymtdl/2132.

Ighodaro, A., Stefanovics, E., Makanjuola, V., & Rosenheck, R. (2015). An assessment of attitudes towards people with mental illness among medical students and physicians in Ibadan, Nigeria. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 39*(3), 280-285. doi:10.1007/s40596-014-0169-9

Igwe, C. N., Oyelola, O. T., Ajiboshin, I. O., & Raheem, S. (2013). A Review: Nigeria's Transportation System and the Place of Entrepreneurs. *Journal of Sustainable Development Studies*, 3(2).

Ihaji, E. O., Awopetu, R. G., & Aku, M. M. (2013). Attitude of tiv people of Benue state Nigeria towards mental illness. *IFE PsychologIA: An International Journal, 21*(2), 309-314.

Iheanacho, T., Marienfeld, C., Stefanovics, E., & Rosenheck, R. A. (2014). Attitudes toward mental illness and changes associated with a brief educational intervention for medical and nursing students in Nigeria. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38*(3), 320-324. doi:10.1007/s40596-014-0073-3

Iheanacho, T., Kapadia, D., Ezeanolue, C. O., Osuji, A. A., Ogidi, A. G., Ike, A., . . . Ezeanolue, E. E. (2016). Attitudes and beliefs about mental illness among church-based lay health workers: Experience from a prevention of mother-to-child HIV transmission trial in Nigeria. *International Journal of Culture and Mental Health, 9*(1), 1-13.

Iheanacho, T., Stefanovics, E., & Ezeanolue, E. E. (2018). Clergy's beliefs about mental illness and their perception of its treatability: Experience from a church-based prevention of mother-to-child HIV transmission (PMTCT) trial in Nigeria. *Journal of Religion and Health, 57*(4), 1483-1496.

Ihezue, U. (1983). Psychiatric in-patients in Anambra state, Nigeria: A psychosocial study. *Acta Psychiatrica Scandinavica, 68*(4), 277-286.

Ihezue, U. H., & Kumaraswamy, N. (1986). Socio-demographic factors of depressive illness among Nigerians. *Acta Psychiatrica Scandinavica, 73*(2), 128-132.

Ihezue, U., Kumaraswamy, N., & Onuora, A. (1986). Socio-economic status and mental Disorder—Profile of a Nigerian psychiatric inpatient population. *International Journal of Social Psychiatry, 32*(1), 29-38.

Ikime, O. (1985) In Search of Nigerians: Changing Patterns of Inter-group Relations in an Evolving Nation-State, Nigeria: *Historical Society of Nigeria.*

Ikime, O. (2002). The Nigerian civil war and the national question: A historical analysis. Osaghae EE, Onwudiwe, E & Suberu, RT the Nigerian Civil War and its Aftermath. *Ibadan: John Archers Publishers Ltd.*

Ikuteyijo L.O. (2020) Irregular Migration as Survival Strategy: Narratives from Youth in Urban Nigeria. In: McLean M. (eds) West African Youth Challenges and Opportunity Pathways. *Gender and Cultural Studies in Africa and the Diaspora. Palgrave Macmillan*, Cham. https://doi.org/10.1007/978-3-030-21092-2_3.

Ikwuka, U., Galbraith, N., & Nyatanga, L. (2014). Causal attribution of mental illness in south-eastern Nigeria. *International Journal of Social Psychiatry, 60*(3), 274-279.

Ikwuka, U., Galbraith, N., Manktelow, K., Chen-Wilson, J., Oyebode, F., & Muomah, R. C. (2016). Attitude towards mental illness in southeastern Nigeria: The contradictions of a communitarian culture. *Journal of Community Psychology, 44*(2), 182-198.

Ikwuyatum, G. O. (2018). Self-rated mental health status among households in Ibadan region, Nigeria. *Human Geography,*

Ilechukwu, S. T. C. (1988). Inter-relationships of beliefs about mental illness, psychiatric diagnoses, and mental health care delivery among Africans. *International Journal of Social Psychiatry, 34*(3), 200-206. doi:10.1177/002076408803400305

Ilesanmi, O. S., & Ige, O. K. (2013). Equity of care: A comparison of National Health Insurance Scheme enrolees and fee-paying patients at a private health facility in Ibadan, Nigeria. *Journal of Public Health and Epidemiology*, 5, 51-5. DOI: 10.5897/JPHE12.047. ISSN 2141-2316.

International Organisation for Migration. (2011). World migration report 2011: Communicating effectively about migration *International Organization for Migration.*

International Organisation for Migration (2019) Glossary on Migration. *International Organization for Migration.*

International Organisation for Migration. (2020). World migration report 2020: Migration and health: Current issues, governance and knowledge gaps. e-ISBN 978-92-9068-789-4. *https://publications.iom.int/system/files/pdf/wmr_2020.pdf.*

International Organisation for Migration (2021, August) Displacement tracking matrix (DTM). *Displacement Report 37.*

Irani, E. (2019). The Use of Videoconferencing for Qualitative Interviewing: Opportunities, Challenges, and Considerations. *Clinical Nursing Research*, 28(1), 3–8. https://doi.org/10.1177/1054773818803170,

Irfaeya, M., Maxwell, A. E., & Krämer, A. (2008). Assessing psychological stress among Arab migrant women in the city of Cologne/Germany using the community-oriented primary care (COPC) approach. *Journal of Immigrant and Minority Health, 10*(4), 337-44. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1007/s10903-007-9091-5

Iruonagbe, C. T. (2009). Land ownership patterns and the economic life of women: a study of Ozalla Community, Edo State, Nigeria *Doctoral dissertation, Covenant University.*

Isa, E. W., Ani, C., Bella-Awusah, T., & Omigbodun, O. (2018). Effects of psychoeducation plus basic cognitive behavioral therapy strategies on medication-treated adolescents with depressive disorder in Nigeria. *Journal of Child & Adolescent Mental Health, 30*(1), 11-18.

Isiugo- Abanihe, U. (1995). Bridewealth, marriage, and fertility in the east-central states of Nigeria. *Genus*, 51(3/4), 151-178. Retrieved April 23, 2021, from http://www.jstor.org/stable/29789205

Ismayilova, L., Lee, H. N., Shaw, S., El-Bassel, N., Gilbert, L., Terlikbayeva, A., & Rozental, Y. (2014). Mental health and migration: Depression, alcohol abuse, and access

to health care among migrants in central Asia. *Journal of Immigrant and Minority Health, 16*(6), 1138-1148. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1007/s10903-013-9942-1

Issa, B. A., Parakoyi, D. B., Yussuf, A. D., & Musa, I. O. (2008). caregivers' knowledge of etiology of mental illness in a tertiary health institution in Nigeria. *Iranian Journal of Psychiatry and Behavioral Sciences (IJPBS)*, 2(1), 43-49.

Issa, B. A., Yussuf, A. D., Olanrewaju, G. T., & Abiodun, O. A. (2014). Mental health of doctors in a tertiary hospital in Nigeria. *The Pan African Medical Journal, 19*, 178-178. doi:10.11604/pamj.2014.19.178.3642

Iweze, D. (2020). Insurgency in the northeast region of Nigeria and its implications on inter-state and trans-border mobility, 2009-2016. *Canadian Journal of African Studies/Revue Canadienne Des Études Africaines, 54*(2), 319-327.

Jack-Ide, I., Amiegheme, F., & Ongutubor, K. (2016a). Undergraduate nursing students' mental health and psychiatric clinical experience and their career choice in nursing: Perspectives from the Niger Delta region of Nigeria. *Journal of Mental Disorder Treatment, 2*(2), 116-121.

Jack-ide, I. O., Azebri, B., Ongutubor, K., & Amiegheme, F. (2016b). Secondary school students' awareness and attitudes towards mental health disorders in Bayelsa state, Nigeria. *Annals of Behavioral Science, 2*(2)

Jack-Ide, I. O., Uys, L. R., & Middleton, L. E. (2013). Caregiving experiences of families of persons with serious mental health problems in the Niger Delta region of Nigeria. *International Journal of Mental Health Nursing, 22*(2), 170-179.

Jackson, A. (2007). Nigeria: A security overview. *The Round Table, 96*(392), 587-603.

James, B. O., Igbinomwanhia, N. G., & Omoaregba, J. O. (2014). Clergy as collaborators in the delivery of mental health care: An exploratory survey from Benin city, Nigeria. *Transcultural Psychiatry, 51*(4), 569-580. doi:10.1177/1363461514525219

James, B. O., Omoaregba, J. O., & Okogbenin, E. O. (2012). Stigmatising attitudes towards persons with mental illness: A survey of medical students and interns from southern Nigeria. *Mental Illness, 4(1) ISSN: 2036-7465.*

James, B. O., Thomas, I. F., Omoaregba, J. O., Okogbenin, E. O., Okonoda, K. M., Ibrahim, A. W., . . . Aweh, B. E. (2017). Psychosocial correlates of perceived stress among undergraduate medical students in Nigeria. *International Journal of Medical Education, 8*, 382-388. doi: ijme.8.382388 [pii]

James, P. B., Wardle, J., Steel, A., & Adams, J. (2018). Traditional, complementary and alternative medicine use in Sub-Saharan Africa: A systematic review. *BMJ Global Health*, 3, e000895. doi:10.1136/ bmjgh-2018-000895

Janes, G. (2016). Silent slips, trips, and broken hips: the recovery experiences of young adults following an isolated fracture of the proximal femur. *ProQuest Dissertations Publishing.*

Janes, G., Serrant, L., & Sque, M. (2018). Fragility hip fracture in the under 60s: a qualitative study of recovery experiences and the implications for nursing. *Journal of Trauma and Orthopaedic Nursing*, 2(1).

Janes, G., Serrant, L., & Sque, M. (2019). Screaming silences: lessons from the application of a new research framework. *Nurse researcher*, 26(2), 32-36.

Jegede, R. O. (1981). A study of the role of socio-cultural factors in the treatment of mental illness in Nigeria. *Social Science and Medicine, 15A* (1), 49-54.

Jestl, S., Moser, M., & Raggl, A. K. (2017). Can't keep up with the joneses: How relative deprivation pushes internal migration in Austria. *Wiiw Working Paper.*, doi:(No. 137).

Jidda, M., Abdulmalik, J., Abddulaziz, M., Uwakwe, R., Wakil, M., & Rabbebe, I. (2013). Prevalence and factors responsible for stigmatization of the mentally ill among student nurses in north-eastern Nigeria. *Nigerian Journal of Psychiatry, 11*(1), 18-23.

Jidong, D. E., Bailey, D., Sodi, T., Gibson, L., Sawadogo, N., Ikhile, D., ... & Mbah, M. (2021). Nigerian cultural beliefs about mental health conditions and traditional healing: a qualitative study. *The Journal of Mental Health Training, Education and Practice*, 16(4) ISSN: 1755-6228.

John-Akinola, Y. O., Ajayi, A. O., & Oluwasanu, M. M. (2020). Experience of stress and coping mechanism among police officers in southwestern Nigeria. *International Quarterly of Community Health Education*, *41*(1), 7-14.

Johnnie, P. B. (1988). Rural-urban migration in Nigeria: Consequences on housing, healthcare, and employment. *Migration World Magazine, 16*(3), 22-29.

Johnson, O. E., & Benson, B. M. (2017). Perception of and attitude towards mental illness among residents of a community in south-south Nigeria. *Perception, 10*(2)

Johnson, M., O'Hara, R., Hirst, E., Weyman, A., Turner, J., Mason, S., ... & Siriwardena, A. N. (2017). Multiple triangulation and collaborative research using qualitative methods to explore decision-making in pre-hospital emergency care. *Bio-Med Central medical research methodology*, *17*(1), 1-11.

Johnson, J. E., and Taylor, E. J. (2019). The long-run health consequences of rural-urban migration. *Quantitative Economics*, 10(2), 565-606.

Joint United Nations Programme on HIV/AIDS (2002, July) Report on the global HIV/AIDS epidemic. *UN/AIDS/02.26E*. ISBN 92-1973-185-4.

Jombo, H. E., & Idung, A. U. (2018). Stigmatising attitudes towards persons with mental illness among university students in uyo, south-south Nigeria. *International Journal of Health Sciences and Research, 8*(4), 24-31.

Jombo, H. E., Idung, A. U., & Iyanam, V. E. (2019). Knowledge, attitudes, and perceptions about mental illness in ekom iman community in Akwa Ibom state, south-south Nigeria. *Asian Journal of Medicine and Health*, 1-9.

Jyothi, N. U., Bollu, M., Ali, S. F., Chaitanya, D. S., & Mounika, S. (2015). A questionnaire survey on students' attitudes towards individuals with mental illness. *Journal of Pharmaceutical Sciences and Research, 7*(7), 393.

Kabeer, N. (2010) Can the MDGs Provide a Pathway to Social Justice? The Challenge of Intersecting Inequalities, *MDG Achievement Fund*, Brighton: IDS.

Kabir, M., Iliyasu, Z., Abubakar, I. S., & Aliyu, M. H. (2004). Perception and beliefs about mental illness among adults in karfi village, northern Nigeria. *BMC International Health and Human Rights, 4*(1), 1-5.

Kadafa, A. A. (2012). Oil exploration and spillage in the Niger Delta of Nigeria. *Civil and Environmental Research*, 2(3), 38-51.

Kaduna State, Nigeria. (2018, May 30). Population statistics, charts, map and location". *Retrieved from www.citypopulation.de.* Retrieved 2018-05-30.

Kahuna, V.K. (2000) 'Being' native versus 'going native': Conducting social work research as an insider. *Social Work*, 45:5, p439-447.

Kaiser, B. N., Ticao, C., Boglosa, J., Minto, J., Chikwiramadara, C., Tucker, M., & Kohrt, B. A. (2020). Mental health and psychosocial support needs among people displaced by Boko haram in Nigeria. *Global Public Health, 15*(3), 358-371.

Kapadia, D., Iheanacho, T., Osuji, A., Ike, A., Patel, D., Obiefune, M., & Ezeanolue, E. E. (2015). Perception and attitudes towards mental illness among volunteer health advisors in Nigeria. *Annals of Global Health,* 81(1). *doi: 10.1016/j.aogh.2015.02.717.*

Kayode, O., Babatunde, O., & Abiodun, F. (2013). An empirical analysis of transport infrastructure investment and economic growth in Nigeria. *Social Sciences*, 2(6), 179-188.

Keanu, G.C., (no date): Zoom at a Glance. UC Riverside. *The University of California*.

Kearney, R. N., & Miller, B. D. (1988). Suicide and internal migration in Sri Lanka. *Journal of Asian and African Studies, 23*(3-4), 287-304.

Kelechi, O. S., Effiong, W. U., & Pam, M. J. (2019). Epilepsy Knowledge among Medical Students of University of Calabar, Nigeria. *Saudi Journal of Medical and Pharmaceutical Sciences.* DOI:10.21276/sjmps.2019.5.1.5

Kenny, A. J. (2005). Interaction in cyberspace: An online focus group. *Journal of Advanced Nursing, 49*(4), 414-422.

Kesornsri, S., Sitthimongkol, Y., Punpuing, S., Vongsirimas, N., & Hegadoren, K. M. (2019). Mental health and related factors among migrants from Myanmar in Thailand. *Journal of Population and Social Studies [JPSS], 27*(2), 124-138.

Keyes, C. L. (2006). Mental health in adolescence: is America's youth flourishing? *American journal of orthopsychiatry*, *76*(3), 395-402.

Keyes, C. L. (2014). Mental health as a complete state: How the salutogenic perspective completes the picture. *Bridging occupational, organizational and public health*, 179-192.

Khan, M. M. H., & Kraemer, A. (2014). Are rural-urban migrants living in urban slums more vulnerable in terms of housing, health knowledge, smoking, mental health, and general health? *International Journal of Social Welfare, 23*(4), 373-383. doi:10.1111/ijsw.12053

Khawaja, N. G., & Dempsey, J. (2008). A comparison of international and domestic tertiary students in Australia. *Journal of Psychologists and Counsellors in Schools, 18*(1), 30-46.

Kim, H. J., Pearce, M., & Choi-kwon, S. (2015). Religious attendance, health-promoting lifestyle behaviors, and depressive symptoms among Koreans in the United Arab Emirates (UAE). *Journal of Immigrant and Minority Health, 17*(4), 1098-1104.

Kincheloe, JL, & McLaren, P. (2008). Critical pedagogy: What are we talking about, where are we (Vol. 23). *Grao*.

King, N., Horrocks, C., & Brooks, J. (2018). Interviews in qualitative research *SAGE Publications Limited.*

Kirchner, T., & Patiño, C. (2011). Latin-American immigrant women and mental health: Differences according to their rural or urban origin. *The Spanish Journal of Psychology, 14*(2), 843-850.

Kirk, N., Alan C., Fishman, N., and McIlroy, J. eds., (2003) British trade unions and industrial politics. *International Labour and Working-Class History*, *63*, 165-167.

Koelet, S., & de Valk, H. A. (2016). Social networks and feelings of social loneliness after migration: The case of European migrants with a native partner in Belgium. *Ethnicities*, 16(4), 610-630.

Kosec, K., Mueller, V., & Chen, J. (2018). Moving to despair? Migration and well-being in Pakistan. *Research in Agricultural and Applied Economics.*

Koubi, V., Spilker, G., Schaffer, L., & Böhmelt, T. (2016). The role of environmental perceptions in migration decision-making: Evidence from both migrants and non-migrants in five developing countries. *Population and Environment, 38*(2), 134-163.

Krämer, A., Prüfer-Krämer, L., Stock, C., & Tshiananga, J. T. (2004). Differences in health determinants between international and domestic students at a German university. *Journal of American College Health, 53*(3), 127-32.

Krueger, R. A., & Casey, M. A. (2009). Focus groups: A practical guide for applied research (4th ed.). San Francisco: *Sage*

Krupinski, J. (1984). Changing patterns of migration to Australia and their influence on the health of migrants. *Social Science & Medicine (1982), 18*(11), 927-937.

Kryza, F. T. (2007). The race of Timbuktu. *Harper Collins, New York.,* (978-0-06-056064-5.)

Kumparatana, P., Cournos, F., Terlikbayeva, A., Rozental, Y., & Gilbert, L. (2017). Factors associated with self-rated health among migrant workers: Results from a population-based cross-sectional study in Almaty, Kazakhstan. *International Journal of Public Health, 62*(5), 541-550. doi:10.1007/s00038-017-0944-y

Kurré, J., Scholl, J., Bullinger, M., & Petersen-Ewert, C. (2011). Integration and health-related quality of life of undergraduate medical students with migration backgrounds results of a survey. *Psycho-Social Medicine, 8*, Doc07-Doc07. doi:10.3205/psm000076

Kuyinu, Y. A., Femi-Adebayo, T. T., Adebayo, B. I., Abdurraheem-Salami, I., & Odusanya, O. O. (2020). Health literacy: Prevalence and determinants in Lagos state, Nigeria. *Plos One, 15*(8), e0237813.

Kvale, S., & Brinkmann, S. (2009). Interviews: Learning the craft of qualitative research interviewing. *Sage*.

Kwaja, C. (2011). Nigeria's pernicious drivers of ethnoreligious conflict *Africa Centre for Strategic Studies Washington, DC.*

Labinjo, T., Serrant, L., Ashmore, R., & Turner, J. (2020). Perceptions, attitudes and cultural understandings of mental health in Nigeria: A scoping review of published literature. *Mental Health, Religion & Culture, 23*(7), 606-624.

Lacey, L. (1985). Interurban flows of population and occupational skills to three cities in Nigeria. *International Migration Review, 19*(4), 686-707. doi:10.2307/2546104

Lambu, I. B. (2020). Hausanization of Nigerian cultures. *Handbook of the changing world language map*, 1145-1153.

Larkin, M., Watts, S. and Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 102-120.

Lasebikan, V. O. (2016). Cultural aspects of mental health and mental health service delivery with a focus on Nigeria within a global community. *Mental health, religion & culture*, 19(4), 323-338.

Lasebikan, V. O., & Ayinde, O. O. (2013). Family burden in caregivers of schizophrenia patients: Prevalence and socio-demographic correlates. *Indian Journal of Psychological Medicine, 35*(1), 60-66. doi:10.4103/0253-7176.112205

Lasebikan, V. O., & Oyetunde, M. O. (2012). Burnout among nurses in a Nigerian general hospital: Prevalence and associated factors. *ISRN Nursing, 2012*, 402157-402157. doi:10.5402/2012/402157.

Lawal, A. M., Alhassan, E. O., Mogaji, H. O., Odoh, I. M., & Essien, E. A. (2020). Differential effect of gender, marital status, religion, ethnicity, education, and

employment status on mental health during COVID-19 lockdown in Nigeria. *Psychology, Health & Medicine*, 1-12.

Lawan, U., Iliyasu, Z., & Daso, A. M. (2012). Challenges to the scale-up of the Nigerian national health insurance scheme: Public knowledge and opinions in urban Kano, Nigeria. *Annals of Tropical Medicine & Public Health, 5*(1).

Lawrence, K. C. (2021). A study on the psycho-social factors associated with the mental health of uniformed personnel in internally displaced persons' camps in Nigeria. *Community Mental Health Journal, 57*(4), 764-770.

Leavey, G., & King, M. (2007). The devil is in the detail: Partnerships between psychiatry and faith-based organisations. *British Journal of Psychiatry*, 191(2), 97–98. doi:10.1192/bjp.bp.106.034686

Lebimoyo, A., Ola, B., Adewuya, A., Atilola, O., & Popoola, A. (2020). Mental health and quality of life among patients with gynaecological cancers in Lagos, Nigeria. *Malaysian Journal of Psychiatry, 29*(2).

Lee, S. H., Park, Y. C., Hwang, J., Im, J. J., & Ahn, D. (2014). Mental health of intermarried immigrant women and their children in South Korea. *Journal of Immigrant and Minority Health, 16*(1), 77-85. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1007/s10903-012-9747-7

Leithead, A., (2017, August 21) The city that won't stop growing. How can Lagos cope with its spiraling population? *BBC News.* Retrieved from: https://www.bbc.co.uk/news/resources/idt-sh/lagos.

León-Pérez, G. (2019). Internal migration and the health of Indigenous Mexicans: A longitudinal study. *SSM-population health*, 8, 100407.

Leung, C. (2001). The socio-cultural and psychological adaptation of Chinese migrant adolescents in Australia and Canada. *International Journal of Psychology, 36*(1), 8-19.

Li, L., Wang, H. M., Ye, X. J., Jiang, M. M., Lou, Q. Y., & Hesketh, T. (2007). The mental health status of Chinese rural-urban migrant workers. *Social Psychiatry and Psychiatric Epidemiology., 42*(9), 716-722.

Li, J., Chang, S. -., Yip, P. S. F., Li, J., Jordan, L. P., Tang, Y., . . . Zeng, Q. (2014). Mental wellbeing amongst younger and older migrant workers in comparison to their urban counterparts in Guangzhou city, China: A cross-sectional study. *BMC Public Health, 14*(1) doi:10.1186/1471-2458-14-1280

Li, J., & Rose, N. (2017). Urban social exclusion and mental health of China's rural-urban migrants – A review and call for research. *Health and Place, 48*, 20-30. doi: 10.1016/j.healthplace.2017.08.009

Li, Q., Zhou, X., Ma, S., Jiang, M., & Lu, L. (2017). The effect of migration on social capital and depression among older adults in China. *Social Psychiatry and Psychiatric Epidemiology, 52*(12), 1513-1522.

Lin, D., Li, X., Wang, B., Hong, Y., Fang, X., Qin, X., & Stanton, B. (2011). Discrimination perceived social inequity and mental health among rural-to-urban migrants in China. *Community Mental Health Journal, 47*(2), 171-180. doi:10.1007/s10597-009-9278-4

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. *Sage.*

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences revisited. *The Sage handbook of qualitative research*, 4(2), 97-128.

Liu, C., Munakata, T., & Onuoha, F. N. (2005). Mental health condition of the only-child: A study of urban and rural high school students in China. *Adolescence, 40*(160)

Lo Iacono, V., Symonds, P., & Brown, D. H. (2016). Skype as a tool for qualitative research interviews. *Sociological research online*, 21(2), 103-117.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative health research*, 14(5), 726-735.

Lorber, J. (2006). Shifting Paradigms and Challenging Categories. Social Problems (Berkeley, Calif.), 53(4), 448–453. https://doi.org/10.1525/sp.2006.53.4.448

Lotsu, B. K. (2014). Knowledge, attitudes, and recognition of depression by physicians in primary care settings in Lagos state, Nigeria. *Faculty of Psychiatry.*

Lovejoy, P. E. (1978). Plantations in the economy of the Sokoto caliphate. *The Journal of African History, 19*(3), 341-368.

Lovejoy, P. E. (1980). Caravans of kola: The Hausa kola trade, 1700-1900 *Ahmadu Bello University Press Limited.*

Lu, Y. (2010). Rural-urban migration and health: Evidence from longitudinal data in Indonesia. *Social Science & Medicine, 70*(3), 412-419.

Lu Y. (2012). Household migration, social support, and psychosocial health: the perspective from migrant-sending areas. *Social science & medicine* (1982), 74(2), 135–142. https://doi.org/10.1016/j.socscimed.2011.10.020.

Lu, Y., Hu, P., & Treiman, D. J. (2012). Migration and depressive symptoms in migrant-sending areas: Findings from the survey of internal migration and health in China. *International Journal of Public Health, 57(4), 691-698., 57*(4), 691-698.

Lu, Y., & Qin, L. (2014). Healthy migrant and salmon bias hypotheses: A study of health and internal migration in China. *Social Science & Medicine, 102*, 41-48.

Lucas, R. E. (1997). Internal migration in developing countries. *Handbook of population and family economics*, *1*, 721-798.

Lunacy Act (1958) the law of the Federation of Nigeria and Lagos. In: Kingdom D. Nigeria: the revised edition. *London: Eyre and Spottiswoode*, 1958: pp 2290–307

Lund, C. (2010). Mental Health in Africa: Findings from the Mental Health and Poverty Project, *International Review of Psychiatry*, 22:6, 547-549.

Lund, E., Kumle, M., & Sandaune, A. -. (1998). The pattern of internal migration among Norwegian women aged 34-69 years and its effect on how they evaluate their health. 34-69 år] *Tidsskrift for Den Norske Laegeforening*, *118*(24), 3752-3755.

Lutz, H. (2002, July). Intersectional analysis: a way out of multiple dilemmas? In *International Sociological Association conference, Brisbane.*

Ma, C., Qu, Z., & Xu, Z. (2020). Internal migration and mental health: An examination of the healthy migration phenomenon in China. *Population Research and Policy Review.*, *39*(3), 493-517.

Mabogunje, A. L., Hardoy, J. E., Misra, R. P., & Jackson, C. I. (1978). Shelter provision in developing countries; the influence of standards and criteria. *Chichester (UK) Wiley*. https://agris.fao.org/agris-search/search.do?recordID=XF2015008506

Mabragana, M., Carballo-Diéguez, A., & Giguere, R. (2013). Young women's experience with using videoconferencing for the assessment of sexual behavior and microbicide use. *Telemedicine and e-Health, 19*(11), 866-871.

Mac- Leva, F., Ibrahim, H., Akor, O., & Mutum, R., (2020, September 10): Nigeria: 264 Nigerians Commit Suicide in Four Years. *Daily Trust*. Assessed from: https://allafrica.com/stories/202009100109.html. Assessed 31 January 2021.

Madison, G. (2006). Experiencing groove induced by music: consistency and phenomenology. *Music perception*, *24*(2), 201-208.

Madsen, R. K., Trab Damsgaard, M., Smith Jervelund, S., Christensen, U., Stevens, G. G., Walsh, S., ... & Holstein, B. E. (2016). Loneliness, immigration background and self-identified ethnicity: a nationally representative study of adolescents in Denmark. *Journal of Ethnic and Migration Studies*, 42(12), 1977-1995.

Magana, C. G., & Hovey, J. D. (2003). Psychosocial stressors associated with Mexican migrant farmworkers in the Midwest united states. *Journal of Immigrant Health, 5*(2), 75-86.

Maggi, S., Ostry, A., Callaghan, K., Hershler, R., Chen, L., D'Angiulli, A., & Hertzman, C. (2010). Rural-urban migration patterns and mental health diagnoses of adolescents and young adults in British Columbia, Canada: A case-control study. *Child and Adolescent Psychiatry and Mental Health, 4*, 13-13. doi:10.1186/1753-2000-4-13

Maiangwa, B., & Agbiboa, D. E. (2013). Oil Multinational Corporations, Environmental Irresponsibility and Turbulent Peace in the Niger Delta. *Africa Spectrum*, 48(2), 71–83. http://www.jstor.org/stable/24589097

Makama, G. A. (2013). Patriarchy and gender inequality in Nigeria: The way forward. *European scientific journal*, 9(17).

Makanju, A. O., & Uriri, A. E. (2018). The Lagos Experience: Evidence of the Circularity of Northern Male Migrants in Nigeria. *African Human Mobility Review*, 1140.

Makanjuola, A. B. (2006). Public stigma towards psychiatric patients in a south-western Nigerian town. *The Nigerian Postgraduate Medical Journal, 13*(3), 210-215.

Makanjuola, R. (1985). Clinical and socio-cultural parameters in Nigerian psychiatric patients: A prospective study. *Acta Psychiatrica Scandinavica, 72*(6), 512-521.

Makanjuola, V., Doku, V., Jenkins, R., & Gureje, O. (2012). Impact of a one-week intensive 'training of trainers' workshop for community health workers in southwest Nigeria. *Mental health in family medicine*, 9(1), 33.

Makanjuola, A., Elegbede, A., & Abiodun, O. (2010). Predictive factors for psychiatric morbidity among women with infertility attending a gynecology clinic in Nigeria. *African Journal of Psychiatry, 13*(1)

Makanjuola, V., Esan, Y., Oladeji, B., Kola, L., Appiah-Poku, J., Harris, B., . . . Gureje, O. (2016). Explanatory model of psychosis: Impact on perception of self-stigma by patients in three sub-Saharan African cities. *Social Psychiatry and Psychiatric Epidemiology, 51*(12), 1645-1654.

Makanjuola, R. O., & Jaiyeola, A. A. (1987). Yoruba traditional healers in psychiatry. II. management of psychiatric disorders. *African Journal of Medicine and Medical Sciences, 16*(2), 61-73.

Makinde, O., Björkqvist, K., & Österman, K. (2016). Overcrowding as a risk factor for domestic violence and antisocial behaviour among adolescents in Ejigbo, Lagos, Nigeria. *Global Mental Health*, 3.

Maldow, David S., Esq. (2013, January 27). "Zoom's Full Featured UME Videoconferencing Platform Exceeds Expectations." *Telepresence Options.*

Mao, Z., & Zhao, X. (2012). The effects of social connections on self-rated physical and mental health among internal migrant and local adolescents in Shanghai, China. *BMC Public Health, 12*, 97. doi:http://dx.doi.org.lcproxy.shu.ac.uk/10.1186/1471-2458-12-97

Martyns-Yellowe, I. (1992). The burden of schizophrenia on the family. A study from Nigeria. *The British Journal of Psychiatry: The Journal of Mental Science, 161,* 779-782.

Márquez-Montero, G., Loret de Mola, C., Bernabé-Ortiz, A., Smeeth, L., Gilman, R. H., & Miranda, J. J. (2011). Health-related quality of life among urban and rural to urban migrant populations in Lima, Peru. *National Institute of Health.* https://rpmesp.ins.gob.pe/rpmesp/article/view/453

Mba, H. C. (2017). Management of environmental problems and hazards in Nigeria *Routledge.*

Mba, N., Famuyiwa, O., & Aina, O. (2008). Psychiatric morbidity in two urban communities in Nigeria. *East African Medical Journal, 85*(8), 368-377.

Mbaka, C. A., & Nwaolikpe, O. N. (2020). Newspaper coverage of internal youth migration in Nigeria. *Handbook of research on the global impact of media on migration issues* (pp. 222-234) IGI Global.

Mbamalu, S. (2019). Nigeria has a mental health problem. *Aljazeera News.*

Mberu, B. U. (2005). Who moves and who stays? Rural out-migration in Nigeria. *Journal of Population Research, 22*(2), 141-161.

Mberu, B. U. (2008). Internal migration and premarital reproductive behavior among adolescents in Nigeria (*Doctoral dissertation, Brown University*).

Mberu, B. U., & Mutua, M. (2015). Internal migration and early life mortality in Kenya and Nigeria. *Population, Space and Place, 21*(8), 788-808.

Mberu, B. U., & Pongou, R. (2010). Nigeria: Multiple forms of mobility in Africa's demographic giant. *Migration Information Source,*

Mberu, B. U., & White, M. J. (2011). Internal migration and health: Premarital sexual initiation in Nigeria. *Social Science & Medicine, 72*(8), 1284-1293.

McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of women in culture and society*, *30*(3), 1771-1800.

McKelvey, R. S., & Webb, J. A. (1996). Pre-migratory expectations and post-migratory mental health symptoms in Vietnamese Amerasians. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(2), 240-245.

McLeod, J. 2001. Qualitative research in counselling and psychotherapy. *London: Sage.*

McLoughlin, G., & Bouchat, C. J. (2013). Nigerian unity: In the balance. *Army War College Carlisle Barracks PA Strategic Studies Institute.*

Merriam, S. B. (1998). Qualitative Research and Case Study Applications in Education. Revised and expanded from" Case Study Research in Education.". *Jossey-Bass Publishers*, 350 Sansome St, San Francisco, CA 94104. ISBN-0-7879-1009-0.

Mertens, D. M. (2003). Mixed methods and the politics of human research: The transformative-emancipatory perspective. *Handbook of mixed methods in social and behavioural research*, 135-164.

Mertens, D. M. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of mixed methods research*, 1(3), 212-225.

Mertens, D. M. (2010). Transformative mixed methods research. *Qualitative inquiry*, 16(6), 469-474.

Meyer, S. R., Robinson, W. C., Chhim, S., & Bass, J. K. (2014). Labor migration and mental health in Cambodia: A qualitative study. *The Journal of Nervous and Mental Disease, 202*(3), 200-208. doi:10.1097/NMD.0000000000000101

Meyer, S. R., Decker, M. R., Tol, W. A., Abshir, N., Mar, A. A., & Robinson, W. C. (2016). Workplace and security stressors and mental health among migrant workers on the Thailand Myanmar border. *Social Psychiatry and Psychiatric Epidemiology, 51*(5), 713-723. doi:http://dx.doi.org.lcproxy.shu.ac.uk/10.1007/s00127-015-1162-7

Mezger, C., (2016): Education data from Nigeria's national household surveys. *EDOREN*. *edoren-2014-education-data-in-hh-survey-reports.pdf.*

Mgbakor M. N., Patrick, O., & Ifechukwude, J. (2014). Effects of Rural-Urban migration by youths on agricultural labour in aniocha south local government area of delta state, Nigeria. *Research in Agriculture and Animal Science, 2*(6), 14-22.

Miclutia, I., Junjan, V., Popescu, C. A., & Tigan, S. (2007). Migration, mental health and costs consequences in Romania. *The Journal of Mental Health Policy and Economics, 10*(1), 43-50.

Miconi, D., Moscardino, U., Ronconi, L., & Altoè, G. (2017). Perceived parenting, self-esteem, and depressive symptoms in immigrant and non-immigrant adolescents in Italy: A multigroup path analysis. *Journal of Child and Family Studies, 26*(2), 345-356.

Migration Data Portal (2021, June) Forced Migration or Displacement. https://www.migrationdataportal.org/themes/forced-migration-or-displacement.

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded sourcebook. *Sage.*

Mills, J., Chapman, Y., Bonner, A., Francis, K. (2007) Grounded theory: a methodological spiral from positivism to postmodernism. *Journal of Advanced Nursing*, 58:1, pp72-79.

Mirsky, J., Kohn, R., Levav, I., Grinshpoon, A., & Ponizovsky, A. M. (2008). Psychological distress and common mental disorders among immigrants: Results from the Israeli-based component of the world mental health survey. *The Journal of Clinical Psychiatry*,

Mirsky, J. (2009). Mental health implications of migration: A review of mental health community studies on Russian-speaking immigrants in Israel. *Social Psychiatry and Psychiatric Epidemiology, 44*(3), 179-187. doi:10.1007/s00127-008-0430-1

Moghalu, K., (2019, June 17): Northern Nigeria's Prosperity: Imperative of Social, Economic Transformation. *This Day Newspapers*. Assessed from: https://www.thisdaylive.com/index.php/2019/06/17/northern-nigerias-prosperity-imperative-of-social-economic-transformation/

Mohammed, A. S. (2017, July 17). National health insurance (NHIS) and matters arising. *Daily Trust Newspapers*. Retrieved from *https://www.dailytrust.com.ng/national-health-insurance-nhis-and-matters-arising.html*

Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: *The PRISMA Statement. PLoS Med* 6(7): e1000097. doi:10.1371/journal. pmed1000097

Mojiminiyi, I. (2020). Knowledge and attitude towards mental disorders among adults in an urban community in south-west Nigeria. *Malawi Medical Journal, 32*(2), 87-94.

Mood, C., Jonsson, J. O., & Låftman, S. B. (2017). The mental health advantage of immigrant-background youth: The role of family factors. *Journal of Marriage and Family, 79*(2), 419-436. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1111/jomf.12340

Morgan, D. L. (2002). Focus group interviewing. Handbook of interview research: *Context and method*, 141-159.

Mosaku, K. S., & Wallymahmed, A. H. (2017). Attitudes of primary care health workers towards mental health patients: A cross-sectional study in Osun state, Nigeria. *Community Mental Health Journal, 53*(2), 176-182. doi:10.1007/s10597-016-0017-3

Mosanya, T. J., Adelufosi, A. O., Adebowale, O. T., Ogunwale, A., & Adebayo, O. K. (2014). Self-stigma, quality of life and schizophrenia: An outpatient clinic survey in Nigeria. *The International Journal of Social Psychiatry, 60*(4), 377-386.

Mossakowski, K. N. (2003). Coping with perceived discrimination: Does ethnic identity protect mental health? *. *Journal of Health and Social Behavior, 44*(3), 318-31.

Mossakowski, K. N. (2007). Are immigrants healthier? The case of depression among Filipino Americans. *Social Psychology Quarterly, 70*(3), 290-304.

Mou, J., Cheng, J., Griffiths, S. M., Wong, S. Y., Hillier, S., & Zhang, D. (2011). Internal migration and depressive symptoms among migrant factory workers in Shenzhen, China. *Journal of Community Psychology, 39*(2), 212-230. doi:10.1002/jcop.20428

Moustakas, C. (1994). Phenomenological research methods. *Sage publications*.

Mukhtar, S., Che Rose, R. A., & Lam, K. C. (2020). Profiling internal forced migrants in north-eastern Nigeria. *Social and Management Research Journal (SMRJ), 17*(2), 289-310.

Mulcahy, K., & Kollamparambil, U. (2016). The impact of rural-urban migration on subjective well-being in South Africa. *The Journal of Development Studies, 52*(9), 1357-1371.

Müller, M. J., & Koch, E. (2017). Gender differences in stressors related to migration and acculturation in patients with psychiatric disorders and Turkish migration background. *Journal of Immigrant and Minority Health, 19*(3), 623.

Murphy, H. B. M. (1977). Migration, culture and mental health1. *Psychological Medicine, 7*(4), 677-684.

Murtala, H. H., Umar, A. A., Kamilu, A., Ibrahim, U. M., Anyebe, E. E., Suleiman, A. D., & Yalwa, T. (2020). Perception and beliefs about mental illness among adults in

Birnin Kudu Metropolis Jigawa State. *IFE PsychologIA: An International Journal*, 28(2), 44-51.

Mustapha, A. (2009). The impact of rural-urban migration on the economy of rural areas in wudil local government area of kano state Nigeria. *Techno Science Africana Journal, 3*(1), 27-38.

Mustapha, A., Odu, O., & Akande, O. (2013). Knowledge, attitudes, and perceptions of epilepsy among secondary school teachers in osogbo south-west Nigeria: A community-based study. *Nigerian Journal of Clinical Practice*, *16*(1), 12-18.

National Bureau of Statistics (2006- 2016) National Population Estimates. *National Bureau of Statistics.*

National Bureau of Statistics (2012) Annual Abstracts of Statistics. Assessed from: https://www.nigerianstat.gov.ng/pdfuploads/annual_abstract_2012.pdf

National Bureau of Statistics (2016/17) Multiple Indicator Cluster Survey. Assessed from: *https://www.nigerianstat.gov.ng/nada/index.php/catalog/59*

National Bureau of Statistics (2016/ 2013/ 2004) Inequality snapshot in Nigeria. Assessed from: *https://www.nigerianstat.gov.ng/pdfuploads/Inequality%20snap%20shot%202003,%202013,%202016.pdf*

National Bureau of Statistics (2016) Social Statistics Report. *National Bureau of Statistics.*

Assessed from: *https://www.nigerianstat.gov.ng/elibrary?queries[search]=social*

National Bureau of Statistics (2017) Social Statistics Report. *National Bureau of Statistics.* Assessed from Reports | National Bureau of Statistics (nigerianstat.gov.ng)

National Bureau of Statistics (2017) Demographic Statistics Bulletin. Assessed from: *https://nigerianstat.gov.ng/elibrary.?queries[search]=demographic%20statistics%20bulletin*

National Bureau of Statistics (2017) Annual Abstracts of Statistics. *National Bureau of Statistics.* Assessed from: *https://nigerianstat.gov.ng/elibrary/read/1182*.

National Bureau of Statistics (2018) Statistical Report on women and men in Nigeria. *National Bureau of Statistics.* Assessed from: https://nigerianstat.gov.ng/elibrary/read/952

National Bureau of Statistics (2018) Labour Force Statistics. Unemployment and underemployment by state. Volume 2. *National Bureau of Statistics.* https://nigerianstat.gov.ng/elibrary.?page=6&offset=50

National Bureau of Statistics (2018) Drug use and Health in Nigeria. *National Bureau of Statistics.* Assessed from: *https://nigerianstat.gov.ng/nada/index.php/catalog/64*

National Bureau of Statistics (2019) Annual Abstract of Statistics. *National Bureau of Statistics*. *Reports | National Bureau of Statistics (nigerianstat.gov.ng)*.

National Bureau of Statistics (2019) Poverty and Inequity in Nigeria. *National Bureau of Statistics.* Assessed from: *https://nigerianstat.gov.ng/elibrary/read/1092*

National Bureau of Statistics (2019) Corruption in Nigeria: Patterns and Trends. Assessed from: *https://www.nigerianstat.gov.ng/elibrary?queries[search]=corruption*

National Bureau of Statistics (2020a) Labour Force Statistics: Unemployment and underemployment report. Abridged Labour force survey under Covid-19. Assessed from *https://www.nigerianstat.gov.ng/pdfuploads/Q2_2020_Unemployment_Report.pdf*

National Bureau of Statistics (2020b) Labour Force Statistics: Unemployment and underemployment report (Q4 2020). *National Bureau of Statistics.*

National Bureau of Statistics (2020) Social Statistics in Nigeria. *National Bureau of Statistics.*

National Bureau of Statistics (2020) Statistical Report on women and men in Nigeria. *National Bureau of Statistics.*

National Bureau of Statistics (2020) Survey Report on awareness and perception of the dangers of irregular migration in Nigeria. Assessed https://nigerianstat.gov.ng/elibrary/read/1241031

National Bureau of Statistics (2020) Nigeria Living Standards Survey. Assessed from: *https://nigerianstat.gov.ng/nada/index.php/catalog/68/study-description.*

National Bureau of Statistics (2021) Rail transport data (Q1 2019- Q1 2021). Assessed from: https://nigerianstat.gov.ng/elibrary/read/1241043.

National Bureau of Statistics (2020) Road Transport Data Q3. Assessed from: https://nigerianstat.gov.ng/elibrary/read/1209

National Bureau of Statistics (2021) Road Transport Data (Q4, 2020, Q1 & Q2 2021). *National Bureau of Statistics.*

National Bureau of Statistics (2021) Liquified Petroleum Gas (Cooking Gas) Price Watch. *National Bureau of Statistics.*

National Bureau of Statistics (2021) Mineral Production Statistics 2019-2020. *National Bureau of Statistics.*

National Bureau of Statistics (2021) Premium Motor Spirit (Petrol) Price Watch. *National Bureau of Statistics.*

National Bureau of Statistics (2021) Transport Fare Watch (November 2021). *National Bureau of Statistics.*

National Drug Law Enforcement Agency (2018) Statistics of Arrests carried out by the *National Drug Law Enforcement Agency (NDLEA)* nationwide 2018. Assessed from: *https://www.ohchr.org/Documents/Issues/Detention/Call/NHRIs/NigeriaNHRI.pdf*

National Population Commission (2012) National Internal Migration Survey Report. *(NPC)*

National Population Commission [Nigeria] and ICF. (2019). Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: *NPC and ICF*.

National Youth Service Corporation Directorate Headquarters (2017) *National Youth Service Corps (NYSC) Official Website*. About the Scheme. Assessed on NYSC - About Scheme.

Nauman, E., VanLandingham, M., Anglewicz, P., Patthavanit, U., & Punpuing, S. (2015). Rural-to-urban migration and changes in health among young adults in Thailand. *Demography, 52*(1), 233-257.

Nesterko, Y., Friedrich, M., Seidel, N., & Glaesmer, H. (2017). Health-related quality of life in Jewish immigrants from the former Soviet Union in Germany. *International Journal of Migration, Health, and Social Care, 13*(2), 277-288.

Neto, F., & Barros, J. (2000). Predictors of loneliness among adolescents from Portuguese immigrant families in Switzerland. *Social Behavior and Personality: An International Journal, 28*(2), 193-205.

Ngbea, G., & Achunike, H. (2014). Poverty in northern Nigeria. *Asian Journal of Humanities and Social Studies, 2*(2), 266-272.

Nilvarangkul, K., Rungreangkulkij, S., & Wongprom, J. (2010). Perception of stress in Laotian migrant workers in Thailand. *Journal of Immigrant and Minority Health, 12*(5), 678-82.

Nnadi, F., Chikaire, J., Atoma, C., Egwuonwu, H., & Echetama, J. (2012). Rural youth empowerment: A panacea to rural-urban drift. A case study of ethiope-east area of delta state. *Science Journal of Sociology & Anthropology, 2012*

Nnajekwu, C. O., Nnajekwu, U. C., Ikefuna, N. A., & Ojinnaka, C. N. (2021). Mental health of adolescents with epilepsy in Enugu, Nigeria: A cross-sectional study. *Journal of Child Neurology, 36*(2), 116-122.

Nolan, M.R. (1995) Reconciling tensions between research, evidence-based practice and user participation: time for nursing to take the lead. *International Journal of Nursing Studies*, 42:5, pp503-505.

Nonye, A. P., & Oseloka, E. C. (2009). Health-seeking behaviour of mentally ill patients in Enugu, Nigeria. (report). *South African Journal of Psychiatry, 15*(1), 19. doi:10.4102/sajpsychiatry. v15i1.167

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International journal of qualitative methods*, 16(1), 1609406917733847.

Noymer, A., & Lee, R. (2013). Immigrant health around the world: Evidence from the world values survey. *Journal of Immigrant and Minority Health, 15*(3), 614-623.

Nwachukwu, C., Akingbade, A., Olufunmilayo, E., Oyebamiji, T., Odefemi, O., Ikwunne, B., . . . Adebayo, A. (2021a). Family characteristics and mental health status of secondary school students in a rural community in southwest Nigeria. *International Journal of Mental Health and Addiction*, 1-11.

Nwachukwu, C. E., Olufunmilayo, E. O., Otor, V. O., Yakubu, A. O., Akingbade, A. E., Odefemi, O. F., . . . Oyebamiji, T. A. (2021b). Common mental health problems and associated factors among medical students of University of Ibadan, Nigeria. *Journal of Mental Health*, 1-8.

Nwagboso, C. I. (2012). "Security Challenges and Economy of the Nigerian State (2007-2011). *American International Journal of Contemporary Research* 2(6) 244-258.

Nwaopara, U., Abasiubong, F., & Umoh, O. (2016). Mental health care of homeless mentally ill patients in Akwa Ibom State, Nigeria: Rehabilitation model, challenges, and strategies for improvement. *Journal of International Research in Medical and Pharmaceutical Sciences, 10*(2), 60-68.

Nwedu, A. B. (2019). Exploration of the lived experience of young adults diagnosed with a mental illness and being treated at a Nigerian psychiatric hospital regarding their mental health problems *(Doctoral dissertation, University of Salford*).

Nyashanu, M., and Serrant, L. (2016). Engaging Black Sub-Sahara African communities and their gatekeepers in HIV prevention programs: challenges and strategies from England family medicine and community. *Health.* 4, 22–29. doi: 10.15212/FMCH.2016.0130

O'Donoghue, T., & Punch, K. (Eds.). (2003). Qualitative educational research in action: Doing and reflecting. *Routledge.*

Obajimi, G., Esan, O., & Ogunkinle, B. (2019). Depression and anxiety disorders amongst a cohort of infertile women attending an in-vitro fertilization clinic in south-western Nigeria. *Medical Journal of Zambia, 46*(3), 192-196.

Ọbasanjọ, O. (1980). My command: An account of the Nigerian civil war 1967-1970 *East Africa Educational Publishers.*

Obi, C. (2015). Challenges of insecurity and terrorism in Nigeria: Implication for national development. *OIDA International Journal of Sustainable Development*, 8(02), 11-18.

Obi, I., Aniebue, P., Okonkwo, K., Okeke, T., & Ugwunna, N. (2015). Prevalence of depression among health workers in Enugu, southeast Nigeria. *Nigerian Journal of Clinical Practice, 18*(3), 342-347.

Oboh, M. (2012, January 22). *"Islamist insurgents kill over 178 in Nigeria's Kano*". *Reuters*. Retrieved 3 August 2014.

Obot, I. S. (2004). Responding to substance use problems in Nigeria: The role of civil society organizations. *Substance use & misuse*, *39*(8), 1287-1299.

Odaman, O. (1988). Migration and socio-economic aspects of homeward remittances in Nigeria. *Migration World Magazine, 16*(1), 16-20.

Odebiyi, A. I., & Ogedenge, R. O. (1990). Mentally disturbed patients in Nigeria: Problems and prospects. Paper presented at the *International Sociological Association,* Retrieved fromhttp://lcproxy.shu.ac.uk/login?url=https://search-proquest-com.lcproxy.shu.ac.uk/docview/61699409?accountid=13827

Odejide, A., Olatawura, M., Sanda, A. O., & Oyeneye, A. (1978). Traditional healers and mental illness in the city of Ibadan. *Journal of Black Studies, 9*(2), 195-205.

Odejide, A. O. (1981). A Nigerian long-stay psychiatric unit: A survey of its psychiatric service. *Tropical and Geographical Medicine, 33*(1), 66-70.

Oderinde, K. O., Dada, M. U., Ogun, O. C., Awunor, N. S., Kundi, B. M., Ahmed, H. K., ... & Yusuff, A. A. (2018). Prevalence and predictors of depression among adolescents in Ido Ekiti, Southwest Nigeria. *International Journal of Clinical Medicine*, 9(3), 187-202.

Odimegwu, C. O., & Adewoyin, Y. (2020). Ethnic fertility behaviour and internal migration in Nigeria: revisiting the migrant fertility hypotheses. *Genus,* 76(1), 1-17.

Odinka, P. C., Oche, M, Ndukuba, A. C., Muomah, R. C., Osika, M. U., Bakare, M. O, . . . Uwakwe, R. (2014). The socio-demographic characteristics and patterns of help-seeking among patients with schizophrenia in south-east Nigeria. *Journal of Health Care for the Poor and Underserved, 25*(1), 180-91.

Oduguwa, A. O., Adedokun, B., & Omigbodun, O. O. (2017). Effect of a mental health training programme on Nigerian school pupils' perceptions of mental illness. *Child and Adolescent Psychiatry and Mental Health, 11*(1) doi:10.1186/s13034-017-0157-4

Odunmayowa, A. I., & Tinuola, I. Y. (2020). Evaluation of the knowledge of mental health first aid among workers manning sick bays in schools in EGOR local government area of Benin City, Nigeria. *International Journal of Psychiatry Research, 3*(3), 1-4.

Ofuoku, A. U. (2013). Willingness of farmers to participate in farmers' groups. *Journal of Extension Systems, 29*(1), 51-63.

Ofuoku, A. (2015). Examination of urban-rural migration in delta state, Nigeria: Implications for the agricultural extension service. *Journal of Agricultural Faculty of Gaziosmanpasa University, 32*(2015-2), 79-79. doi:10.13002/jafag745

Ogbe, A. (2020). The Travails of Women and Girls in Northern Nigeria. Potential*: Journal of International Affairs*, 11.

Ogbolu, R. E., Ijadunola, M. Y., Adepoju, O. A., Ola, B. A., Quadri-Asorona, B., Ogundiran, A., ... & Alaba, O. A. (2020). Channeling the Right Path-to-care: Improving Religious Leaders' Knowledge and Beliefs about Suicide Prevention in Southwest Nigeria. *Research Square.*

Ogbonna, P. N., Iheanacho, P. N., Ogbonnaya, N. P., Mbadugha, C. J., Ndubuisi, I., & Chikeme, P. C. (2020). Prevalence of mental illness among adolescents (15–18 years) treated at federal neuropsychiatric hospital, Enugu Nigeria, from 2004 to 2013. *Archives of Psychiatric Nursing, 34*(1), 7-13.

Ogechi, O. A., & Ezadueyan, Z. A. (2020). Insurgency and internal displacement: Implications on psychological health and agricultural development in Nigeria. *IFE PsychologIA: An International Journal, 28*(1), 66-72.

Ogu, U. K., Ezeonwuka, E. C., & Sule, R. K. (2016). Gender Equality and Poverty Reduction in the Post 2015 Agenda: Foundation for Sustainable Development in Nigeria. *Canadian Social Science,* 12(11), 59-66.

Ogueji, I. A., Ojo, T. E., & Gidado, T. N. (2020). Perceived stigmatization, sociodemographic factors, and mental health help-seeking behaviors among psychiatric outpatients attending a psychiatric hospital in Lagos, Nigeria. *Medrxiv,*

Ogunfowokan, T. R., Omitogun, E. O., Owoeye, I. D., Ogbebor, E. O., & Atekoja, O. E. (2020). Gender belief and mental illness: A study of public and private of secondary school in Ogun State, Nigeria. *Gender & Behaviour, 18*(2), 15409-15415.

Ogunlesi, A., & Adelekan, M. (1988). Nigerian primary health care workers: A pilot survey on attitude to mental health. *Bulletin of the Royal College of Psychiatrists, 12*(10), 441-443.

Ogunlesi, A. O., & Ogunwale, A. (2012). Mental health legislation in Nigeria: Current leanings and future yearnings. *International Psychiatry, 9*(3), 62-64.

Ogunmakinde, O. E., Oladokun, S. D., & Oke, O. E. (2015). Rural-urban migration in southwestern Nigeria: A menace to national development. *Civil and Environmental Research, 7*(5), 42-47.

Ogunsemi, O. O., Oluwole, F. A., Abasiubong, F., Erinfolami, A. R., Amoran, O. E., Ariba, A. J., . . . Olatawura, M. O. (2010). Detection of mental disorders with the patient health questionnaire in primary care settings in Nigeria. *Mental Illness, 2*(1), e10-e10. doi:10.4081/mi.2010.e10

O'Hare, M., (2017, September 13) Revealed: The world's least stressful cities. *CNN Travel.* Retrieved from: *https://edition.cnn.com/travel/article/least-stressful-cities-2017/index.html.*

Ohaeri, J. U., & Fido, A. A. (2001). The opinion of caregivers on aspects of schizophrenia and major affective disorders in a Nigerian setting. *Social Psychiatry and Psychiatric Epidemiology, 36*(10), 493-499.

Ojedokun, O., & Balogun, S. K. (2015). The costs of policing: Psychosocial capital and mental health outcomes in a Nigeria police sample. *The Spanish Journal of Psychology, 18*, E78-E78. doi:10.1017/sjp.2015.76

Ojeleye, O. (2010). The politics of post-war demobilisation and reintegration in Nigeria *Ashgate Publishing, Ltd.*

Ojo, O., (2008). The organization of the Atlantic slave trade in Yoruba land, ca.1777 to ca.1856". *International Journal of African Historical Studies, 41*(1).

Ojukwu, E. (1969). Ahiara Declaration. *Retrieved August 2016 from www. biafraland. com/ahiara_declaration_1969. htm*.

Okafor, F. N. (2012). The zest for migration and national development in Nigeria: Bridging the gap between illusion and Reality/ Treatises and documents: *Journal of ethnic studies treatises and documents: Journal of ethnic studies.* (68), 72-86,89.

Okasha, A. (2002). Mental health in Africa: The role of the WPA. *World Psychiatry: Official of the World Psychiatric Association (WPA), 1*(1), 32-35.

Oketayo, A. O., & Olaleye, Y. (2016). Effect of rural-urban migration of youths on rural development in Ogbomosho south local government area, Oyo state. Nigeria. *Journal of Humanities, 11*(1), 2.

Okojie, C.E.E., et al., (2013, July) Migration and Nigeria Development (external and internal). Seminar/Term Paper Presented by Group 11, *Department of Economics and Statistics.*

Okoro, J. N., Ezeonwuka, C. N., & Onu, J. U. (2018). Socio-demographic characteristics as correlates of psychological distress. *International Journal of Prisoner Health, 14*(3), 210-219. doi:10.1108/IJPH-10-2017-0042

Okpalauwaekwe, U., Mela, M., & Oji, C. (2017). Knowledge of and attitude to mental illnesses in Nigeria: A scoping review. *Integrative Journal of Global Health, 1*(5), 1-14.

Okpara, E. E. (1986). Rural-urban migration and urban employment opportunities in Nigeria. *Transactions Institute of British Geographers: 1965), 11*(1), 67-74.

Okwuezolu, F. A., Obaghwarhievwo, A. J., & Ego, C. H. (2020). Effects of crude oil exploration on the physical and mental health of residents of okpai community, delta state, Nigeria. *Journal of Complementary and Alternative Medical Research*, 1-12.

Okwuwa, C. (2016). Terrorism and migration: Addressing issues of internally displaced persons in gwagwalada, federal capital territory of Nigeria. *International Journal of Arts & Sciences, 9*(2), 99.

Ola, B., Crabb, J., Tayo, A., Ware, S. H. G., Dhar, A., & Krishnadas, R. (2011). Factors associated with an antenatal mental disorder in West Africa: A cross-sectional survey. *BMC Pregnancy and Childbirth, 11*(1), 1-6.

Olade, R. A. (1979). Attitudes towards mental illness: A comparison of post-basic nursing students with science students. *Journal of Advanced Nursing, 4*(1), 39-46.

Olade, R. A. (1983). Attitudes towards mental illness: Effect of integration of mental health concepts into a post-basic nursing degree programme. *Journal of Advanced Nursing, 8*(2), 93-97.

Oladeji, B. D., Makanjuola, V. A., & Gureje, O. (2010). Family-related adverse childhood experiences as risk factors for psychiatric disorders in Nigeria. *The British Journal of Psychiatry, 196*(3), 186-191.

Oladeji, B. D., & Gureje, O. (2011). Parental mental disorders and suicidal behavior in the Nigerian survey of mental health and well-being. *Archives of Suicide Research, 15*(4), 372-383.

Oladeji, S. A., & OlaOlorun, A. D. (2018). Depression among infertile women in Ogbomoso land. *South African Family Practice*, 60(2), 41-45.

Olagundoye, O., Akhuemokhan, V., & Alugo, M. (2017). Towards caring for caregivers: Assessing the burden of care and experience of associative stigma among caregivers of patients with chronic mental illnesses at a mental health care facility in Lagos metropolis, Nigeria. *Family Medicine and Primary Care Review, 19*(2), 149-155.

Olagunju, A. T., Olutoki, M. O., Ogunnubi, O. P., & Adeyemi, J. D. (2015). Late-life depression: Burden, severity, and relationship with social support dimensions in a West African community. *Archives of gerontology and geriatrics*, 61(2), 240-246.

Olagunju, A. T., Oluwaniyi, S. O., Fadipe, B., Ogunnubi, O. P., Oni, O. D., Aina, O. F., & Chaimowitz, G. A. (2018). Mental health services in Nigerian prisons: lessons from a four-year review and the literature. *International journal of law and psychiatry*, 58, 79-86.

Olatona, F. A., Ezeobika, E. N., Okafor, I. P., & Owoeye, O. B. (2014). Work-related stress and coping mechanisms among bankers in Lagos, Nigeria. *African Journal of Medicine and Medical Sciences, 43*(1), 59-65.

Olatunji, O. A., Idemudia, E. S., & Olawa, B. D. (2020). Family support, self-efficacy, and suicidal ideation at emerging adulthood: a mediation analysis. *International Journal of Adolescence and Youth*, 25(1), 920-931.

Olawande, T. I., Ajayi, M. P., Amoo, E. O., & Olawole-Isaac, A. (2020). Treatment pathways of Alzheimer's in Nigeria. *Heliyon, 6*(12), e05724.

Olawande, T. I., Jegede, A. S., Edewor, P. A., & Fasasi, L., T. (2018). Gender differentials in the perception of mental illness among the Yoruba of Ogun state, Nigeria. *IFE PsychologIA: An International Journal, 26*(1), 134-153.

Olibamoyo, O., Ola, B., Coker, O., Adewuya, A., & Onabola, A. (2021). Analysis of media reporting of suicidal behaviour in Nigeria. *Mental Health & Prevention*, 21, 200197.

Olley, B. (2007). Changes in attitudes towards mental illness after exposure to a course in abnormal psychology among students of a Nigerian university. *University of Ibadan Institutional Repository*. http://ir.library.ui.edu.ng/handle/123456789/1622.

Olonade, O.Y., & Adetunde, C.O. (2021). Understanding the gender issues in Nigeria: the imperative for sustainable development. https://doi.org/10.1016/j.heliyon. 2021.e07622.

Olowa, O. W., & Awoyemi, T. T. (2012). Determinants of migration and remittances in rural Nigeria. *Journal of development and agricultural economics*, 4(7), 191-198.

Olowokere, A. E., & Okanlawon, F. A. (2014). The effects of a school-based psychosocial intervention on resilience and health outcomes among vulnerable children. *Journal of School Nursing, 30*(3), 206-215. doi:10.1177/1059840513501557

Olubunmi, M. B. (2009). Attitude towards epilepsy and mental illness in Ekiti state, Nigeria. *African Research Review, 3*(1)

Olugbile, O. B., Coker, A. O., & Zachariah, M. P. (2013). Cost of treatment as a barrier to access and continuity of healthcare for patients with mental ill-health in Lagos, Nigeria. *Healthcare in Low-Resource Settings, 1*(1), e8-e8.

Olugbile, O., Zachariah, M. P., Kuyinu, A., Coker, A., Ojo, O., & Isichei, B. (2009). Yoruba worldview and the nature of the psychotic illness. *African Journal of Psychiatry, 12*(2), 149-156.

Olukotun, A. (2002). The media and the Nigerian civil war: An overview. The Nigerian Civil War and its Aftermath. *Ibadan: John Archers.*

Olukoya, O. (2017, Aug 10). NHIS has covered less than 5% of Nigeria's population —Ibrahim. *Nigerian Tribune*. Retrieved from https://tribuneonlineng.com/106226/

Oluleyẹ, J. J. (1985). Military leadership in Nigeria *, 1966-1979 University Press Limited*.

Olurinola, I. O., Fadayomi, T. O., Amoo, E. O., & Ola-David, O. (2014). Internal migration and welfare of street traders in the urban informal economy of Nigeria. *Journal of South African Business Research*, (21/145).

Olutoki, M. O., Olagunju, A. T., & Adeyemi, J. D. (2014). Correlates of depressive illness among the elderly in a mixed urban community in Lagos, Nigeria. *Aging & Mental Health, 18*(5), 561-569.

Oluwole, L. O., & Obadeji, A. (2014). Knowledge and attitudes about mental disorder amongst media practitioners in southwest Nigeria. *International Journal of Community Medicine and Public Health, 1*(1), 52-57.

Oluwole, L. O., Obadeji, A., & Dada, M. U. (2016). Perceptions and attitudes of students of mass communication toward mental illness in Nigerian tertiary institution. *Indian Journal of Social Psychiatry, 32*(4), 315.

Omigbodun, O., Dogra, N., Esan, O., & Adedokun, B. (2008). Prevalence and correlates of suicidal behaviour among adolescents in southwest Nigeria. *International journal of social psychiatry*, 54(1), 34-46.

Omigbodun, O. O., Odukogbe, A. A., Omigbodun, A. O., Yusuf, O. B., Bella, T. T., & Olayemi, O. (2006). Stressors and psychological symptoms in students of medicine and allied health professions in Nigeria. *Social Psychiatry and Psychiatric Epidemiology, 41*(5), 415-421.

Omolayo, B., Auta, M., Akinyemi, E., & Dennis, U. (2020). Knowledge and awareness of autism spectrum disorder among teachers in Ekiti State, Nigeria. *African Journal of Teacher Education, 9*(2), 43-61.

Omoniyi, S. O., Aliyu, D., Adeleke, I. T., Ndu, A., & Paul, M. K. (2016). Perceptions of Nigerian mental health nurses towards community mental health nursing practice in Nigeria. *World, 4*(2), 25-31.

Omorodion, F. I. (1993). The socio-cultural context of health behaviour among esan communities, Edo state, Nigeria. *Health Transition Review: The Cultural, Social, and Behavioral Determinants of Health, 3*(2), 125-136.

Onifade, C., Imhonopi, D., & Urim, U. M. (2013). Addressing the insecurity challenge in Nigeria: The imperative of moral values and virtue ethics. *Global journal of human social science political* science, 13(2), 52-63.

Onumonu, U. P., & Anutanwa, P. O. (2017). Rethinking the impact of Nigerian civil war: Commerce in the post-civil war Nnewi and its challenges, 1970-2000. *Mgbakoigba: Journal of African Studies, 6*(2), 155-167.

Onwujekwe, O., Okereke, E., Onoka, C., Uzochukwu, B., Kirigia, J., & Petu, A. (2010). Willingness to pay for community-based health insurance in Nigeria: Do economic status and place of residence matter? *Health Policy and Planning, 25*(2), 155-161.

Onyeji, E., (2020, January 14). Many Nigerians link mental illness to supernatural causes – survey. *Premium Times.* Retrieved from https://www.premiumtimesng.com/health/health-news/372686-many-nigerians-link-mental-illness-to-supernatural-causes-survey.html.

Onyeonoro, U. U., Ogah, O. S., Ukegbu, A. U., Chukwuonye, I. I., Madukwe, O. O., & Moses, A. O. (2016). Urban-rural differences in the health-care-seeking pattern of residents of Abia State, Nigeria, and the implication in the control of NCDs. *Health services insights*, 9, HSI-S31865.

Onyeoziri, F. (2002). What caused the Nigerian civil war? In Osaghae, E.E, Onwudiwe, E. & Suberu, R.T. (Eds.), The Nigerian civil war and its aftermath. *Ibadan: John Archers.*

Oriaku, R. (2002). Continuing the civil war by other means: Points of view in selected Nigerian civil war memoirs. The Nigerian Civil War and its Aftermath. *Ibadan: John Archers.*

Orji, A., & Agu, C. (2018). Analysis of migration, regional characteristics, and socioeconomic outcomes in developing economies: Empirical evidence from Nigeria. *Journal of International Migration and Integration, 19*(3), 565-581.

Ornelas, I. J., & Perreira, K. M. (2011). The role of migration in the development of depressive symptoms among Latino immigrant parents in the USA. *Social Science & Medicine, 73*(8), 1169-1177.

Orngu, T. D., Francis, A., La Rosa, P., Sankaran, L., & Rajeev, S. P. (2015). Cultural perspectives and attitudes toward mental health in Nigeria: Social workers at a dilemma.

Orok, E., David, S., Olajide, T., Sulaiman, A., & Oyewole, E. (2020). Effect of COVID-19 on the mental health and social activities of healthcare students in southwestern Nigeria. *European Journal of Medical and Educational Technologies, 13*(4), em2015.

Osagie, J., Fred, A., & Samuel, E. (2010). Causes of conflicts in the Niger Delta region of Nigeria as expressed by the youth in delta state. *Procedia-Social and Behavioral Sciences, 5*, 82-89.

Osasona, S. O., & Koleoso, O. N. (2015). Prevalence and correlates of depression and anxiety disorder in a sample of inmates in a Nigerian prison. *The International Journal of Psychiatry in Medicine, 50*(2), 203-218. doi:10.1177/0091217415605038.

Oshodi, Y. O., Abdulmalik, J., Ola, B., James, B. O., Bonetto, C., Cristofalo, D., . . . Thornicroft, G. (2014). Pattern of experienced and anticipated discrimination among people with depression in Nigeria: A cross-sectional study. *Social Psychiatry and Psychiatric Epidemiology, 49*(2), 259-266. doi:10.1007/s00127-013-0737-4

Osumah, O. (2013). Boko haram insurgency in northern Nigeria and the vicious cycle of internal insecurity. *Small Wars & Insurgencies, 24*(3), 536-560.

Oucho, J. O. (1998). Recent internal migration processes in sub-Saharan Africa: Determinants, consequences, and data adequacy issues. *Migration, urbanization, and development*: *New directions and issues*, 89-120.

Owoaje, E. T., Uchendu, O. C., Ajayi, T. O., & Cadmus, E. O. (2016). A review of the health problems of the internally displaced persons in Africa. *The Nigerian Postgraduate Medical Journal, 23*(4), 161-171. doi:10.4103/1117-1936.196242 [doi]

Oxford Business Group (2021) Nigeria: Economy. Rapid urbanisation in Abuja, Nigeria, drives infrastructure and real estate investment. Retrieved from: https://oxfordbusinessgroup.com/overview/keys-city-rapid-urbanisation-one-continent%E2%80%99s-most-prosperous-cities-drives-investment-infrastructure

Oyeniyi, B. A. (2010). Mobility and social conflicts in Yoruba land, 1893-1983: A socio-historical re-interpretation *VDM Publishing.*

Oyeniyi, B. A. (2013). Internal migration in Nigeria: A positive contribution to human development. *African Caribbean Pacific Observatory on Migration Research Report.*

Oyewole, S. (2013). Boko haram and the challenges of Nigeria's war on terror. *Defense & Security Analysis, 29*(3), 253-262.

Özlü-Erkilic, Z., Winkler, D., Popow, C., Zesch, H. E., & AKKAYA-KALAYCI, T. (2015). A comparative study of Turkish-speaking migrants and natives living in Vienna/Austria concerning their life satisfaction – with a particular focus on satisfaction regarding their health. *International Journal of Migration, Health, and Social Care, 11*(3), 206-217.

Padilla, A. M., Cervantes, R. C., Maldonado, M., & Garcia, R. E. (1988). Coping responses to psychosocial stressors among Mexican and Central American immigrants. *Journal of Community Psychology, 16*(4), 418-427.

Pam, Y. D. (2014). Rural-urban migration among youths in Nigeria: The impacts on agriculture and rural development. *IOSR Journal of Humanities and Social Science (IOSR-JHSS), 19*(3), 120-123.

Pascale, C. M. (2007). Making sense of race, class, and gender. New York: R*outledge.*

Parker, L., & Lynn, M. (2002). What's race got to do with it? Critical race theory's conflicts with and connections to qualitative research methodology and epistemology. *Qualitative inquiry*, 8(1), 7-22.

Patel, V. (2011). Traditional healers for mental health care in Africa. *Global Health Action*, 4, 7956. doi:10.3402/gha.v4i0.7956

Patton, M. Q. (1980). Qualitative evaluation methods (Vol. 381). Beverly Hills, CA: *Sage publications.*

Patton, M. Q. (1990). Qualitative evaluation and research methods. *SAGE Publications, incorporation.*

"Peace and Security Council Report" (PDF). *ISS*. (2012, February). Retrieved 30 July 2014.

Pederson, A. B., Burnett-Zeigler, I., Fokuo, J. K., Wisner, K. L., Zumpf, K., & Oshodi, Y. (2020). Mental health stigma among university health care students in Nigeria: A cross-sectional observational study. *The Pan African Medical Journal, 37*

Pelias, R.J. (2011) Writing into Position. IN: Denzin, N.K. and Lincoln, Y.S. (Eds) (2011) *The SAGE Handbook of Qualitative Research* (4th Ed). London: Sage.

Perone, J. S., & Tucker, L. (2003). An exploration of triangulation of methodologies: Quantitative and qualitative methodology fusion in an investigation of perceptions of transit safety (*No. NCTR-416-08.1).*

Perreira, K. M., Marchante, A. N., Schwartz, S. J., Isasi, C. R., Carnethon, M. R., Corliss, H. L., . . . Delamater, A. M. (2019). Stress and resilience: Key correlates of mental health and substance use in the Hispanic community health study of Latino youth. *Journal of Immigrant and Minority Health, 21*(1), 4-13.

Pham, N. N. K., Do, M., Bui, V. H., & Nguyen, G. T. (2018). Rural-to-urban migration in Vietnam: Conceptualized youth's vulnerabilities in the city. *International Journal of Migration, Health, and Social Care, 14*(1), 117-130. doi:10.1108/IJMHSC-11-2015-0044

Pheko, M. M., Monteiro, N., Tlhabano, K. N., & Mphele, S. B. (2014). Rural-to-urban migrations: Acculturation experiences among university students in Botswana. *International Journal of Adolescence and Youth., 19*(3), 306-317.

Pinnegar, S., & Daynes, J. G. (2007). Locating narrative inquiry historically. *Handbook of narrative inquiry:* Mapping a methodology, 3-34.

Plummer, K. (2012). A Manifesto for critical humanism in sociology. *Sociology Humanism Narrative Sexualities*. https://kenplummer.com/manifestos/a-manifesto-for-a-critical-humanism-in-sociology/

Polit, D.F., & Hungler, B.P. (1999). Nursing Research. Principles and Methods, sixth ed. J.*B. Lippincott Company, Philadelphia*, New York, Baltimore.

Poopola, N. (2017, December 22). NHIS: Health insurance still elusive for many Nigerians. *Punch News Papers*. Retrieved from https://punchng.com/nhis-health-insurance-still-elusive-for-many-nigerians/

Potochnick, S. R., & Perreira, K. M. (2010). Depression and anxiety among first-generation immigrant Latino youth: key correlates and implications for future research. *The Journal of Nervous and Mental Disease, 198*(7), 470-477. doi:10.1097/NMD.0b013e3181e4ce24 [doi]

Prapas, C., & Mavreas, V. (2019). The relationship between quality of life, psychological wellbeing, satisfaction with life, and acculturation of immigrants in Greece. *Culture, Medicine and Psychiatry, 43*(1), 77-92.

Premium Times Nigeria (2018, February 23) "Buhari speaks on abducted Dapchi schoolgirls –". *Premium Times Nigeria*. Premium Times Nigeria. Retrieved 24 February 2018.

Premium Times Nigeria (2018, May 18)*"Nigerian soldiers battle Boko Haram, kill 15, rescue 49 women, children"*. Premium Times Nigeria*. Retrieved* 18 May *2018.*

Provost, C., (2013, September 13) Does migration change life for the better for people from poor countries? *The Guardian*. https://www.theguardian.com/global-development/2013/sep/13/migration-improve-life-people-poor-countries.

Pulgar, C. A., Trejo, G., Suerken, C., Ip, E. H., Arcury, T. A., & Quandt, S. A. (2016). Economic hardship and depression among women in Latino farmworker families. *Journal of Immigrant and Minority Health, 18*(3), 497-504.

Puyat, J. H. (2013). Is the influence of social support on mental health the same for immigrants and non-immigrants? *Journal of Immigrant and Minority Health, 15*(3), 598-605.

Pyakuryal, A., Tausig, M., Subedi, S., & Subedi, J. (2011). Strangers in a familiar land: The psychological consequences of internal migration in a developing country. *Stress and Health, 27*(3), e199-e208. doi:10.1002/smi.1363

Quang, V. D. (2008). Viet Nam: workers in transition. In Globalization, flexibilization and working conditions in Asia and the Pacific (pp. 383-411). *Chandos Publishing.*

Rees, P. (2001). Internal migration (rural-urban): Industrialized countries. *Elsevier*

Rees, P. (2020). Demography, International Encyclopaedia of Human Geography (Second Edition), *Elsevier*. Pages 239-256, ISBN 9780081022962. https://doi.org/10.1016/B978-0-08-102295-5.10252-5.

Regier, D. A., Boyd, J. H., Burke, J. D., Rae, D. S., Myers, J. K., Kramer, M., . . . Locke, B. Z. (1988). One-month prevalence of mental disorders in the United States: Based on five epidemiologic catchment area sites. *Archives of General Psychiatry, 45*(11), 977-986.

Reitmanova, S., & Gustafson, D. L. (2009). Mental health needs of visible minority immigrants in a small urban center: Recommendations for policymakers and service providers. *Journal of Immigrant and Minority Health, 11*(1), 46-56.

Richardson D. (2004). Background to annexation: Anglo-African credit relations in the bright of Biafra, 1700-1891 from slave trade to empire. *First Edition, ISBN-9780203323090. Routledge*.

Ringrose, J. (2007). Successful girls? Complicating post-feminist, neoliberal discourses of educational achievement and gender equality. *Gender and education*, *19*(4), 471-489.

Ritsner, M., & Ponizovsky, A. (1999). Psychological distress through immigration: The two-phase temporal pattern? *The International Journal of Social Psychiatry, 45*(2), 125-139.

Ritsner, M., Ponizovsky, A., Nechamkin, Y., & Modai, I. (2001). Gender differences in psychosocial risk factors for psychological distress among immigrants. *Comprehensive Psychiatry, 42*(2), 151-160.

Ritsner, M., & Ponizovsky, A. (2003). Age differences in the stress process of recent immigrants. *Comprehensive Psychiatry, 44*(2), 135-141.

Ro, A., & Goldberg, R. E. (2017). Post-migration employment changes and health: A dyadic spousal analysis. *Social Science & Medicine, 191*, 202-211.

Roberts, C., & Sarangi, S. (2005). Theme-oriented discourse analysis of medical encounters. *Medical education*, 39(6), 632-640.

Robley, L. R. (1995). The ethics of qualitative nursing research. *Journal of Professional Nursing*, *11*(1), 45-48.

Rodriguez Alvarez, E., Lanborena Elordui, N., Errami, M., Rodriguez Rodriguez, A., Vallejo de la Hoz, G., & Moreno Marquez, G., (2009). Relationship between migrant

status and social support and quality of life in Moroccans in the Basque country (Spain). *Gaceta Sanitaria, 23(Suppl. 1)., 23*(1), 29-37.

Rodriguez, J. K., Holvino, E., Fletcher, J. K., & Nkomo, S. M. (2016). The theory and praxis of intersectionality in work and organisations: Where do we go from here? *Gender, Work and Organization*, *23*(3), 201-222.

Rodriguez, L., & Smith, J. A. (2014). 'Finding your own place': an interpretative phenomenological analysis of young men's experience of early recovery from addiction. *International Journal of Mental Health and Addiction*, 12(4), 477-490.

Roley, M. E., Kawakami, R., Baker, J., Hurtado, G., Chin, A., & Hovey, J. D. (2014). Family cohesion moderates the relationship between acculturative stress and depression in Japanese adolescent temporary residents. *Journal of Immigrant and Minority Health, 16*(6), 1299-1302.

Ronzoni, P., Dogra, N., Omigbodun, O., Bella, T., & Atitola, O. (2010). Stigmatization of mental illness among Nigerian schoolchildren. *The International Journal of Social Psychiatry, 56*(5), 507-514.

Rose, T., Lindsey, M. A., Xiao, Y., Finigan-Carr, N. M., & Joe, S. (2017). Mental health and educational experiences among black youth: A latent class analysis. *Journal of Youth and Adolescence, 46*(11), 2321-2340.

Rosemberg, F., & Troya, E. (2000). Culture, migration, and mental health: Southern cone youth in Mexico. *Nueva Antropologia, 17*(57), 23-32.

Rossetto, M., Brand, É. M., Teixeira, L. B., Oliveira, Dora Lucia Leidens Correa de, & Serrant, L. (2018). The silences framework: Method for research of sensitive themes and marginalized health perspectives. *Texto & Contexto-Enfermagem, 26*(4).

Rowley, J. (2012). Conducting research interviews. *Management Research Review,*

Ruiz-grosso, P., Bernabe-ortiz, A., Diez-canseco, F., Gilman, R. H., Checkley, W., Bennett, I. M., & Miranda, J. J. (2015). Depressive mood among within-country migrants in peri-urban shantytowns of Lima, Peru. *Journal of Immigrant and Minority Health, 17*(6), 1635-1642.

Ryan, C. O. N. (2015). Lagos Never Spoils: The Aesthetics, Affect, and Politics of the City in Nigerian Screen Media. *Michigan State University. English-Doctor of Philosophy.*

Salaam, T. (2003) A Brief Analysis on The Situation of Women In Nigeria Today, *DSM.*

Salami, B., Yaskina, M., Hegadoren, K., Diaz, E., Meherali, S., Rammohan, A., & Ben-Shlomo, Y. (2017). Migration and social determinants of mental health: Results from the Canadian health measures survey. *Canadian Journal of Public Health = Revue Canadienne De Sante Publique, 108*(4), e362-e367. doi:10.17269/cjph.108.6105

Salgado de Snyder, V.N., Cervantes, R. C., & Padilla, A. M. (1990). [Migration and post-traumatic stress disorders: The case of Mexicans and central Americans in the United States]. *Acta Psiquiatrica y Psicologica De America Latina, 36*(3-4), 137-145.

Salgado, H., Haviland, I., Hernandez, M., Lozano, D., Osoria, R., Keyes, D., . . . Zúñiga, M. L. (2014). Perceived discrimination and religiosity as potential mediating factors between migration and depressive symptoms: A transnational study of an indigenous Mayan population. *Journal of Immigrant and Minority Health, 16*(3), 340-7.

Salmons, J. (2014). Qualitative online interviews: Strategies, design, and skills. *Sage Publications.*

Sam, D. L. (2000). Psychological adaptation of adolescents with immigrant backgrounds. *The Journal of Social Psychology, 140*(1), 5-25.

Sam, D. L. (2001). Satisfaction with life among international students: An exploratory study. *Social Indicators Research, 53*(3), 315-337.

Sanchez, M., Dillon, F., Ruffin, B., & De La Rosa, M. (2012). The influence of religious coping on the acculturative stress of recent Latino immigrants. *Journal of Ethnic and Cultural Diversity in Social Work,* 21(3), 171-194.

Sankoh, O., Sevalie, S., & Weston, M. (2018). Mental health in Africa. *The Lancet. Global Health, 6*(9), e954-e955. doi:S2214-109X(18)30303-6 [pii]

Sanni, O., Fm, O., An, A., Ayinmode, B., & Buhari, O. (2020). Epidemiology of depression in a primary care setting in north-central Nigeria. *Age (Years), 20*(29), 32.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., ... & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & quantity*, *52*(4), 1893-1907.

Sawicki, J. (1991). Disciplining Foucault: Feminism, Power, and the Body. New York and London: *Routledge.*

Schachter, A., Kimbro, R. T., & Gorman, B. K. (2012). Language proficiency and health status: Are bilingual immigrants healthier? *Journal of Health and Social Behavior, 53*(1),124-45.

Schultz, T. P. (1982). Lifetime migration within educational strata in Venezuela: Estimates of a logistic model. *Economic Development and Cultural Change, 30*(3), 559-593.

Schultz, T. P. (2003). Wage rentals for reproducible human capital: Evidence from Ghana and the ivory coast. *Economics & Human Biology, 1*(3), 331-366.

Schwartz, S. J. (2007). The applicability of familism to diverse ethnic groups: A preliminary study. *The Journal of Social Psychology, 147*(2), 101-18.

Seibold, C. (2000). Qualitative research from a feminist perspective in the postmodern era: Methodological, ethical, and reflexive concerns. *Nursing Inquiry,* 7(3), 147-155.

Seitz, S. (2016). Pixilated partnerships, overcoming obstacles in qualitative interviews via Skype: A research note. *Qualitative Research,* 16(1), 229-235. doi: 10.1177/1.468794115577011

Serrant, L. (2020). Silenced Knowing: An Intersectional Framework for Exploring Black Women's Health and Diasporic Identities. *Frontiers in Sociology*, 5, 1.

Serrant-Green, L. (2004) Black Caribbean men, sexual health decisions and silences. Ph.D. Thesis, *Nottingham School of Nursing,* University of Nottingham, UK.

Serrant-Green, L. (2005). We need to talk--the role of interviewing in research. *Nurse Researcher,* 13(1), 3-4.

Serrant-Green, L. (2011). The sound of 'silence': A framework for researching sensitive issues or marginalised perspectives in health. *Journal of Research in Nursing, 16*(4), 347-360. doi:10.1177/1744987110387741

Seun-Fadipe, C. T., Akinsulore, A. A., & Oginni, O. A. (2019). Workplace violence and risk for psychiatric morbidity among health workers in a tertiary health care setting in Nigeria: Prevalence and correlates. *Psychiatry Research, 272*, 730-736.

Sheikh, T. L., Adekeye, O., Olisah, V. O., & Mohammed, A. (2015). Stigmatisation of mental illness among employees of a northern Nigerian university. *Nigerian Medical Journal: Journal of the Nigeria Medical Association, 56*(4), 244-248. doi:10.4103/0300-1652.169697 [doi]

Shittu, R., Odeigah, L., Issa, B., Olanrewaju, G., Mahmoud, A., & Sanni, M. (2014). Association between depression and social demographic factors in a Nigerian family practice setting. *Open Journal of Depression, 3*(01), 18.

Sibiri, A. E., Ayinmoro, A. D., & Jack Jackson, T. C. B. (2014). The socio-cultural effects of internal migration among the people of akutupa Kiri in the north-central zone, Nigeria. *Mediterranean Journal of Social Sciences, 5*(15), 494-503.

Sidorchuk, A., Engström, K., Johnson, C. M., Kayser Leeoza, N., & Möller, J. (2017). Employment status and psychological distress in a population-based cross-sectional study in Sweden: The impact of migration. *BMJ Open, 7*(4), e014698-e014698. doi:10.1136/bmjopen-2016-014698

Sijuwade, P. O. (1994). Sex differences in stress, illness, and coping resources among the Nigerian elderly. *Social Behavior and Personality: An International Journal, 22*(3), 239-260.r

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression, and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors. *The British Journal of Psychiatry: The Journal of Mental Science, 170,* 351-357.

Silveira, E., & Allebeck, P. (2001). Migration, ageing and mental health: An ethnographic study on perceptions of life satisfaction, anxiety, and depression in older Somali men in east London. *International Journal of Social Welfare, 10*(4), 309-320.

Skeldon, R. (2018). Of migration, great cities, and markets: Global systems of development. *Global history and migrations* (pp. 183-215*). Routledge.*

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., ... & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12-20.

Smith, D. J. (2006). Internal migration and the escalation of ethnic and religious violence in urban Nigeria. Cities in contemporary Africa (pp. 53-69) *Springer. Palgrave Macmillan,* New York. https://doi.org/10.1057/9780230603349_3.

Smith D. J. (2010a). Promiscuous Girls, Good Wives, and Cheating Husbands: Gender Inequality, Transitions to Marriage, and Infidelity in South-eastern Nigeria. *Anthropological Quarterly*, 83(1), 10.1353/anq.0.0118.

Smith, J.A., Flowers, P. and Larkin, M. (2009). Interpretive phenomenological analysis: Theory, method, and research. London: *Sage.*

Smith, J. (2010b). Interpretative Phenomenological Analysis. *Existential Analysis*, 21(2), 186-192.

Solórzano, D. G., & Villalpando, O. (1998). Critical race theory, marginality, and the experience of students of color in higher education. *Sociology of education: Emerging perspectives,* 21, 211-222.

Song, C., Fu, Z., & Wang, J. (2019). Social support and academic stress in the development of psychological adjustment in Chinese migrant children: Examination of compensatory model of psychological resilience. *Child Indicators Research, 12*(4), 1275-1286.

Sparks R. J. (2004). The two princes of Calabar: An eighteenth-century Atlantic odyssey. *Harvard University Press,* (0-674-01312-3).

Spiegelberg, H. (1982). The Phenomenological Movement: A Historical Introduction. 3rd edition. Boston: *Martinus Nijhoff.*

Sque, M., & Payne, S. A. (1996). Dissonant loss: the experiences of donor relatives. *Social science & medicine*, *43*(9), 1359-1370.

Strauss, A., & Corbin, J. M. (1997). Grounded theory in practice. *Sage.*

Stake, R. E. (2005). Qualitative case studies. *The Sage handbook of qualitative research,* 3, 443-466.

Stanley, N., & Chinwe, E. S. (2020). Prevalence of mental disorders in abakaliki, Ebonyi state, southeastern Nigeria. *Journal of the American Psychiatric Nurses Association*, 1078390320951910.

Steel, J. L., Dunlavy, A. C., Harding, C. E., & Theorell, T. (2017). The psychological consequences of pre-emigration trauma and post-migration stress in refugees and immigrants from Africa. *Journal of Immigrant and Minority Health, 19*(3), 523-532.

Steiger, S. and Goritz, A. S. 2006. Using instant messaging for Internet-based interviews. *Cyberpsychology & Behavior*, 9(5): 552–559.

Steinhausen, H., Bearth-Carrari, C., & Metzke, C. W. (2009). Psychosocial adaptation of adolescent migrants in a Swiss community survey. *Social Psychiatry and Psychiatric Epidemiology*, *44*(4), 308-316.

Stewart, A. J., & McDermott, C. (2004). Gender in psychology. *Annual Review of Psychol*ogy, 55, 519-544.

Sucharew, H., & Macaluso, M. (2019). Progress notes methods for research evidence synthesis: the scoping review approach. *Journal of hospital medicine*, *14*(7), 416-418.

Sugisawa, H., Shibata, H., Hougham, G. W., Sugihara, Y., & Liang, J. (2002). The impact of social ties on depressive symptoms in U.S. and Japanese elderly. *The Journal of Social Issues, 58*(4), 785-804. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1111/1540-4560.00290

Suleiman, D. E. (2016). Mental health disorders in Nigeria: A highly neglected disease. *Annals of Nigerian Medicine, 10*(2), 47.

Switek, M. (2012). Internal migration and life satisfaction: Well-being effects of moving as a young adult. *IZA Discussion Paper* No. 7016,

Taft, P., and Lawrence, K., (2016, February 29) Confronting the Unthinkable: The Complex Dimensions Behind Women and Child Suicide Bombers in Northern Nigeria. *The Fund for Peace*. Assessed from: https://fundforpeace.org/2016/02/29/confronting-the-unthinkable-the-complex-dimensions-behind-women-and-child-suicide-bombers-in-northern-nigeria/

Taiwo, H., Ladapo, O., Aina, O. F., Lawal, R. A., Adebiyi, O. P., Olomu, S. O., & Aina, R. B. (2008). Long stay patients in a psychiatric hospital in Lagos, Nigeria. *African Journal of Psychiatry, 11*(2), 128-132.

Taloyan, M., Johansson, S. E., Sundquist, J., Koctürk, T. O., & Johansson, L. M. (2008). Psychological distress among Kurdish immigrants in Sweden. *Scandinavian Journal of Public Health., 36*(2), 190-196.

Tang, T. N., Oatley, K., & Toner, B. B. (2007). Impact of life events and difficulties on the mental health of Chinese immigrant women. *Journal of Immigrant and Minority Health, 9*(4), 281-90. doi:http://dx.doi.org.lcproxy.shu.ac.uk/10.1007/s10903-007-9042-1

Tarricone, I., Boydell, J., Kokona, A., Triolo, F., Gamberini, L., Sutti, E., . . . Berardi, D. (2016). Risk of psychosis and internal migration: Results from the bologna first-episode psychosis study. *Schizophrenia Research, 173*(1-2), 90-93.

Taru, M. Y., Bamidele, L. I., Makput, D. M., Audu, M. D., Philip, T. F., John, D. F., . . . Annah, G. B. (2018). Posttraumatic stress disorder among internally displaced victims of Boko haram terrorism in north-eastern Nigeria. *Jos Journal of Medicine, 12*(1-2), 8-15.

Tedheke, M.E.U. (2007). A political economy explanation of the Nigerian civil war. Unpublished Ph.D. Thesis, *Ahmadu Bello University, Zaria.*

Tezcan, T. (2014). The complex nature of migration at a conceptual level: an overlook of the internal migration experience of Gebze through fuzzy cognitive mapping method. In Fuzzy Cognitive Maps for Applied Sciences and Engineering (pp. 319-354). *Springer, Berlin, Heidelberg.*

Thapa, S. B., & Hauff, E. (2005). Gender differences in factors associated with psychological distress among immigrants from low-and middle-income countries. *Social Psychiatry and Psychiatric Epidemiology., 40*(1), 78-84.

The Guardian. (2012, September 25) Boko Haram attacks – timeline". *The Guardian* Retrieved 30 July 2014.

The Guardian. (2018, December 28) Boko Haram launches series of attacks in north-east Nigeria". *The Guardian* Retrieved 28 December 2018.

The Guardian *(2020, December 26)* "Boko Haram kidnaps 40 loggers and kills three in north-east Nigeria". Retrieved 26 December 2020.

The Telegraph (2014, November 16)"Nigerian army retakes control of key Boko Haram town". *The Telegraph*. Retrieved 21 November 2020.

This Day Newspaper (2017, December 05) Growing Rate of Suicides in Nigeria. *This Day Newspaper* https://www.thisdaylive.com/index.php/2017/12/05/growing-rate-of-suicides-in-nigeria/. Assessed 03 February 2021.

Thomas, J. (1993). Doing critical ethnography (Vol. 26). *Sage.*

Thomas, C. S. (2015). A new look at the black middle class: Research trends and challenges. *Sociological Focus, 48*(3), 191-207.

Thurmond, V. A. (2001). The point of triangulation. *Journal of nursing scholarship*, *33*(3), 253-258.

Tinghög, P., Al-Saffar, S., Carstensen, J., & Nordenfelt, L. (2010). Immigrant-and non-immigrant-specific factors' association with mental ill-health among immigrants in Sweden. *International Journal of Social Psychiatry., 56*(1), 74-93.

Tinghög, P., Hemmingsson, T., & Lundberg, I. (2007). To what extent may the association between immigrant status and mental illness be explained by socioeconomic factors? *Social Psychiatry and Psychiatric Epidemiology., 42*(12), 990-996.

Tomita, A., Labys, C. A., & Burns, J. K. (2014). The relationship between immigration and depression in South Africa: Evidence from the first south African national income dynamics study. *Journal of Immigrant and Minority Health, 16*(6), 1062-8.

Tomlinson, M. (2008). Major depressive disorder is common in the elderly population of Yoruba-speaking regions of Nigeria. *Evidence-Based Mental Health, 11*(2), 58-58.

Tong, Y., & Piotrowski, M. (2012). Migration and health selectivity in the context of internal migration in China, 1997–2009. *Population Research and Policy Review, 31*(4), 497-543.

Torres, J. M., Alcántara, C., Rudolph, K. E., & Viruell-Fuentes, E. A. (2016). Cross-border ties as sources of risk and resilience: Do cross-border ties moderate the relationship between migration-related stress and psychological distress for Latino migrants in the United States? *Journal of Health and Social Behavior, 57*(4), 436-452.

Troy, P. H., Wyness, L. A., & McAuliffe, E. (2007). Nurses' experiences of recruitment and migration from developing countries: a phenomenological approach. *Human Resources for Health*, *5*(1), 1-7.

Tseng, W. (2001). Handbook of cultural psychiatry *Academic Press.*

Tuller, M. A. (2013). The healthy migrant hypothesis and internal migration in Accra, Ghana (M.A.). Available from *ProQuest Dissertations & Theses A&I.* (1466612892).

Tungchama, F. P., Egbokhare, O., Omigbodun, O., & Ani, C. (2019). Health workers' attitude towards children and adolescents with mental illness in a teaching hospital in north-central Nigeria. *Journal of Child & Adolescent Mental Health, 31*(2), 125-137.

Tylor, E.B. (1871) Primitive Culture: Researching into the development of mythology, philosophy, religion, art and custom (Volume 2). *J. Murray.*

Ubaka, C. M., Chikezie, C. M., Amorha, K. C., & Ukwe, C. V. (2018). Health professionals' stigma towards the psychiatric ill in Nigeria. *Ethiopian Journal of Health Sciences, 28*(4)

Udodiong, I., (2019, October 30). Lagos stress: 5 Nigerian cities that are better for your mental health. *Pulse. Ng.* Retrieved from https://www.pulse.ng/bi/lifestyle/lagos-stress-5-nigerian-cities-that-are-better-for-your-mental-health/p5m4n4j.

Ugochukwu, O., Mbaezue, N., Lawal, S. A., Azubogu, C., Sheikh, T. L., & Vallieres, F. (2020). The time is now: Reforming Nigeria's outdated mental health laws. *The Lancet. Global Health, 8*(8), e989-e990. doi: S2214-109X(20)30302-8 [pii]

Ugwu, C., Onyeneho, N. G., & I'Aronu, N. J. (2012). The place of autochthonous disease aetiology in mental health-seeking behaviors in a globalizing Nigerian community. *International Quarterly of Community Health Education, 32*(4), 325-337.

Ukpong, D. I. (2006). Demographic factors and clinical correlates of burden and distress in relatives of service users experiencing schizophrenia: A study from south-western Nigeria. *International Journal of Mental Health Nursing, 15*(1), 54-59.

Ukpong, D. I., & Abasiubong, F. (2010). Stigmatising attitudes towards the mentally ill: A survey in a Nigerian university teaching hospital. *South African Journal of Psychiatry, 16*(2), 56-60.

United Nations, (1982). International Migration Policies and Programmes: A World Survey. *New York: United Nations.*

United Nations (1998) Guiding principles on internal displacement. E/CN.4/1998/53/Add. https://www.un.documentsnet/gpid.htm.

United Children's Fund (UNICEF) (2021): Nigeria, Key Demographic indicators. https://data.unicef.org/country/nga/

United Nations Department of Economic and Social Affairs (2019): World Population prospects. Assessed from: *https://population.un.org/wpp/.*

United Nations Development Programme (2009) Human Development Report: Overcoming Barriers: Human Mobility and Development, available at http://hdr.undp.org/en/reports/global/ hdr2009/; accessed on 19th June 2012.

United Nations Development Programme (2018) National Human Development Report 2018: Nigeria. Assessed from National Human Development Report 2018: Nigeria | Human Development Reports (undp.org)

United Nations Development Programme (2020) Human Development Report: The Next Frontier: Human Development and the Anthropocene. Assessed from:

http://hdr.undp.org/sites/default/files/Country-Profiles/NGA.pdf

United Nations High Commission for Refugees (2021, June[a]) Refugee Data Finder. https://www.unhcr.org/refugee-staistics

United Nations High Commission for Refugees (2021b) Internally Displaced People. https://www.unhcr.org/internally-displaced-people.html

United Nations Office on Drugs and Crime. (2018). Drug use in Nigeria. United Nations Office on Drugs and Crime. Retrieved from https://www.unodc.org/documents/data-and-analysis/statistics/Drugs/

United States AID (2018, January 23) Nigeria Country Profile Fact Sheet. Nigeria. Retrieved from: https://www.usaid.gov/documents/1860/nigeria-country-profile-fact-sheet

United States. Department of State (2013, June 3) Rewards for Justice – First Reward Offers for Terrorists in West Africa".

Ussher, J. M. and Mooney-Somers, J. (2000) Negotiating lesbian desire and sexual subjectivity: narratives of young lesbian avengers. *Sexualities*, 3(2), pp. 183-200

Uwakwe, R. (2000). The pattern of psychiatric disorders among the aged in a selected community in Nigeria. *International Journal of Geriatric Psychiatry, 15*(4), 355-362. doi:10.1002/(SICI)1099-1166(200004)15:4<355: AID-GPS126>3.0.CO;2-8

Uwakwe, R., Oladeji, B. D., & Gureje, O. (2012). Traumatic events and suicidal behaviour in the Nigerian survey of mental health and well-being: Trauma and suicidal outcomes in Nigeria. *Acta Psychiatrica Scandinavica, 126*(6), 458-466. doi:10.1111/j.1600-0447.2012.01852. x.

Uyanga, J. (1979). The characteristics of patients of spiritual healing homes and traditional doctors in South-eastern Nigeria. *Social Science and Medicine. Part A Medical Psychology and Medical Sociology*, 13, 323–329. doi:10.1016/0271-7123(79)90053-1.

Uzokwe, A. O. (2003). Surviving in Biafra: The story of the Nigerian civil war: Over two million died *I Universe.*

Vahabi, M., Wong, J. P., & Lofters, A. (2018). Migrant live-in caregivers' mental health in Canada. *Community Mental Health Journal, 54*(5), 590-599.

Van Manen, M. (1990) Researching Lived Experience: Human Science for an Action Sensitive Pedagogy. Albany, New York: State *University of New York Press.*

van Mens-Verhulst, J., & Radtke, L. (2009). Intersectionaliteit en Sociale inclusie: het ei... van Troje. Deel 1: Het ei van Columbus. *Journal of Social Intervention: Theory and Practice*, 18(3), 4-22.

Vanguard (2014, August 08) "Boko Haram plans more attacks, recruits many young people". . Retrieved 8 August 2014.

Varghese, A., & Jenkins, S. R. (2009). Parental overprotection, cultural value conflict, and psychological adaptation among Asian Indian women in America. *Sex Roles, 61*(3-4), 235-251.

Varrella, S., (2020) Literacy rate in Nigeria 2018, by zone and gender. *Statista.* Assessed from: https://www.statista.com/statistics/1124745/literacy-rate-in-nigeria-by-zone-and-gender/.

Vega, W. A., Kolody, B., & Valle, J. R. (1987). Migration and mental health: An empirical test of depression risk factors among immigrant Mexican women. *The International Migration Review, 21*(3), 512-530.

Verloo, M. (2006). Multiple inequalities, intersectionality, and the European Union. *European Journal of Women's Studies*, *13*(3), 211-228.

Virupaksha, H. G., Kumar, A., & Nirmala, B. P. (2014). Migration and mental health: An interface. *Journal of Natural Science, Biology, and Medicine*, *5*(2), 233-239. doi:10.4103/0976-9668.136141

Waage, T. (2015). Mutual dependency: Young male migrants from the Central African Republic in urban Cameroon. *Zeitschrift Für Ethnologie*, 111-130.

Wada, Y. H., Rajwani, L., Anyam, E., Karikari, E., Njikizana, M., Srour, L., & Khalid, G. M. (2021). Mental health in Nigeria: A Neglected issue in Public Health. *Public Health in Practice*, 2, 100166.

Walker, A. (June 2012) What is Boko Haram. United States Institute for Peace. *Special Report 308*. https://www.usip.org/sites/default/files/resources/SR308.pdf

Wang, J., Zou, J., Luo, J., Liu, H., Yang, Q., Ouyang, Y., . . . Lin, Q. (2019). Mental health symptoms among rural adolescents with different parental migration experiences: A cross-sectional study in China. *Psychiatry Research, 279*, 222-230.

Wang, B., Li, X., Stanton, B., & Fang, X. (2010). The influence of social stigma and discriminatory experience on psychological distress and quality of life among rural-to-urban migrants in China. *Social Science & Medicine, 71*(1), 84-92.

Warfa, N., Curtis, S., Watters, C., Carswell, K., Ingleby, D., & Bhui, K. (2012). Migration experiences, employment status and psychological distress among Somali immigrants: A mixed-method international study. *BMC Public Health, 12*, 749-749. doi:10.1186/1471-2458-12-749

Warner, L. R. (2008). A best practice guide to intersectional approaches in psychological research. *Sex roles*, *59*(5), 454-463.

Waterman, A. S. (1993). Two conceptions of happiness: Contrasts of personal expressiveness (eudaimonia) and hedonic enjoyment. *Journal of personality and social psychology*, *64*(4), 678.

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *Annual Review of Sociology*, 40, 431-457.

Watson, K. (2005). Queer theory. *Group analysis*, 38(1), 67-81.

Weber, L., & Fore, M. E. (2007). Race, ethnicity, and health: An intersectional approach. In *Handbooks of the sociology of racial and ethnic relations* (pp. 191-218). Springer, Boston, MA.

Weishaar, H. B. (2008). Consequences of international migration: A qualitative study on stress among polish migrant workers in Scotland. *Public Health, 122*(11), 1250-1256. doi: 10.1016/j.puhe.2008.03.016

Wells, K. B., Stewart, A., Hays, R. D., Burnam, M. A., Rogers, W., Daniels, M., . . . Ware, J. (1989). The functioning and well-being of depressed patients: Results from the medical outcomes study. *Jama, 262*(7), 914-919.

Wen, Y., & Hanley, J. (2016). Enhancing social support for migrant families: A case study of community services in a Shanghai urban village and implications for intervention. *Asian Social Work and Policy Review,* 10(1), 76-89.

Wertz, F. J. (2011). Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry. *Guilford Press.*

Westbrook, A. H. (2011). Mental health legislation and involuntary commitment in Nigeria: A call for reform. *Washington. University. Global Studies. Law. Review., 10,* 397.

Westphal, C. (2016). Healthy migrants? Health selection of internal migrants in Germany. *European Journal of Population, 32*(5), 703-730.

White, A. M., & Dotson, W. (2010). It takes a village to raise a researcher: Narrative interviewing as intervention, reconciliation, and growth. *Journal of Black Psychology,* 36(1), 75-97.

Wilding, S. (2018). (Un) healthy migrants: Unpacking the relationship between health and migration within Great Britain. *(Doctoral Dissertation, University of Southampton).,*

Wilding, S., Martin, D., & Moon, G. (2016). The impact of limiting long term illness on internal migration in England and Wales: New evidence from census microdata. *Social Science & Medicine, 167,* 107-115.

Wilding, S., Martin, D., & Moon, G. (2018). Place and preference effects on the association between mental health and internal migration within Great Britain. *Health & Place, 52,* 180-187. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1016/j.healthplace.2018.06.008

Williams, C. L., & Berry, J. W. (1991). Primary prevention of acculturative stress among refugees: application of psychological theory and practice. *American psychologist,* 46(6), 632.

Williams, M., and May, M.T. (1996) Introduction to the philosophy of social research. *London: UCL Press.*

Williams, E., Tillin, T., Richards, M., Tuson, C., Chaturvedi, N., Hughes, A., & Stewart, R. (2015). Depressive symptoms are doubled in older British south Asian and black Caribbean people compared with Europeans: Associations with excess co-morbidity and socioeconomic disadvantage. *Psychological Medicine, 45*(9), 1861-1871.

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity & Health,* 5(3-4), 243-268.

Winkelman, S. B., Chaney, E. H., & Bethel, J. W. (2013). Stress, depression and coping among Latino migrant and seasonal farmworkers. *International Journal of Environmental Research and Public Health, 10*(5), 1815-1830.

Wojcik, W., & Bhugra, D. (2010). Loss and cultural bereavement. *Mental Health of Refugees and Asylum Seekers*, 211-224.

Wolcott, H. F. (2008). Writing up qualitative research. *Sage Publications.*

Wong, F. K. D., Chang, Y. L., & He, X. S. (2009). Correlates of psychological wellbeing of children of migrant workers in Shanghai, China. *Social Psychiatry and Psychiatric Epidemiology, 44*(10), 815-824.

Wong, D. F. K., & Chang, Y. (2010). Mental health of Chinese migrant workers in factories in Shenzhen, China: Effects of migration stress and social competence. *Social Work in Mental Health, 8*(4), 305-318.

Wong, D. F., Keung, He, X., Leung, G., Lau, Y., & Chang, Y. (2008). Mental health of migrant workers in China: Prevalence and correlates. *Social Psychiatry and Psychiatric Epidemiology, 43*(6), 483-489. doi:http://dx.doi.org.lcproxy.shu.ac.uk/10.1007/s00127-008-0341-1

Wong, D. F. K., Lam, D., Yan, P., & Hung, M. (2004). The impacts of acculturative stress and social competence on the mental health of mainland Chinese immigrant youth in Hong Kong. *British Journal of Social Work, 34*(7), 1009-1024.

World Bank (2020): Nigeria- Overview. *The world Bank in Nigeria. https://www.worldbank.org/en/country/nigeria/overview#1*

Working Group on Environmental Audit Conference (2016). Paper presented at the ABUJA. *Retrieved from http://www.oaugf.ng/6thawam2016/index.php/about/abuja.*

World Health Organization. (2001). The world health report 2001: Mental health: new understanding, new hope. *World Health Organization.*

World Health Organization. (2006). The world health report 2006: Working together for health *World Health Organization.*

World Health Organization. (2014). Social determinants of mental health. *World Health Organization.*

World Health Organization. (2015). Mental health atlas 2014. *World Health Organization*. Available at: *https://apps.who.int/iris/handle/10665/178879*

World Health Organization. (2016). World health statistics 2016: Monitoring health for the SDGs sustainable development goals *World Health Organization.*

World Health Organization. (2019a). Suicide in the World: Global Health Estimates, *World Health Organization.*

World Health Organisation (2019, Octoberb) The challenge of gender inequality in Nigeria's surveillance network. *World Health Organization.* Assessed from: *https://www.afro.who.int/news/challenge-gender-inequality-nigerias-surveillance-network*

World Health Organisation (2019, November) Mental disorders. *World Health organisation.*

World Watch Research (2019, January) Nigeria: Country Dossier. Assessed from *Microsoft Word - TEMPLATE - COUNTRY DOSSIER.docx (opendoors.no).*

Wu, H., Wu, S., Wu, H., Xia, Q., & Li, N. (2017). Living arrangements and health-related quality of life in Chinese adolescents who migrate from rural to urban schools: Mediating effect of social support: *International Journal of Environmental Research and Public Health, 14*(10), 1249.

Wu, Q., Ge, T., Emond, A., Foster, K., Gatt, J. M., Hadfield, K., . . . Wouldes, T. A. (2018). Acculturation, resilience, and the mental health of migrant youth: A cross-country comparative study. *Public Health, 162*, 63-70. doi: 10.1016/j.puhe.2018.05.006

Wylie, A. (2012). Annual abstract of statistics. *Refer*, *28*(2), 12.

Xu, C., Gong, X., Fu, W., Xu, Y., Xu, H., Chen, W., & Li, M. (2020). The role of career adaptability and resilience in mental health problems in Chinese adolescents. *Children and Youth Services Review*, 112, 104893.

Xuesong, H., Keung, W. F., & Shouchui, Z. (2010). Rural-Urban Migration and mental health: Evidence from Shanghai. *Sociological Studies*, 1, 111-29.

Yan, Y., Wang, S., Zhou, W., Wang, S., & Gong, S. (2019). Does immigrant generation matter? Re-examining the ethnic density effects on mental health of ethnic minorities in Britain. *American Journal of Health Behavior, 43*(5), 924-936. doi:10.5993/AJHB.43.5.5

Yang, M. S. (2017). The impacts of life events on depression in later life among older Hmong immigrants *University of Massachusetts Boston.*

Yang, M., Dijst, M., & Helbich, M. (2018). Mental health among migrants in Shenzhen, China: Does it matter whether the migrant population is identified by hukou or birthplace? *International Journal of Environmental Research and Public Health, 15*(12), 2671.

Yang, M., Dijst, M., & Helbich, M. (2020). Migration trajectories and their relationship to mental health among internal migrants in urban China: A sequence alignment approach. *Population, Space and Place, 26*(5), e2304.

Yin, R. K. (2009). How to do better case studies. *The SAGE handbook of applied social research methods*, 2(254-282).

Ying, L., Yan, Q., Shen, X., Jia, X., & Lin, C. (2019). Economic pressure and loneliness in migrant children in China: The mediating roles of parent-child communication and parental warmth. *Child Psychiatry & Human Development, 50*(1), 142-149.

Young, R. A., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of vocational behavior*, *64*(3), 373-388.

Yu, P., & Berryman, D. L. (1996). The relationship among self-esteem, acculturation, and recreation participation of recently arrived Chinese immigrant adolescents. *Journal of Leisure Research*, *28*(4), 251-273.

Yu, X., Stewart, S. M., Liu, I. K., & Lam, T. H. (2014). Resilience and depressive symptoms in mainland Chinese immigrants to Hong Kong. *Social Psychiatry and Psychiatric Epidemiology*, *49*(2), 241-249.

Yu, C., Lou, C., Cheng, Y., Cui, Y., Lian, Q., Wang, Z., . . . Wang, L. (2019). Young internal migrants' major health issues and health-seeking barriers in shanghai, China: A qualitative study. *BMC Public Health, 19*(1) doi:10.1186/s12889-019-6661-0

Yue, Z., Li, S., & Feldman, M. (2017). Acculturation and health among rural-urban migrants in China. Paper presented at the *2017 International Population Conference*,

Yussuf, A. D., Issa, B. A., Ajiboye, P. O., & Buhari, O. I. (2013). The correlates of stress, coping styles, and psychiatric morbidity in the first year of medical education at a Nigerian university. *African Journal of Psychiatry*, *16*(3), 206-215.

Yusuf, A., & Adeoye, E. (2011). Prevalence and causes of depression among civil servants in Osun state: Implications for counselling. *Edo Journal of Counselling, 4*(1-2), 92-102.

Záleská, V., Brabcová, I., & Vacková, J. (2014). Migration and its impact on mental and physical health: social support and its main functions. *Kontakt,* 16(4), e236-e241.

Zea, M. C., Jarama, S. L., & Bianchi, F. T. (1995). Social support and psychosocial competence: Explaining the adaptation to college of ethnically diverse students. *American Journal of Community Psychology*, *23*(4), 509.

Zever, I. S. Y. (2017). Assessment of relative's beliefs and attitude on mental illness and treatment in Kano, Nigeria. *Annals of Medical and Health Sciences Research, 7*(7)

Zhang, Q., Luo, Y., Chen, H., Zhang, X., Deng, S., Zeng, W., & Wang, Y. (2019). Migrate with parent(s) or not? Developmental outcomes between migrant and left-behind children from rural China. *Child Indicators Research, 12*(4), 1147-1166.

Zhao, X., Chen, J., Chen, M., Lv, X., Jiang, Y., & Sun, Y. (2014). Left-behind children in rural China experience higher levels of anxiety and poorer living conditions. *Acta Paediatrica, 103*(6), 665-670.

Zhong, B., Liu, T., Chiu, H. F., Chan, S. S., Hu, C., Hu, X., . . . Caine, E. D. (2013). Prevalence of psychological symptoms in contemporary Chinese rural-to-urban migrant workers: An exploratory meta-analysis of observational studies using the SCL-90-R. *Social Psychiatry and Psychiatric Epidemiology, 48*(10), 1569-1581.

Zhong, H., Xu, J., & Piquero, A. R. (2017). Internal migration, social exclusion, and victimization: An analysis of Chinese rural-to-urban migrants. *Journal of Research in Crime and Delinquency, 54*(4), 479-514.

Zhou, Y., & Wang, J. (2020). Social support and mental health status of internal migrants in Beijing. *Social Behavior and Personality: an international journal*, 48(4), 1-16.

Zhu, Y., Gao, J., Nie, X., Dai, J., & Fu, H. (2019). Associations of individual social capital with subjective well-being and mental health among migrants: a survey from five cities in China. *International Health*, 11(Supplement_1), S64-S71.

Zhuang, X. Y., & Wong, D. F. K. (2017). Differential impacts of social support on mental health: A comparison study of Chinese rural-to-urban migrant adolescents and their urban counterparts in Beijing, China. *The International Journal of Social Psychiatry, 63*(1), 48-56. doi:http://dx.doi.org.hallam.idm.oclc.org/10.1177/0020764016678015

Zoom Video Communications Inc, (2018). GDPR Compliance. Available at: *https://support.zoom.us/hc/en-us/articles/360000126326-Official-Statement-EU-GDPR-Compliance*

Zoom Video Communications Inc, (2019a). Zoom Security Guide. Available at: *https://zoom.us/security*

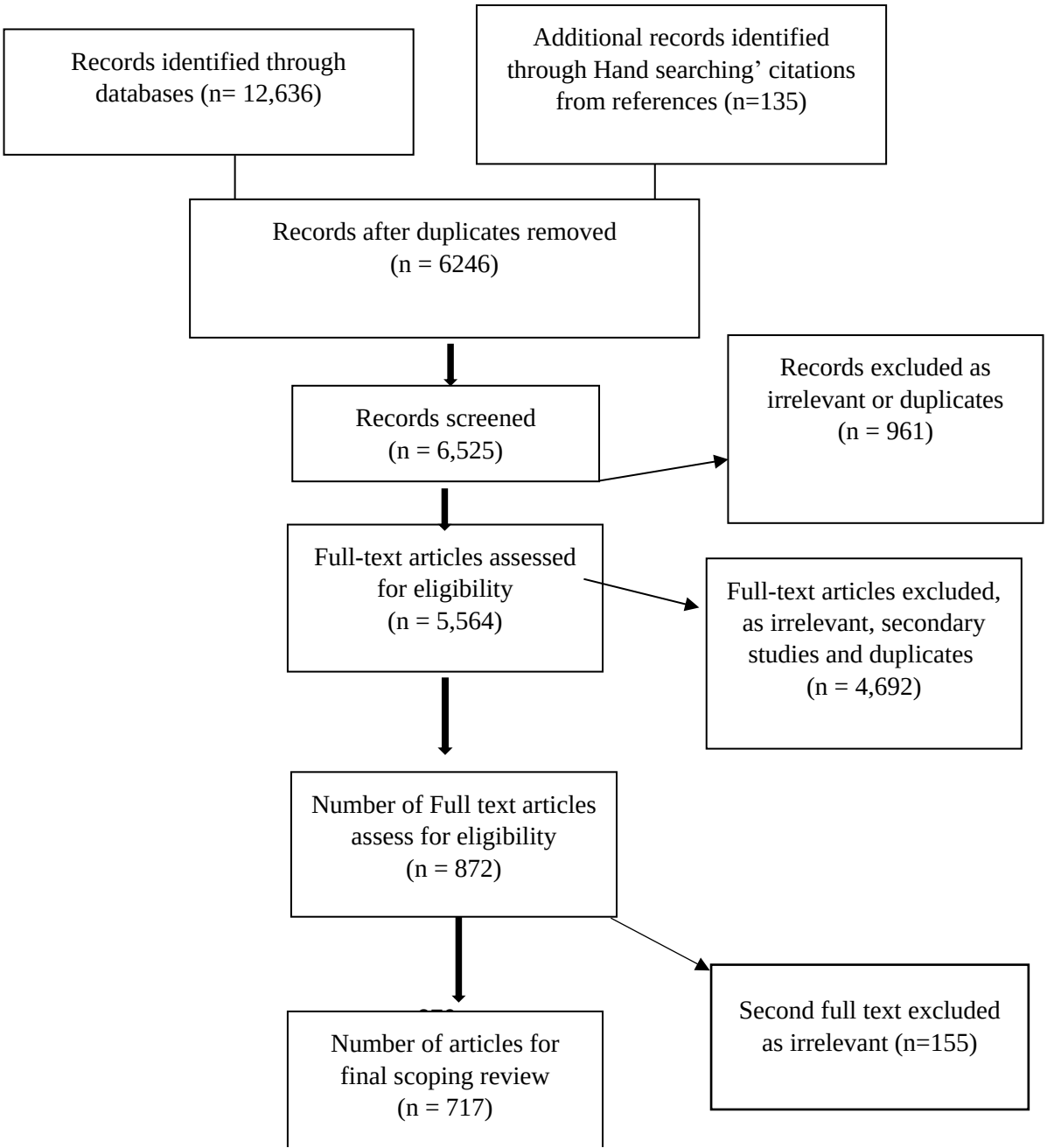
Zoom Video Communications Inc, (2019b). Zoom Privacy Policy. Available at: *https://zoom.us/privacy*

Zoom Video Communications Inc, (2021, June). Zoom Privacy Statement. Available at *https://zoom.us.*

Zvolensky, M., Bakhshaie, J., Paulus, D. J., Garza, M., Valdivieso, J., Sampogna, O., . . . Schmidt, N. B. (2016). The role of negative affect in the relation between subjective social status and mental health among economically disadvantaged Latinos in primary care. *International Journal of Human Rights in Healthcare, 9*(4), 219-228.

Appendix 1: PRISMA Flow Diagram

PRISMA 2009 Flow Diagram



Appendix 2: Participant Information Sheet

Title of Project: EXPLORING EXPERIENCES OF MENTAL HEALTH AMONG INTERNAL MIGRANTS IN NIGERIA

1. I would like to invite you to participate in this project, which is a study to explore your views about mental health issues. I am also interested in understanding factors that can impact mental health and if internal migrants' experiences can have an impact on their mental health. The researcher is inviting internal migrants in Nigeria aged 25 years and above and have lived in the current state of residence for a minimum of 1 year. This forms part of the informed consent to enable you to understand this study before deciding to take part.

2. **Why have you asked me to take part?** You have been selected to take part in this study because you are an internal migrant who moved from your state of origin to reside in _____ state. Participation in this research is voluntary. A copy of the information provided here is yours to keep, along with the consent form if you do decide to take part. You can still decide to withdraw at any time without giving a reason, or you can decide not to answer a particular question.

3. **What will I be required to do?** You will be required to talk about your experience and views about mental health. You will be required to describe any factors you feel will impact the mental health and wellbeing as an individual and as an internal migrant in Nigeria

4. **Where will this take place?** the interview can take place in your home or another setting that is convenient to you. I will arrange a time to meet when it is convenient for you and at your comfort if it is appropriate.

5. **How often will I have to take part, and for how long?** The interview will last for about an hour and the interview is a one-off. You might be contacted if further assistance is required, subject to your approval.

6. **Are there any possible risks or disadvantaged in taking part**? There are no risks in taking part in this research. You may find this stressful, but the study would not pose any risk to your health, safety, or wellbeing. However, I have to report to my project supervisor any information that concerns me as well as local agencies that help provide support.

7. **What are the possible benefits of taking part?** The outcome of this study will help to create more research to help provide more access and delivery of mental health services in Nigeria. A written report of the results will be sent to you if you want one.

8. **When will I have the opportunity to discuss my participation?** You can discuss any issues or questions you have before and after the interview.

9. **Will anyone be able to connect me with what is recorded and reported?** Any information you provide will be kept confidential (subject to the above). The researcher will not use your personal information for any purposes outside of this research project. If you agree to take part, your name will not be recorded in the study and your information will not be disclosed. Your responses to the questions will be used for this project only. You can be assured that if you take part in the project, you will remain anonymous. Your responses will be kept secure by password-protected computers and locked cabinets.

10. **Who will be responsible for all the information when this study is over**? The research will be kept with the researcher secured in password-protected computers and locked cabinets.

11. **Who will have access to it?** The researcher and the research team will have access to the data

12. **What will happen to the information when this study is over?** Your responses to the interview will be kept for a maximum of ten years but the transcribed data where the participants' identity has been changed will be kept in the university's online system.

13. **How will we use what is find out?** The project is part of the requirement for the completion of my Ph.D. degree in the Health & Wellbeing Faculty at Sheffield Hallam University, it is hoped that the project could be useful to improve the knowledge base about mental health issues and in the future create culturally relevant policies in Nigeria.

14. **How long is the whole study likely to last?** The study will last for four years and will be completed in September 2021.

15. **How can I find out about the results of the study?** A written report of the findings of the study can be sent to you if you want to.

16. **Will the findings of this project be published?** Yes, your responses will be published but only the anonymised version if you consent to your anonymised responses to be published.

This study was approved by UREC with Converis number ER7565232. Further information at https://www.shu.ac.uk/research/ethics-integrity-and-practice.

Details of who to contact if you have any concerns after the study is given below.

Researcher/ Research Team Details:

you may contact the researcher (Temi Labinjo) via email: labinjotemitope@gmail.com, b5038070@my.shu.ac.uk or call 07404282665.

Prof. Laura Serrant (Director of Studies/ Professor of Nursing) via email hwbls8@exchange.shu.ac.uk

Dr. Russell Ashmore (Second Supervisor/ Senior Mental health Nurse) via email hwbrja@exchange.shu.ac.uk

You should contact the Data Protection Officer if:

- you have a query about how your data is used by the University
- you would like to report a data security breach (e.g. if you think your personal data has been lost or disclosed inappropriately)
- you would like to complain about how the University has used your personal data

DPO@shu.ac.uk

You should contact the Head of Research Ethics (Professor Ann Macaskill) if:

- you have concerns with how the research was undertaken or how you were treated

a.macaskill@shu.ac.uk

Postal address: Sheffield Hallam University, Howard Street, Sheffield S1 1WBT
Telephone: 0114 225 5555

Appendix 2B: Recruitment Letter

Sheffield Hallam University

RECRUITMENT LETTER

Dear Potential Participant,

My name is Temitope Labinjo, a PhD student at Sheffield Hallam University, United Kingdom. I am writing to invite you to take part in my research study. I like to interview individuals who have moved from their state of origin to reside in their current residence for at least one year, aged 25 years and above. I would like to know if you are willing to participate in this study.

The study is exploring the experiences of mental health among internal migrants in Nigeria. According to WHO Report (2001) Mental Health is defined as a state of well-being where an individual can adapt to the condition of daily living, achieve his or her goals or aspirations and work in a productive manner as well as make contributions to their communities. I am seeking to understand your views and experiences about mental health issues and the impact that being an internal migrant in Nigeria may have upon mental health.

If you would like to take part in this study, a face-to-face interview will be conducted. The recordings will be audiotaped. The duration of the interview will last for about an hour. Participation is voluntary, and you are free to opt out anytime if you feel uncomfortable.

You will not receive a direct benefit; however, the outcome of this study will help to create more research to help provide more access and delivery of mental health services in Nigeria.

Please contact the researcher Temitope Labinjo on b5038070@my.shu.ac.uk or labinjotemitope@gmail.com or call ------- if you will like to take part in the study, learn more or if you have further questions/ concerns.

Appendix 2C: Participant Consent Form

PARTICIPANT CONSENT FORM

TITLE OF RESEARCH STUDY: *EXPLORING EXPERIENCES OF MENTAL HEALTH AMONG INTERNAL MIGRANTS IN NIGERIA*

Please answer the following questions by ticking the response that applies

	YES	NO
1. I have read the Information Sheet for this study and have had details of the study explained to me.		
2. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any point.		
3. I understand that I am free to withdraw from the study within the time limits outlined in the Information Sheet, without giving a reason for my withdrawal or to decline to answer any particular questions in the study without any consequences to my future treatment by the researcher.		
4. I agree to provide information to the researchers under the conditions of confidentiality set out in the Information Sheet.		
5. I wish to participate in the study under the conditions set out in the Information Sheet.		
6. I consent to the information collected for the purposes of this research study, once anonymised (so that I cannot be identified), to be published and used for any other research purposes.		

Participant's Signature: _____

Participant's Name (Printed): _____

Contact details: _____

_____

_____

Researcher’s Name (Printed): ____

Researcher’s Signature: _____ _____

Researcher's contact details:
(Name, address, contact number of investigator)
Please keep your copy of the consent form and the information sheet together.

Appendix 3: Ethics Approval Report

EXPLORING EXPERIENCES OF MENTALHEALTH AMONG INTERNAL MIGRANTS INNIGERIA

Ethics Review ID:

ER7565232

Workflow Status: Application Approved

Type of Ethics Review Template: All other research with human participants

Primary Researcher / Principal Investigator

Temitope Labinjo

(Health and Wellbeing)

Converis Project Application:

Q1. Is this project: ii) Doctoral research

Director of Studies

Laura Serrant

(Health and Wellbeing)

Q4.

Q4. Proposed Start Date of Data Collection: 06/05/2019Q5. Proposed End Date of Data Collection : 27/05/2019

Q6. Will the research involve any of the following: i) Participants under 5 years old: No

ii) Pregnant women: No

iii) 5000 or more participants: No

iv) Research being conducted in an overseas country: Yes

Q7. If overseas, specify the location:

NIGERIA

Q8. Is the research externally funded? No

Q9. Will the research be conducted with partners and subcontractors?: No

Q10. Does the research involve one or more of the following?

i. Patients recruited because of their past or present use of the NHS or Social Care: No

ii. Relatives/carers of patients recruited because of their past or present use of the NHS or Social Care: No

iii. Access to data, organs, or other bodily material of past or present NHS patients: No

iv. Foetal material and IVF involving NHS patients: No

v. The recently dead in NHS premises: No

vi. Participants who are unable to provide informed consent due to their incapacity even if the project is not health related: No

vii. Prisoners or others within the criminal justice system recruited for health-related research: No

viii. Prisoners or others within the criminal justice system recruited for non-health-related research:

No

ix. Police, court officials or others within the criminal justice system: No

Q11. Category of academic discipline: Other

Q12. Methodology: Qualitative

Q3. Is your topic of a sensitive/contentious nature or could your funder be considered controversial? No

Q4. Are you likely to be generating potentially security-sensitive data that might need particularly secure storage? No

Q5. Has the scientific/scholarly basis of this research been approved, for example by Research Degrees Sub-committee or an external funding body? No to be submitted

Q6. Main research questions:

1. What are the views, knowledge, and experiences of internal migrants in Nigeria in relation to mental health issues? 2. What are the influencing factors in relation to mental health among internal migrants? 3. What is the impact of migration on mental health and wellbeing?

Q7. Summary of methods including proposed data analyses:

type of study: Qualitative study because the research seeks to study internal migrants in Nigeria by attempting to make sense or interpret mental health issues in terms of the meanings and lived experiences. Research approach: social- constructivism; the study seeks to understand the world in which we live. The research will rely on participants' views with regards to experiences on mental health issues. Research design: phenomenological study; the study describes the common meaning for internal migrants

in Nigeria of their lived experiences of mental health. It focuses on describing what all internal migrants have in common as they experience the underlying factors in relation to mental health and wellbeing. Research instruments: purposive sampling technique; the purposive sample will be selected based on a non-probability sample of internal migrants and the objective of the study to explore their knowledge and factors impacting on mental health and wellbeing. Data collection: in-depth face to face semi-structured interviews to 30 participants in Kaduna, Federal capital territory and Lagos States. Data analysis: The research will be guided using the 'silences' theoretical framework. The theoretical framework is designed to explore the experiences of marginalised and under-researched groups of internal migrants in Nigeria about sensitive issues like mental health because there is no single study on this group especially on a sensitive issue like mental health in Nigeria, identified as 'silences' (Serrant-Green, 2010). The data analysis process begins by stating the researcher's identity and biases by describing personal experiences (bracketing) to avoid any form of bias during data collection and analysis to enable the researcher focus on the participants' data collection process. This involves 'positioning' herself in the qualitative study by exposing in backgrounds such as cultural, social, and other experiences. The process involves four phases. Phase one will involve analysis of data collected with reference to the research questions using thematic analysis which will result in themes created from the data through reading and recording key issues highlighted by participants. The research process will include preparations and organisation of the recorded data transcripts into digital files using an appropriate naming system. Phase two will involve review of initial results collected by the study participants. Phase three will involve inclusion of 'user' or 'collective' voices to increase involvement using the social network of participants. This will involve a reference as collective voices of 2nd generation of internal migrants (these are individuals who were bornin the place of residence to which their parent's migrated Oyeniyi, 2013). The objective is to sample the opinion of these individuals in the social network of internal migrants whose social, cultural or family situation impacts on the lived experiences to add, agree or disagree with issues undisclosed during the interview. This will determine the generalisability of the research. Finally, phase four will involve the critical reflection of the findings by researcher from previous phases and presents a final study outcome. The qualitative data will also be analysed using NVivo computer software (Creswell, 1998).

P3 - Research with Human Participants

Q1. Does the research involve human participants? Yes

Q2. Will any of the participants be vulnerable? Yes

Q3. Is this a clinical trial? No

If yes, will the placebo group receive a treatment plan after the study? If N/A tick no.: No

Q4. Are drugs, placebos or other substances (e.g., food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind? No

Q5. Will tissue samples (including blood) be obtained from participants? No

Q6. Is pain or more than mild discomfort likely to result from the study? No

Q7. Will the study involve prolonged testing (activities likely to increase the risk of repetitive strain injury)? No

Q8. Is there any reasonable and foreseeable risk of physical or emotional harm to any of the participants? No

Q9. Will anyone be taking part without giving their informed consent? No

Q10. Is it covert research? No

Q11. Will the research output allow identification of any individual who has not given their express consent to be identified? Yes

Q12. Where data is collected from human participants, outline the nature of the data, details of anonymisation, storage and disposal procedures if these are required (300 - 750):

The data will be collected by face-to-face in-depth audio taped interviews. the data collected will be transcribed. anonymity will be preserved by masking the participants' names. Data will be kept in secured lockers with padlocks and soft copies stored in password encrypted computers. the original data with names of participants' will be kept in the university's secured password computer assessable only by primary researcher. The original data will be kept for ten years but anonymised data will be published via the university's repository accessible only via access through the university.

P4 - Research in Organisations

Q1. Will the research involve working with an external organisation or using data/material from an external organisation? Yes

Q2. Do you have granted access to conduct the research? Yes

P5 - Research with Products and Artefacts

Q1. Will the research involve working with copyrighted documents, films, broadcasts, photographs, artworks, designs, products, programmes, databases, networks, processes, existing datasets or secure data? Yes

Q2. Are the materials you intend to use in the public domain? No

Q3. If No, do you have explicit permission to use these materials as data? Yes

P6 - Human Participants - Extended

Q1. Describe the arrangements for recruiting, selecting/sampling and briefing potential participants.:

Healthy volunteers will be used in the study, however, while collecting data, there may be situations where participants may disclose poor mental health conditions. In such situations, the researcher will provide participants with local agencies that provide support such as Mental health foundation or Nightingale foundation Nigeria. The researcher will also contact her director of studies in an advisory capacity being an experienced mental health nurse. The researcher will collect data from 30 participants in Kaduna, Federal capital territory and Lagos States comprising of 15 participants from Kaduna State, 10 from FCT and 5from Lagos state. A major justification for sample size

in qualitative research is not only to study a few sites or individuals but also collect extensive detail about each individual study (Creswell & Poth, 2018).The justification for the sample is that, there were few published studies in the north and there were no single reported studies in Federal Capital Territory with a population of approximately over 2.4 million with85.1% of these population being internal migrants (World Population Review, 2018; Annual Abstracts of Statistics, 2016). Majority of the reported published studies were conducted in Lagos State and other states in south-west Nigeria. Hence, the justification for a smaller number of participants in Lagos state Nigeria. A purposive sample will be selected based on a non-probability sample of internal migrants. Sampling will take place in Nigeria across three geographical locations namely Abuja, Kaduna and Lagos states. The potential participants must be a Nigerian adult aged 25 years and above, must be an internal migrant who have moved from state of origin to reside permanently in another state, must reside in new state for at least one year and able to speak and write in English language. Participants not mentioned in these criteria will be excluded. Access will be sought by contacting potential participants of study through recruitment letters, study procedures and their rights and seek consent from appropriate potential individuals for participation (Creswell & Poth, 2018). The Nigerian Institute of Medical Research will be contacted for access for potential participants in Lagos state south-west region. The tight scale of data collection is due to the short and tight duration of the study and long distance of research venue (Nigeria). However, to ease with the stress and rigour of recruiting potential participants, the researcher will contact potential participants via emails by sending the recruitment letters about four months before the trip to Nigeria for data collection for residents in Kaduna and Federal Capital Territory (Northern Regions) in Nigeria, who will be recruited through a network of friends and acquaintances. These potential participants will not feel coerced or obligated to take part in the study because they will be contacted about four months before and agreement established before arrival for data collection. The researcher will assure the potential participants that they are free to opt out at any time. Potential participants will also be recruited through the informal partner to the study in Nigeria (Nigerian Institute of Medical Research), who will act as venue host to the study for potential participants in Lagos states southwest Nigeria. All potential participants will be contacted prior to the trip for data collection, and I will prepare a list of potential participants to collect data from, who have been contacted about fours prior to data collection and having established written consent electronically and oral consent will be obtained prior to the interview.

Q2. Indicate the activities participants will be involved in.:

Potential participants will be required to undertake in a face-to-face in-depth interview to identify the relationship between internal migration and mental health and explore factors that can impact on mental health and well-being.

Q3. What is the potential for participants to benefit from participation in the research?

There are no direct benefits to participants, but the outcome of this study will assist in creation of further research to assist relevant stakeholders provide more access and delivery of mental health services.

Q4. Describe any possible negative consequences of participation in the research along with the ways in which these consequences will be limited:

Mental health issues are sensitive in Nigeria. This may bring anxiety/ distress to some participants. Local agencies providing support and assistance will be contacted and encouraged to seek help, Situations where recording may be interfering or not conducive to researcher or participants. This consequence will be overcome by politely asking participants if they are willing to continue and suggest alternative time or location to continue, if they are willing to (Creswell, 1998).

Q5. Describe the arrangements for obtaining participants' consent.:

Recruitment letters and Information sheets will be given in advance, consent forms will be read and signed by participants at time of interview. The interviews will not be conducted until consent have been obtained both orally and signed.

Q6. Describe how participants will be made aware of their right to withdraw from the research.:

Potential participants will be fully informed and recruitment letters and information sheets will be handed informing participants that participation is voluntary and even during and after data collection they will be informed orally and in the debriefing letter of their rights to withdrawal at any time until the point of data analysis because data will be anonymised at this point.

Q7. If your project requires that you work with vulnerable participants describe how you will implement safeguarding procedures during data collection:

The research involves collecting data about mental health, there is a possibility of interviewing mentally distressed participants during the interview sessions. In such situations, the interview will be stopped, and local agencies will be contacted for help. The Director of Studies will also be contacted in an advisory capacity being an expert mental health nurse.

Q8. If Disclosure and Barring Service (DBS) checks are required, please supply details:

N/A

Q9. Describe the arrangements for debriefing the participants.:

Researcher will thank participants for taking part in the study. A debriefing letter will be handed to the participants stating brief background of research of research and request for feedback. Researcher will notify participants again that participation is voluntary, and they are free to withdraw if they want to. Researcher will inform participants that any request, issues or feedback about the research by the participant should be addressed to the researcher indicating the phone number and email. Contact details of agencies if support is needed following interview include Mental Health Foundation Nigeria (+234 8022 445506, +234 702569 3538), Nightingale Foundation (+2348183405 664, +234 8105 432244) and Grace Cottage Psychiatric Clinic (+234 805788 6636, +234 8055228441).

Q10. Describe the arrangements for ensuring participant confidentiality. This should include details of:

Participants will be informed that their data will be kept confidential, stored in secured locker with padlocks, and soft copies will be stored in password encrypted computers.

The researcher will avoid disclosing participants personal information by masking their names. Situations will be avoided where data might be identifiable to a participant by creating participant profiles. In terms of disclosure of findings, member-checking strategies for sharing procedures and results will be embedded. The researcher will also present multiple perspectives reflective of a complex picture to avoid siding with participants and disclosing only positive results (Creswell, 2007). 'The final written report will include the voices of participants, reflexivity of the researcher, accurate description and interpretation of the research question and its contribution to existing knowledge' (Creswell, 2007). However, identities may not be preserved where sensitive or delicate information is divulged such as mental health state etc., in such situations, this information will be reported to my supervisory team and possible relevant local authorities.

Q11. Are there any conflicts of interest in you undertaking this research?

NONE

Q12. What are the expected outcomes, impacts and benefits of the research?

The outcome of this study will assist in creation of further research to assist relevant stakeholders (e.g., government) provide more access and delivery of mental health services.

Q13. Please give details of any plans for dissemination of the results of the research.:

The researcher will disseminate the results of this study by writing journal papers, presenting in conferences and organisations. The researcher will also produce a written report of the findings to participants. The final outcome of the results will be written as thesis as a requirement towards completion of a PhD programme at Sheffield Hallam University. The data will be recorded, audio taped and transcribed . written consent will be obtained from participants to preserve and share data. The digital data will be collected using NVivo software, this data will be stored in the university's system restricted to researcher's password and protected from 3rd parties. Only pseudonymised data will be made available to public using the university's repository upon request. See data management plan.

P7 - Health and Safety Risk Assessment

Q1. Will the proposed data collection take place only on campus? No

Q2. Are there any potential risks to your health and wellbeing associated with either (a) the venue where the research will take place and/or (b) the research topic itself? Yes (please outline below)

Outline details of risks to your health and wellbeing:

The research will be in three states in Nigeria namely Kaduna, Abuja and Lagos states. The first two states are in Northern Nigeria. There have been reported cases of insecurity in the region such as kidnappings, religious and ethnic riots. The risks will be avoided by going with someone to collect data always, but the individual will wait outside during recording sessions. I will also inform a family member to call about two hours later if they have not heard from me and inform them of my location always. I will also travel to

collect data using a personal car to avoid any potential security risks. Another risk is challenges with the topic itself, mental health issues are still a very sensitive topic in Nigeria and Nigerians hardly talk about these issues. Therefore, I will avoid getting too personal with the questions to avoid upsetting the participants. Environmental changes such as change in weather can impact negatively on researcher. This will be overcome by adequate immunisations and protective clothing.

Q3. Will there be any potential health and safety risks for participants (e.g., lab studies)? If so a Health and Safety Risk Assessment should be uploaded to P8.: No

Q4. Where else will the data collection take place? (Tick as many venues as apply) Researcher's Residence: false

Participant's Residence: true

Education Establishment: true

Other e.g., business/voluntary organisation, public venue: true

Outside UK: true

Q5. How will you travel to and from the data collection venue? By car

Q6. Please outline how you will ensure your personal safety when travelling to and from the data collection venue.:

I will ensure my personal safety by going with someone to collect data always, but the individual will wait outside during recording sessions. I will also inform a family member to call about two hours later if they have not heard from me and inform them of my location always.

Q7. If you are carrying out research off-campus, you must ensure that each time you go out to collect data you ensure that someone you trust knows where you are going (without breaching the confidentiality of your participants), how you are getting there (preferably including your travel route), when you expect to get back, and what to do should you not return at the specified time. (See Lone Working Guidelines). Please outline here the procedure you propose using to do this.:

I will be travelling via a personal car as this is the safest method of travel in the country. I will inform my family member (spouse) to call about two hours later if they have not heard from me and I will update the individual via text regularly of my location. I will also send an email to my supervisory team of my planned interview schedules with times and locations.

Q8. How will you ensure your own personal safety whilst at the research venue, (including on campus where there may be hazards relating to your study)?

I will ensure my personal safety at the research venue by being conscious and alert but not attempting to scare or upset my participants. I will always keep my personal belongings with me. I will travel with a family member (spouse) who will be waiting outside to avoid breaching the confidentiality of my participants. I will, however, call him should there be a situation where my security is threatened.

P8 – Attachments

Are you uploading any recruitment materials (e.g., posters, letters, etc.)? Yes

Are you uploading a participant information sheet? Yes

Are you uploading a participant consent form? Yes

Are you uploading details of measures to be used (e.g., questionnaires, etc.)? Non-Applicable

Are you uploading an outline interview schedule/focus group schedule? Yes

Are you uploading debriefing materials? Yes

Are you uploading a Risk Assessment Form? Yes

Are you uploading a Serious Adverse Events Assessment (required for Clinical Trials and Interventions)? Non-Applicable

Are you uploading a Data Management Plan? Yes

P9 - Adherence to SHU Policy and Procedures

Primary Researcher / PI Sign-off:

I can confirm that I have read the Sheffield Hallam University Research Ethics Policy and Procedures: true

I can confirm that I agree to abide by its principles and that I have no personal or commercial conflicts of interest relating to this project.: true

Date of PI Sign-off: 08/08/2018

Director of Studies Sign-off:

I confirm that this research will conform to the principles outlined in the Sheffield Hallam University Research Ethics policy: true

I can confirm that this application is accurate to the best of my knowledge: true

Director of Studies' Comments:

changes now completed following meeting

Date of submission and supervisor sign-off: 08/08/2018

Director of Studies Sign-off

Laura

Serrant

P10 - Review

Comments collated by Lead Reviewer (Or FREC if escalated):

Please see attached comments

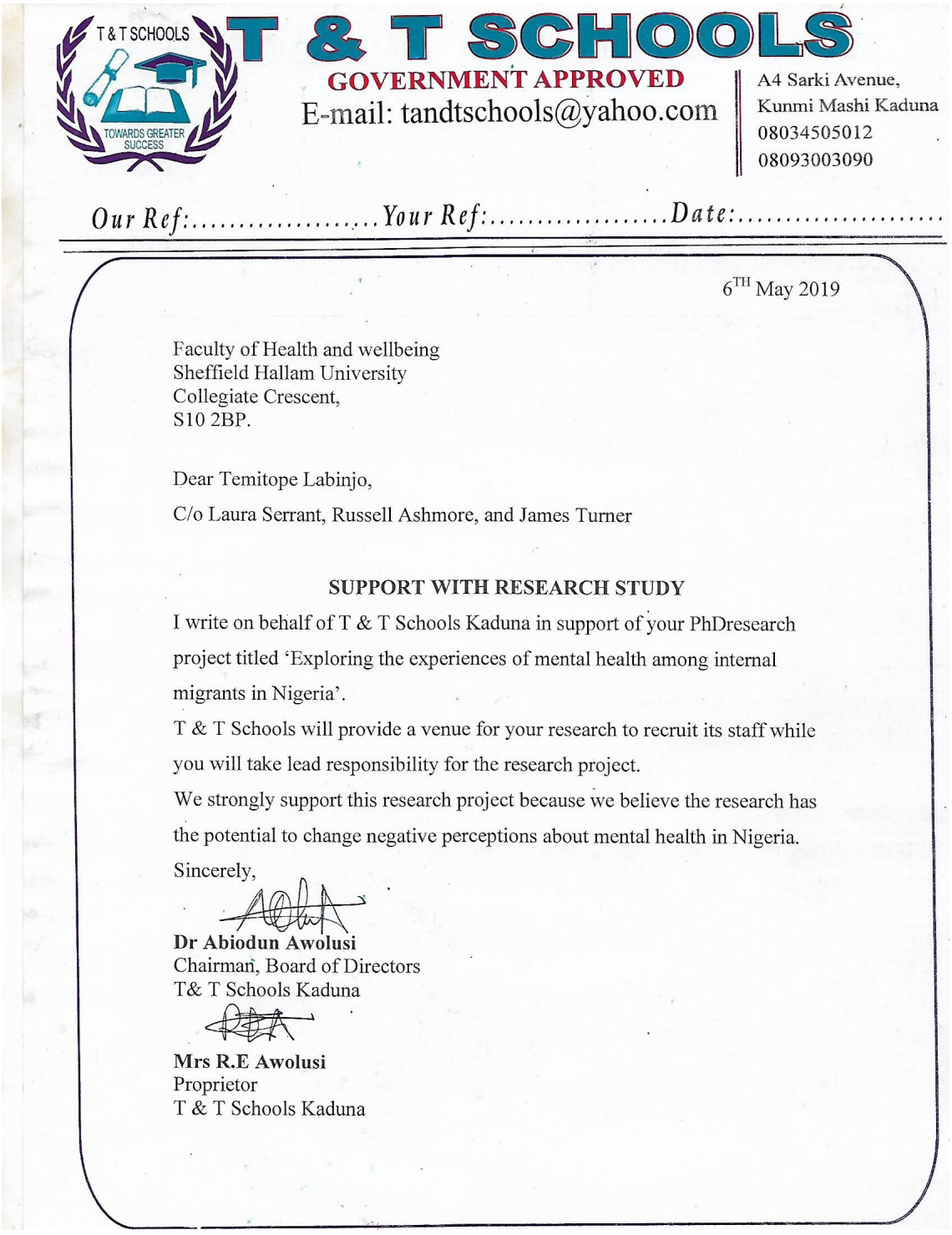
Upload:

Lead Reviewer comments.docx

Final Decision to be completed by Lead Reviewer (or FREC if escalated): Application referred back for resubmission

Date of Final Decision: 07/09/2018

Appendix 4: Letter of support from T&T Schools Kaduna



T & T SCHOOLS
GOVERNMENT APPROVED
E-mail: tandtschools@yahoo.com

A4 Sarki Avenue,
Kunmi Mashi Kaduna
08034505012
08093003090

Our Ref:.....Your Ref:.....Date:.....

6TH May 2019

Faculty of Health and wellbeing
Sheffield Hallam University
Collegiate Crescent,
S10 2BP.

Dear Temitope Labinjo,

C/o Laura Serrant, Russell Ashmore, and James Turner

SUPPORT WITH RESEARCH STUDY

I write on behalf of T & T Schools Kaduna in support of your PhDresearch project titled 'Exploring the experiences of mental health among internal migrants in Nigeria'.

T & T Schools will provide a venue for your research to recruit its staff while you will take lead responsibility for the research project.

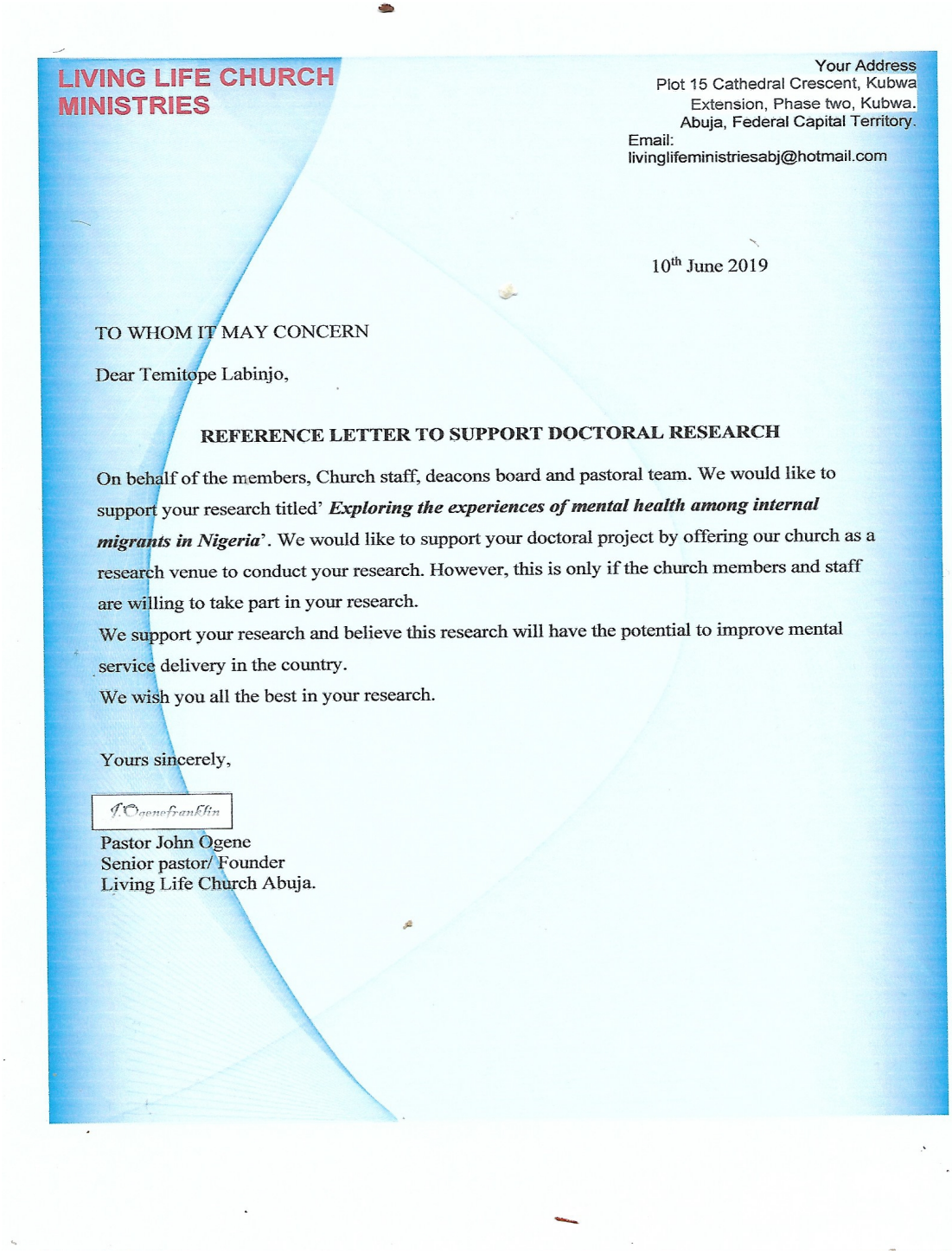
We strongly support this research project because we believe the research has the potential to change negative perceptions about mental health in Nigeria.

Sincerely,

Dr Abiodun Awolusi
Chairman, Board of Directors
T& T Schools Kaduna

Mrs R.E Awolusi
Proprietor
T & T Schools Kaduna

Appendix 5: Letter of support from Living Life Church Abuja



LIVING LIFE CHURCH MINISTRIES

Your Address
Plot 15 Cathedral Crescent, Kubwa
Extension, Phase two, Kubwa.
Abuja, Federal Capital Territory.
Email:
livinglifeministriesabj@hotmail.com

10th June 2019

TO WHOM IT MAY CONCERN

Dear Temitope Labinjo,

REFERENCE LETTER TO SUPPORT DOCTORAL RESEARCH

On behalf of the members, Church staff, deacons board and pastoral team. We would like to support your research titled' ***Exploring the experiences of mental health among internal migrants in Nigeria***'. We would like to support your doctoral project by offering our church as a research venue to conduct your research. However, this is only if the church members and staff are willing to take part in your research.

We support your research and believe this research will have the potential to improve mental service delivery in the country.

We wish you all the best in your research.

Yours sincerely,

JOgenefranklin

Pastor John Ogene
Senior pastor/ Founder
Living Life Church Abuja.

Appendix 6: Letter of Support from Nigerian Institute of Medical Research (NIMR)

October 3, 2017

Faculty of Health and wellbeing
Sheffield Hallam University
Collegiate Crescent,
S10 2BP.

Dear Temitope Labinjo,
C/o Laura Serrant

I write on behalf of the Nigerian Institute of Medical Research (NIMR) in support of your PhD research project titled 'A Global Perspective on Mental Health Related Disparities among Nigerians' resident in Nigeria and United Kingdom'.

NIMR will provide academic support by providing a venue for health research throughout the research process, while you will take lead responsibility for the research project.

We strongly support this research project because we believe the expected outputs have the potential to stimulate aspects of Nigeria's health policy landscape.

NIMR look forward to supporting your research.

Sincerely,

Dr Olaoluwa P. Akinwale, PhD
Director of Research
Department of Public Health and Epidemiology

Appendix 7: Risk Assessment

Description of the Process/Activity: in-depth face to face semi-structured interviews to 30 participants in Kaduna, Federal capital territory and Lagos States Nigeria.					Location(s): Nigeria RA Ref:			
Hazard	Who could be harmed?	Existing safety precautions	Risk level	Additional safety precautions needed to reduce the risk level?	Revised risk level	Action by whom?	By when?	Date completed
Security risk	Researcher and/or potential participants	Researcher will travel in a personal car to conduct interviews. An individual follows the researcher to research venue	High	notify family to call after two hours. Send an email of scheduled location and times of interview sessions to supervisory team	Zoom video conferencing used making it a low risk for security.	Researcher	May 2019	23/9/19
Sensitive or delicate information are divulged resulting in anxiety or distress to participants OR when a participant discloses a mental health condition.	Participants	Stop the interview sessions immediately and attempt to calm the individual	High	Notify participant of local agencies that provide support and help. Inform my supervisory to offer more advice being mental health experts		Researcher/ Supervisory team/ Local mental health agencies	May 2019	08/8/18

Possible harm to researcher during process of recruitment	Researcher	Researcher will travel along with someone during data recruitment.	Medium	After contact with potential participants, recruitment letters will be given to participants to read and take-home including contact details to be provided.	Risk of physical harm eliminated by using Zoom video tool.	Researcher	May 2019	23/9/19
Unconducive or uncomfortable environment while recording	Researcher and participant	politely asking participants if they are willing to continue	Low	suggest alternative time or location to continue if they are willing to.	This risk physical harm is eliminated by using Zoom tool. The venue to also be confirmed by participant.	Researcher	May 2019	23/9/19

Communication of significant findings		
Method of communication (describe): The outcome of this findings will be given to the participants and supervisory team The outcome of the findings will be written as a thesis as a requirement for completion of a PhD	Person/people to communicate findings: Participants, the university (SHU), researchers and public including policy makers.	Target date(s): Sep 2021
Approval		

Carried out by: Temitope Labinjo	Post: Primary Researcher	Signature: ***T.Labinjo***	Date: 23/9/2019
Approved by Russell Ashmore	Post: Director of Studies	Signature: 	Date: 23/09/2019

Review of risk assessment
The frequency of the review is (refer to guidance):

Review date : 08/08/2018	Carried out by: Temitope Labinjo	Signature:
Review date : 23/9/2019	Carried out by:	Signature:
Review date :	Carried out by:	Signature:
Review date :	Carried out by:	Signature:
Review date :	Carried out by:	Signature:
Review date :	Carried out by:	Signature:

Appendix 8: Interview Schedule

Interview Guide

1. What state are you from in Nigeria?
2. where do you currently reside in Nigeria?
3. what does mental health mean to you?
4. What do you think could be the cause of mental health issues?
5. What is it like to move from your state of origin to your current state of residence?
6. How did moving impact your mental health and wellbeing?
7. how were you able to overcome any challenges you faced? If any.
8. could you share any situation or circumstance that has helped your mental health?
9. Any other information, in general, comments, anything?

Appendix 9: Data Processing Addendum (DPA)

Zoom Video Communications, Inc.
Global Data Processing Addendum
This Data Processing Addendum ("Addendum") forms part of the Master Subscription Agreement, Terms of Service, Terms of Use, or any other agreement pertaining to the delivery of services (the "Agreement") between Zoom Video Communications, Inc. and subsidiaries ("Zoom") and the Customer named in such Agreement to reflect the parties' agreement with regard to the Processing of Personal Data (as those terms are defined below). All capitalized terms not defined herein shall have the meaning set forth in the Agreement.
In the course of providing the Services to Customer pursuant to the Agreement, Zoom may Process Personal Data on behalf of Customer and the Parties agree to comply with the following provisions with respect to any Personal Data, each acting reasonably and in good faith.
If the entity signing this Addendum is not a party to an effective Agreement with Zoom, this Addendum shall not be valid or legally binding. In the event of a conflict between the terms and conditions of this Addendum and the Agreement, the terms and conditions of this Addendum shall supersede and control to the extent of such conflict.
HOW TO EXECUTE THIS ADDENDUM:
1. This Addendum (and Standard Contractual Clauses in Exhibit B, if applicable) may have been pre-signed on behalf of Zoom as the data importer.
2. To complete this Addendum, Customer must:
a. Complete the information in the signature box and sign on Pages 5, 12 and 14.
b. Complete the information as the data exporter on Pages 7 and 12.
3. Send the completed and signed Addendum to Zoom by email, indicating the [Customer's Account Number (as set out on the applicable invoice)], to privacy@zoom.us. Upon receipt of the validly completed Addendum by Zoom at this email address, this Addendum will become legally binding.
1. Definitions
1.1 "Anonymous Data" means Personal Data that has been processed in such a manner that it can no longer be attributed to an identified or identifiable natural person
1.2 "Applicable Data Protection Law" means PIPEDA, where PIPEDA applies to Personal Data processed by Zoom pursuant to this Addendum; the GDPR, where the GDPR applies to Personal Data processed by Zoom pursuant to this addendum; or the LGPD, where the LGPD applies to Personal Data processed by Zoom pursuant to this Addendum.
1.3 "Authorized Employee" means an employee of Processor who has a need to know or otherwise access Personal Data to enable Processor to perform their obligations under this Addendum or the Agreement.
1.4 "Authorized Individual" means an Authorized Employee or Authorized Subprocessor.
1.5 "Authorized Subprocessor" means a third-party subcontractor, agent, reseller, or auditor who has a need to know or otherwise access Personal Data to enable Processor to perform its obligations under this Addendum or the Agreement, and who is either

(i) listed on the list available at zoom.us/subprocessors (such URL may be updated by Processor from time to time) or (ii) authorized by Controller to do so under Section 4.2 of this Addendum.
1.6 “Controller” or “data exporter” means Customer.
1.7 “Data Subject” means an identified or identifiable person to whom Personal Data relates.
1.8 “GDPR” means Regulation (EU) 2016/679, the General Data Protection Regulation.
1.9 “Instruction” means a direction, either in writing, in textual form (e.g., by e-mail) or by using a software or online tool, issued by Controller to Processor and directing Processor to Process Personal Data.
1.10 “LGPD” means Brazil’s Lei Geral de Proteção de Dados, Law 13,709/ 2018, when in force.
1.11 “Personal Data” means any information relating to Data Subject which Processor Processes on behalf of Controller other than Anonymous Data and includes Sensitive Personal Information.
1.12 “Personal Data Breach” means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to, personal data transmitted, stored, or otherwise processed.
1.13 “PIPEDA” means Canada’s Personal Information Protection and Electronic Documents Act, S.C. 2000, ch. 5 and any provincial legislation deemed substantially similar to PIPEDA pursuant to the procedures set forth therein.
1.14 “Privacy Shield Principles” means the Swiss-U.S. and EU-U.S. Privacy Shield Framework and Principles issued by the U.S. Department of Commerce, both available at https://www.privacyshield.gov/EU-US-Framework.
1.15 “Process” or “Processing” means any operation or set of operations which is performed upon the Personal Data, whether or not by automatic means, such as collection, recording, organization, storage, adaptation or alteration, retrieval, consultation, disclosure by transmission, dissemination or otherwise making available, alignment or combination, blocking, erasure, or destruction.
1.16 “Processor” or “data importer” means Zoom.
1.17 “Sensitive Personal Information” means a Data Subject’s (i) government-issued identification number (including social security number, driver’s license number or state-issued identification number); (ii) financial account number, credit card number, debit card number, credit report information, with or without any required security code, access code, personal identification number or password, that would permit access to an individual’s financial account; (iii) genetic and biometric data or data concerning health; or (iv) Personal Data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, sexual orientation or sexual activity, criminal convictions and offences (including commission of or proceedings for any offense committed or alleged to have been committed), or trade union membership.
1.18 “Services” shall have the meaning set forth in the Agreement.
1.19 “Standard Contractual Clauses” means the agreement executed by and between Controller and Processor and attached hereto as Exhibit B pursuant to the European Commission’s decision (C(2010)593) of February 5, 2010 on standard contractual clauses for the transfer of personal data to processors established in third countries which do not ensure an adequate level of protection.
1.20 “Supervisory Authority” means an independent public authority with jurisdiction to oversee the processing of personal data covered by this Addendum.

2. Processing of Data

2.1 The rights and obligations of the Controller with respect to this Processing are described herein. Controller shall, in its use of the Services, at all times Process Personal Data, and provide instructions for the Processing of Personal Data, in compliance with Applicable Data Protection Laws. Controller shall ensure that its instructions comply with all laws, rules and regulations applicable in relation to the Personal Data, and that the Processing of Personal Data in accordance with Controller's instructions will not cause Processor to be in breach of Applicable Data Protection Law. Controller is solely responsible for the accuracy, quality, and legality of (i) the Personal Data provided to Processor by or on behalf of Controller; (ii) the means by which Controller acquired any such Personal Data; and (iii) the instructions it provides to Processor regarding the Processing of such Personal Data. Controller shall not provide or make available to Processor any Personal Data in violation of the Agreement or otherwise inappropriate for the nature of the Services and shall indemnify Processor from all claims and losses in connection therewith.

2.2 Processor shall Process Personal Data only (i) for the purposes set forth in the Agreement and/or Exhibit A; (ii) in accordance with the terms and conditions set forth in this Addendum and any other documented instructions provided by Controller; and (iii) in compliance with Applicable Data Protection Law. Controller hereby instructs Processor to Process Personal Data in accordance with the foregoing and as part of any Processing initiated by Controller in its use of the Services.

2.3 The subject matter, nature, purpose, and duration of this Processing, as well as the types of Personal Data collected and categories of Data Subjects, are described in Exhibit A to this Addendum.

2.4 Following completion of the Services, at Controller's choice, Processor shall return or delete the Personal Data, except as required to be retained by law, rule or regulation that is binding upon Zoom or, if the Personal Data is in the possession of an Authorized Subprocessor or Subprocessors, as required to be retained by an Authorized Subprocessor by law, rule or regulation that is binding upon the Subprocessor. If return or destruction is impracticable or prohibited by law, rule or regulation, Processor shall take measures to block such Personal Data from any further Processing (except to the extent necessary for its continued hosting or Processing required by law, rule or regulation) and shall continue to appropriately protect the Personal Data remaining in its possession, custody, or control and, where any Authorized Subprocessor continues to possess Personal Data, require the Authorized Subprocessor to take the same measures that would be required of Processor. If Controller and Processor have entered into Standard Contractual Clauses as described in Section 6 (Transfers of Personal Data), the parties agree that the certification of deletion of Personal Data that is described in Clause 12(1) of the Standard Contractual Clauses shall be provided by Processor to Controller only upon Controller's request..

3. Authorized Employees

3.1 Processor shall take commercially reasonable steps to ensure the reliability and appropriate training of any Authorized Employee.

3.2 Processor shall ensure that all Authorized Employees are made aware of the confidential nature of Personal Data and have executed confidentiality agreements that prevent them from disclosing or otherwise Processing, both during and after their engagement with Processor, any Personal Data except in accordance with their obligations in connection with the Services.

3.3 Processor shall take commercially reasonable steps to limit access to Personal Data to only Authorized Individuals.

4. Authorized Subprocessors

4.1 Controller acknowledges and agrees that Processor may (i) engage its affiliates and the subprocessors listed at zoom.us/subprocesses (such URL may be updated by Processor from time to time) (the "List") to access and Process Personal Data in connection with the Services and (ii) from time to time engage additional third parties for the purpose of providing the Services, including without limitation the Processing of Personal Data.

4.2 A list of Processor's current Authorized Sub processors is available on the List. At least ten (10) days before enabling any third party other than Authorized Sub processors to access or participate in the Processing of Personal Data, Processor will add such third party to the List and notify Controller of that update. Controller may object to such an engagement in writing within ten (10) days of receipt of the aforementioned notice by Controller.

4.2.1 If Controller reasonably objects to an engagement in accordance with Section 4.2, Processor shall provide Controller with a written description of commercially reasonable alternative(s), if any, to such engagement, including without limitation modification to the Services. If Processor, in its sole discretion, cannot provide any such alternative(s), or if Controller does not agree to any such alternative(s) if provided, Controller may terminate this Addendum. Termination shall not relieve Controller of any fees owed to Processor under the Agreement.

4.2.2 If Controller does not object to the engagement of a third party in accordance with Section 4.2 within ten (10) days of notice by Processor, that third party will be deemed an Authorized Subprocessor for the purposes of this Addendum.

4.3 Processor shall ensure that all Authorized Subprocessors have executed confidentiality agreements that prevent them from disclosing or otherwise Processing, both during and after their engagement by Processor, any Personal Data both during and after their engagement with Processor.

4.4 Processor shall, by way of contract or other legal act under Applicable Data Protection Law ensure that every Authorized Subprocessor is subject to obligations regarding the Processing of Personal Data that are no less protective than those to which the Processor is subject under this Addendum. Processor shall, exercising reasonable care, evaluate an organization's data protection practices before allowing the organization to act as an Authorized Subprocessor.

4.5 Processor shall be liable to Controller for the acts and omissions of Authorized Subprocessors to the same extent that Processor would itself be liable under this Addendum had it conducted such acts or omissions.

4.6 If Controller and Processor have entered into Standard Contractual Clauses as described in Section 6 (Transfers of Personal Data), (i) the above authorizations will constitute Controller's prior written consent to the subcontracting by Processor of the processing of Personal Data if such consent is required under the Standard Contractual Clauses, and (ii) the parties agree that the copies of the agreements with Authorized Subprocessors that must be provided by Processor to Controller pursuant to Clause 5(j) of the Standard Contractual Clauses may have commercial information, or information unrelated to the Standard Contractual Clauses or their equivalent, removed by the Processor beforehand, and that such copies will be provided by the Processor only upon request by Controller.

5. Security of Personal Data
5.1 Taking into account the state of the art, the costs of implementation and the nature, scope, context and purposes of Processing as well as the risk of varying likelihood and severity for the rights and freedoms of natural persons, Processor shall maintain appropriate technical and organizational measures to ensure a level of security appropriate to the risk of Processing Personal Data, including, but not limited to, the security measures set out in Appendix 2
5.2 The Processor shall implement such measures to ensure a level of security appropriate to the risk involved, including as appropriate:
5.2.1 the pseudonymisation and encryption of personal data;
5.2.2 the ability to ensure the ongoing confidentiality, integrity, availability and resilience of processing systems and services;
5.2.3 the ability to restore the availability and access to personal data in a timely manner in the event of a physical or technical incident; and
5.2.4 a process for regularly testing, assessing and evaluating the effectiveness of security measures.
6. Transfers of EU Personal Data
6.1 Any transfer of Personal Data made subject to this Addendum from member states of the European Union, Iceland, Liechtenstein, Norway, Switzerland or the United Kingdom to any countries which do not ensure an adequate level of data protection within the meaning of the laws and regulations of these countries shall, to the extent such transfer is subject to such laws and regulations, be undertaken by Processor through one of the following mechanisms: (i) in accordance with the Swiss-U.S. and EU-U.S. Privacy Shield Framework and Principles issued by the U.S. Department of Commerce, both available at https://www.privacyshield.gov/EU-USFramework (the "Privacy Shield Principles"), or (ii) the Standard Contractual Clauses set forth in Exhibit B to this Addendum.
6.2 If transfers are made pursuant to 6.1(i), Processor self-certifies to, and complies with, the Swiss-U.S. and EU-U.S. Privacy Shield Frameworks, as administered by the U.S. Department of Commerce, and shall maintain such self-certification and compliance with respect to the Processing of Personal Data transferred from member states of the European Union, Iceland, Lichtenstein, Norway, or the United Kingdom (the "EEA") or Switzerland to any countries which do not ensure an adequate level of data protection within the meaning of the laws and regulations of the foregoing countries for the duration of the Agreement.
6.3 In certain cases, Controller may be considered a controller of personal data and in some cases, Controller may be considered a processor of personal data. For the purposes of this DPA to the extent Controller is a processor, Zoom shall be deemed a "subprocessor" with the meaning of Clause 11 of the Standard Contractual Clauses (and therefore subject to all the provisions of the Standard Contractual Clauses applicable to importers).
7. Rights of Data Subjects
7.1 Processor shall, to the extent permitted by Applicable Data Protection Law, promptly notify Controller upon receipt of a request by a Data Subject to exercise the Data Subject's right of: access, rectification, restriction of Processing, erasure, data portability, restriction or cessation of Processing, withdrawal of consent to Processing, and/or objection to being subject to Processing that constitutes automated decision-making (such requests individually and collectively "Data Subject Request(s)"). If Processor receives a Data Subject Request in relation to Controller's data, Processor will advise the Data

Subject to submit their request to Controller and Controller will be responsible for responding to such request, including, where necessary, by using the functionality of the Services.

7.2 Processor shall, at the request of the Controller, and taking into account the nature of the Processing applicable to any Data Subject Request, apply appropriate technical and organizational measures to assist Controller in complying with Controller's obligation to respond to such Data Subject Request and/or in demonstrating such compliance, where possible, provided that (i) Controller is itself unable to respond without Processor's assistance and (ii) Processor is able to do so in accordance with all applicable laws, rules, and regulations. Controller shall be responsible to the extent legally permitted for any costs and expenses arising from any such assistance by Processor.

8. Actions and Access Requests

8.1 Processor shall, taking into account the nature of the Processing and the information available to Processor, provide Controller with reasonable cooperation and assistance where necessary for Controller to comply with its obligations under Applicable Data Protection Law to conduct a data protection impact assessment and/or to demonstrate such compliance, provided that Controller does not otherwise have access to the relevant information.

8.2 Processor shall, taking into account the nature of the Processing and the information available to Processor, provide Controller with reasonable cooperation and assistance with respect to Controller's cooperation and/or prior consultation with any Supervisory Authority, where necessary and where required by Applicable Data Protection Law.

8.3 Processor shall maintain records sufficient to demonstrate its compliance with its obligations under this Addendum. Controller shall, with reasonable notice to Processor, have the annual right to review such records at Processor's offices during regular business hours.

8.4 Upon Controller's request, Processor shall, no more than once per calendar year make available for Controller's review copies of certifications or reports demonstrating Processor's compliance with prevailing data security standards applicable to the Processing of Controller's Personal Data. (If Controller and Processor have entered into Standard Contractual Clauses as described in Section 6 (Transfers of Personal Data), the parties agree that the audits described in Clause 5(f) and Clause 12(2) of the Standard Contractual Clauses shall be carried out in accordance with this Section 8.4.)

8.5 In the event of a Personal Data Breach, Processor shall, without undue delay but no later than forty-eight (48) hours after confirming that a breach of personal data has occurred, inform Controller of the Personal Data Breach and take such steps as Processor in its sole discretion deems necessary and reasonable to remediate such violation.

8.6 In the event of a Personal Data Breach, Processor shall, taking into account the nature of the Processing and the information available to Processor, provide Controller with reasonable cooperation and assistance necessary for Controller to comply with its obligations under Applicable Data Protection Law with respect to notifying (i) the relevant Supervisory Authority and (ii) Data Subjects affected by such Personal Data Breach without undue delay.

8.7 The obligations described in Sections 8.5 and 8.6 shall not apply in the event that a Personal Data Breach results from the actions or omissions of Controller. Processor's obligation to report or respond to a Personal Data Breach under Sections 8.5 and 8.6 will not be construed as an acknowledgement by Processor of any fault or liability with respect to the Personal Data Breach.

Customer Zoom Video Communications, Inc.

Signature: ***T.Labinjo***	Signature: [redacted]
Customer Legal Name: Temi Labinjo	Print Name: Kari Zeni
Print Name: T.L	Title: DPO
Title: Researcher	Date: 3/18/19
Date: 10/10/2019	

Appendix 10: Checklist for common problems with Zoom

CHECKLIST FOR COMMON PROBLEMS WITH ZOOM

Some of the common issues are:

Video/ Camera not working

If the participant's camera is not showing up in Zoom settings or not showing the video: Test your video to confirm that the correct camera is selected and adjust video settings.

Test the video before the meeting by clicking settings, click the video tab; a preview of the camera is shown, and can choose a different camera.

When in meeting:

Click the arrow next to start video/ stop video

Select video settings- Zoom will display your camera's video and settings.

If you don't see your camera's video, click the drop-down menu and select another camera.

Audio is not working

Speaker issues: if you cannot hear the other speaker in a zoom meeting, follow these steps: Click 'Test speaker/microphone', when the new window pops up, click 'test speaker', if there is a test sound then its ok, if not, then the wrong input is selected.

Echoes sound: This occurs due to multiple devices in the room joining the same meeting. 'mute your microphone and turn down the speaker volume.

The image is skipping or shaking

This happens due to poor internet connection and lacks the bandwidth to send the signals to the destination. You can diagnose the issue by running a speed test if the video meeting on the mobile device/ older computer could be due to inadequate memory or CPU. To resolve this, close other applications to devote more CPU power to the meeting.

Wireless (Wi-Fi) Connection Issues

If you are experiencing any issue(s) with latency, frozen screen, poor quality audio, or meeting getting disconnected while using a home or non-enterprise Wi-Fi connection, try the following:

Watch a video about Wi-Fi connectivity

Check your Internet bandwidth using an online speed test

Try to connect directly via Wired (if your internet router has wired ports)

Try bringing your computer or mobile device closer to the Wi-Fi router or access point in your home or office

Upgrade your Wi-Fi router firmware. Check your Wi-Fi router vendor support site for firmware upgrade availability.

Retrieved from (Zoom Blog, 2013 & Zoom Help Centre, 2019).

Appendix 11: Zoom Ethical Approval

P12 - Post Approval Amendments

Amendment 2

Title of Amendment 2: ZOOM AS A DATA COLLECTION TOOL

Details of Amendment 2: Please see attached amendment report. Also see attached an appendix for your view.

Date of Amendment 2: 16/02/2020

In my judgement amendment 2 should be: Amendment Approved

Reason for amendment 2 decision (if applicable): The issue of data protection relating to the use of zoom for this project have been adequately addressed in the ethics amendment report.
I would expect any identifying data to be stored on J drive rather than Q drive on the SHU It system and you are advised to investigate the possibility of doing this for your project. If you email Prof Shona Kelly , she will be pleased to offer advice and assistance.

Date of Amendment Outcome 2: 21/02/2020

Appendix 12: Updated Interview Guide

INTERVIEW QUESTIONS UPDATED

1. What state are you from in Nigeria?
2. What state do you currently reside in in Nigeria?
3. How did you come to reside in your current state of residence?
4. What was it like to move from your state of origin to this state?
5. How did you cope with the challenges of moving (if any)?
6. What does mental health mean to you?
7. How did moving impact your mental health and wellbeing?
8. Tell me more about your experience of moving and the impact it had on your mental health?

Appendix 13: Debriefing Letter

Sheffield Hallam University

DEBRIEFING LETTER

Thank you for participating in this study. This letter provides background about our research to help you learn more about why we are doing this study. The purpose of this study was to explore your views about mental health issues. I am also interested in understanding factors that can impact on mental health and if internal migrants' experiences can have any impact on their mental health.

Please feel free to ask any questions or to comment on any aspect of the study.

You have just participated in a research study conducted by Temitope O. Labinjo (b5038070@my.shu.ac.uk)

Appendix 14: Initial codes

1	**Purpose of Migration:**	
	Education	4
	Work	7
	NYSC (one-year internship)	2
	Marriage	4
	Better life	2
	Moved with family	4
2	**Experience of Migration**	
	Language barrier	7
	Distance	2
	Weather	4
	Accommodation	6
	Job challenge	6
	No social support	6
	Transport problems	5
	Loneliness	1
	Insecurity challenges	5
	Experienced culture	3
	High cost of living	3
	Better opportunities in new state	7
3	**Coping strategies**	
	Learn new language	4
	Adapt to weather	3
	Perseverance	3
	Religion	3
	Met people/ obtained advice	6
	Support from friends	3
	Support from family	3

	Got a job	4
	Persistence/ determination	1
	Resilient	1
	Hard work	1
4	**Knowledge of mental health**	
	Definition:	
	Psychological/ social wellbeing	5
	State of mind and health (emotions)	2
	Status of being/ state of mind	4
	Process affecting an individual's attitude	1
	ability to meet social and economic needs	1
	Causes:	
	Stress	5
	Pressure	2
	Unemployment	4
	Depression	4
	Lifestyle situation and family issues	4
	Drugs	4
	Alcohol	2
	Spiritual forces	3
	Loneliness	3
	Genetic causes	3
	Accidents	1
	Migration	1
	Lack of necessities	1
	Smoking	1
	Poverty	1
5	**Impact of migration on mental health**	
	Thoughts of returning initially	4
	Impact of crisis/ insecurity on relocation & arrival	4

Appendix 15: Allotment of codes into themes

Main Themes	Codes
Purpose of Migration	Work
	Marriage
	Want a better life
	Education
	Improved standard of living due to opportunities in place of relocation
	Moved to join the family (relative)
Experience of migration	Accommodation issues
	Difficulty paying bills due to the high cost of living/ Financial challenges
	Migration is a result of marriage: once a lifetime commitment
	Problems finding a job
	Communication challenges
	challenges of conflict of understanding their new people
	Transportation challenges
	Challenges of leaving family, friends, and social support
	Challenges making new friends in the new location
	Weather challenges
	Lack of basic amenities from the departure location
	Dependent on a relative on initial arrival to the new location
	Security challenges in place of departure
	A positive experience of moving to the bigger city due to secured security and good road network
	Lack of basic amenities in place of arrival immediately after relocation
	inability to socialise with her new family.
	Inability to enrol at school due to accommodation issues
Coping strategies	Religion and prayers
	hope,
	determination,
	hard work,
	perseverance

	persistence
	Learn the new language and communicate more with people.
	was able to speak the local language which helped interact with people in the community
	Obtained social and family support.
	lack of support after relocation as a factor impacting negatively on wellbeing from one participant.
	Shared apartment
	made new friends.
	cut down costs and engage in savings
	Used public transportation
	Got a new job after some time.
	pick up menial jobs below qualification
	Observed environment
	Got used to the system and adapted
	try to avoid the weather and wear protective clothing
Knowledge of mental health	mental health as a state of wellbeing, or emotion
Definition:	Good health of mind and behaviour of an individual
	an issue with the mind or mental state
	state of mind: the way you think, thought process, stress or having issues/ how you deal with stress
	State of wellbeing; state of your brain, mind, or emotion
	Psychological wellbeing
	The process where an individual's psychological, mental, and social attitude is affected in a positive or negative way
	Mental is someone that is sane or thinks well.
	the right state of mind to live a good life
Cause of mental health problems	social issues- unemployment
	emotional issues- family
	drugs and lifestyle such cocaine, codeine or ‘solution’
	spiritual forces/ black magic/ voodoo
	depression
	biologically/ natural defects sometimes call ‘imbecile’
	stress
	Lack of jobs leads to suicide/ crime.
	Youths engage in evil social vices to sustain drug intake leading to mental instability.
	Accidents cause head injuries.

	rejection
	Unable to achieve targeted goals and aspirations.
	lack of necessities in Nigeria
	smoking
	sexual abuse e.g., Rape, migration
perceptions to mental health	mental instability called 'madness' and supernatural factors.
	‘solution’ drugs taken in rural areas makes them ‘mad’
	Spirit forces make people mad.
	Some children are treated badly by guardians after the loss of parents which affects them negatively.
	when someone is imbalanced and behaving in an erratic behaviour
Impact of internal migration on mental health	emotionally draining, with thoughts of failure and disappointment due to unemployment and lack of basic amenities.
	Psychologically distress due to high expectations and uncertainty of the outcome of migration.
	Thoughts of returning due to hardship.
	Thoughts of returning due to lack of support from family.
	Independent in place of departure but became dependent on relative on arrival to the new location
	lack of funds and inability to rent a flat on arrival lead to depression, confusion, lots of thoughts, and sadness
	Transportation issues while moving luggage due to attack by armed robbers during journey resulting in negative thoughts and psychological distress.
	Cost of moving was very expensive.
	Fear and risk of accidents on road journey while moving.
	Loss of valuables while moving.
	security challenges in place of departure affect mental health
	place of arrival was better and secured gave peace of mind
	State of affairs of the nation affects the negative state of mind
	Squatting affected mentally

Relocated during the time of crisis resulting in the burning of churches and violence attacks resulted in fear, intimidation and impacted negatively on mental state at that time. Was an escape route (positive).

arrival during crisis/ violence-affected psychologically leading to isolation (negative)

Isolation and loneliness due to no friends or family in the first year of relocation

Experienced elements of psychological distress due to isolation

Location changes affected behaviour and way of life.

Missed family and place of origin.

Felt like did not fit in on arrival

Cost of living was higher in place of a relocation than the place of origin

became responsible and independent in the new location

socialized more leading to a sense of maturity and decision making

Appendix 16: Initial findings summary

Initial findings summary
Exploring the experiences of mental health among internal migrants in Nigeria
Initial themes for participant's verification and comment
Five themes emerged from the study:
Purpose of migration
Experience of migration
Coping strategies
Knowledge of mental health
Impact of migration on mental health
A summary of the findings in each theme are provided:
Purpose of migration
People described the reasons for migrating out of their state of origin to education, work, NYSC(one- year compulsory government internship), marriage and moving with family to join family members or relations. There were also descriptions to 'wanting a better life' or seeking 'greener pastures.
Can you see your reason for migrating as reflected in theme 1?
Yes
No- if no, please briefly state why here.
Experience of migration
People revealed several experiences with regards to moving as not easy and challenging. Both positive and negative experiences with regards to moving to a new state were revealed. People described negative experiences of moving to language barriers, distance to new location, adapting to the weather, accommodation challenges, job challenges, lack of social support, transport problems, loneliness, high cost of living in new state and insecurity challenges. However, majority explained that they experienced these challenges initially and with time they were able to adapt. They explained that even after settling down they still experience challenge of lack of social support due to missing family and friends. On the positive side, some people explained that they moved for better opportunities in the new state and that gave them the ability to endure the challenges they experienced initially on arrival. Some also mentioned that they experienced the diversity off culture in the new state. They also said that due to insecurity challenges in the state of departure, they had to move to the new city to experience security. Finally, people escribed that the system and way of life of their state of origin was different from the new city and was difficult to adjust.
Can you see your experiences of migrating reflected in theme 2?
Yes
No- if no, please briefly state why here
Coping strategies
People explained that with time they were able to adapt and got used to the system and way of life in the new state. They were able to cope by learning the new language and adapting to the new weather. Attributes such as perseverance, persistence/ determination, resilient (tough) and hard work were described as terms used to cope. People also explained that religion played a vital role in coping. They also described that they got support from friends and family. They also obtained advice and met people who helped

put them through. Finally, some people described that they got a job and that helped in coping and settling down.

Can you see your experiences of coping as an internal migrant reflected in theme 3?

Yes

No- if No, please briefly state why here.

Knowledge of mental health

People interviewed gave several definitions about their knowledge and views about mental health. Some of the definitions given were that mental health was psychological/ social wellbeing, state of mind (emotion) and health, status of being/ state of mind, a process affecting an individual's attitude and ability to meet social and economic needs.

Does any of these definitions describe your experiences reflected in theme 4?

Yes

No- if no, please briefly state why here.

4B. Causes of mental health issues

People gave several reasons for mental health issues in an individual. Some of the reasons given were stress, pressure, unemployment, depression, lifestyle situation and family issues such as divorce or break up, drugs, alcohol, spiritual attack, loneliness, genetic causes, accidents, migration, lack of basic necessities, smoking and poverty.

Does any of these causes describe your experiences reflected in theme 4?

Yes

No- if no, please briefly state why here.

Impact of migration on mental health

People shared various experiences about the impact moving to a new state had on their mental health. There were both negative and positive experiences. The negative experiences were that people had thoughts of returning back initially on arrival due to hardship and challenges of adjusting to the new environment. For example, some were confused if should relocate back because of non- acceptance in marriage but decide to remain. People also explained that the crisis/ violence and insecurity that occurred led to experiences of isolation and rejection, for example, an individual described encountering armed robbers while transporting goods to the new location, this experience resulted in depression and sadness. Began to question motive for relocation i.e., if making the right decision? There were also experiences of isolation and loneliness due to language barriers. The inability to understand the people in the new location also affected negatively. People described their experiences as emotionally draining especially due to lack of basic amenities and thoughts of disappointment putting a toll on mental health. People also explained that their mode of communication and manner of speech changed and became more outspoken due to the lifestyle and way of living in the new environment. They also described that the state of affairs of the nation such as corruption, insecurity, poor infrastructure, bureaucracy and unfair treatment results in a negative state of mind and fear, for example, while travelling an individual was afraid of risk of accidents as the road are not secured. Another individual explained that the family had to move out of the apartment given after relocation because a higher official wanted the same apartment. People also explained that the high cost of living in the new state such as high cost of accommodation lead to feelings of sadness and confusion due to inability to rent a flat on arrival. They also explained that on initial arrival to the new location, they shared experiences of squatting with friends sometimes with lack of social amenities like electricity etc which had a serious impact on their mental health. People described having lack of social support from family, challenges making new friends and missing family,

this impacted greatly on their mental health. Some individuals explained that they were dependent on family for some time before settling down which impacted negatively on their mental health.

There were also positive experiences with regards to moving and the impact on their mental health. They all described that irrespective of the initial challenges and insecurity/ crisis experienced. They still decided to relocate and stay back because the city is a place of opportunities and a place to become economically independent. There were also experiences of the new city being an escape route from crisis/ violence and insecurity inherent in place of departure. Finally, they also shared experiences of becoming more social and independent in new city.

Can you see your experiences of migration reflected in theme 5?

Yes

No- if no, please briefly state why here.

Appendix 17: Draft one findings summary

Draft one findings summary
Exploring the experiences of mental health among internal migrants in Nigeria
(Changes following participant review/Silence Dialogue highlighted)
Initial themes for participant's verification and comment
Five themes emerged from the study:
Purpose of migration
Experience of migration
Coping strategies
Knowledge of mental health
Impact of migration on mental health
A summary of the findings in each theme are provided:
Purpose of migration
People described the reasons for migrating out of their state of origin to education, work, NYSC(one- year compulsory government internship), marriage and moving with family to join family members or relations. There were also descriptions to 'wanting a better life' or seeking 'greener pastures.
Does any of these causes describe your experiences reflected in theme 4?
Yes
No- if no, please briefly state why here.
Experience of migration
People revealed several experiences with regards to moving as not easy and challenging. Both positive and negative experiences with regards to moving to a new state were revealed. People described negative experiences of moving to language barriers, distance to new location, adapting to the weather, accommodation challenges, job challenges, lack of social support, transport problems including transport fare issues, loneliness, high cost of living in new state and insecurity challenges. However, majority explained that they experienced these challenges initially and with time they were able to adapt. They explained that even after settling down they still experience challenge of lack of social support due to missing family and friends. **Young people who moved with their families said they had to stay at home for a while without going to school due to the challenges of settling down and finding a job and accommodation on arrival. Some participants also explained that it was difficult to make an initial decision to migrate, but it was necessary to have a better life. Some participants described their experiences as a great change from what they were used to.** Finally, people described that the system and way of life of their state of origin was different from the new city and was difficult to adjust.
On the positive side, some people explained that they moved for better **opportunities such as better economy, job opportunities and facilities to make a better life** in the new state and that gave them the ability to endure the challenges they experienced initially on arrival. Some also mentioned that they experienced the diversity of culture in the new state. They also said that due to insecurity challenges in the state of departure, they had to move to the new city to experience security. **Some participants also explained that the new city was commercially buoyant and decided to stay back.**
Does any of these causes describe your experiences reflected in theme 4?
Yes

No- if no, please briefly state why here.

Coping strategies

People explained that with time they were able to adapt and got used to the system and way of life in the new state. They were able to cope by learning the new language and adapting to the new weather. Attributes such as perseverance, persistence/ determination, resilient (tough) and hard work were described as terms used to cope. People also explained that religion played a vital role in coping. They also described that they got support from friends and family. They also obtained advice and met people who helped put them through. Finally, some people described that they got a job and that helped in coping and settling down **while some had to engage in menial jobs to sustain self and family.**

Does any of these causes describe your experiences reflected in theme 4?

Yes

No- if no, please briefly state why here.

Knowledge of mental health

People interviewed gave several definitions about their knowledge and views about mental health. Some of the definitions given were that mental health was psychological/ social wellbeing, state of mind (emotion) and health, status of being/ state of mind, a process affecting an individual's attitude and ability to meet social and economic needs. **Mental health was also defined as mental stability with feelings and comfort a person has. Mental health was also defined as how an individual behaves or relates with people. Mental health was also defined as how an individual perceives situations and how these situations make a person behave or talk. They also described that moving to the new state and having a job enhanced social and economic needs and emotions. This made them able to fit into society properly**.

Does any of these causes describe your experiences reflected in theme 4?

Yes

No- if no, please briefly state why here.

Causes of mental health issues

People gave several reasons for mental health issues in an individual. Some of the reasons given were stress, pressure, unemployment, depression, lifestyle situation and family issues such as divorce or break up, drugs, alcohol, spiritual attack, loneliness, genetic causes, accidents, migration, lack of basic necessities, smoking and poverty. **They also said unemployment and economic pressure results in crime and begging among youths which impacts negatively on their mental health. Some participants also described people with mental health issues to show erratic behaviour thereby displaying signs of madness. Participants also explained that the mental capacity of an individual determines how an individual copes with stress or pressures. Some participants also said that some people used illegal drugs as coping mechanisms which can result in mental problems. They also described that mental health problems can be caused by both internal (within the individual) and external (outside the individual) factors. Some participants also explained that the inability to achieve the necessities in life due to economic hardship and unemployment affects mentally.**

Does any of these causes describe your experiences reflected in theme 4?

Yes

No- if no, please briefly state why here.

Impact of migration on mental health

People shared various experiences about the impact moving to a new state had on their mental health. There were both negative and positive experiences. The negative experiences were that people had thoughts of returning back initially on arrival due to hardship and challenges of adjusting to the new environment. For example, some were confused if should relocate back because of non- acceptance in marriage but decide to remain. People also explained that the crisis/ violence and insecurity that occurred led to experiences of isolation and rejection, for example, an individual described encountering armed robbers while transporting goods to the new location, this experience resulted in depression and sadness. Began to question motive for relocation i.e., if making the right decision? There were also experiences of isolation and loneliness due to language barriers. The inability to understand the people in the new location also affected negatively. People described their experiences as emotionally draining especially due to lack of basic amenities and thoughts of disappointment putting a toll on mental health. People also explained that their mode of communication and manner of speech changed and became more outspoken due to the lifestyle and way of living in the new environment. They also described that the state of affairs of the nation such as corruption, insecurity, poor infrastructure, bureaucracy and unfair treatment results in a negative state of mind and fear, for example, while travelling an individual was afraid of risk of accidents as the road are not secured. Another individual explained that the family had to move out of the apartment given after relocation because a higher official wanted the same apartment. People also explained that the high cost of living in the new state such as high cost of accommodation lead to feelings of sadness and confusion due to inability to rent a flat on arrival. They also explained that on initial arrival to the new location, they shared experiences of squatting with friends sometimes with lack of social amenities like electricity etc which had a serious impact on their mental health. People described having lack of social support from family, challenges making new friends and missing family, this impacted greatly on their mental health. Some individuals explained that they were dependent on family for some time before settling down which impacted negatively on their mental health. **Some people also described missing school due to moving to a new state which impacted negatively leading to feelings of anger and loneliness. They also explained that moving to the new state felt different and had difficulty fitting in due to leaving family and friends behind. Participants expressed that surviving in an unconducive environment with difficult situations impacts on mental health especially among Nigerians. Participants gave scenarios where they became aggressive on occasions due to change in environment. Some participants described that the change in environment with security changes impacted greatly on their mood and feelings. A participant described that in the new environment, people were open and expressed themselves irrespective of the challenges. This taught her to be open and not discrete (which she was used to in her place of origin).**

There were also positive experiences with regards to moving and the impact on their mental health. They all described that irrespective of the initial challenges and insecurity/ crisis experienced. They still decided to relocate and stay back because the city is a place of opportunities and a place to become economically independent. There were also experiences of the new city being an escape route from crisis/ violence and insecurity inherent in place of departure. Finally, they also shared experiences of becoming more social and independent in new city.

Can you see your experiences of migration reflected in theme 5?
Yes
No- if no, please briefly state why here.

Appendix 18: Draft two findings summary

Draft two findings summary

Exploring the experiences of mental health among internal migrants in Nigeria

(Changes following Collective voices review highlighted)

Initial themes for participant's verification and comment

Five themes emerged from the study:

- Purpose of migration
- Experience of migration
- Coping strategies
- Knowledge of mental health
- Impact of migration on mental health

A summary of the findings in each theme are provided:

Purpose of migration

People described the reasons for migrating out of their state of origin to education, work, NYSC(one- year compulsory government internship), marriage and moving with family to join family members or relations. There were also descriptions to 'wanting a better life' or seeking 'greener pastures'. **All collective voices participants described that they were once internal migrants at some particular points in their lives. All participants (collective voices) agreed with the findings with interview participants describing education, job opportunities and NYSC.**

Experience of migration

People revealed several experiences with regards to moving as not easy and challenging. Both positive and negative experiences with regards to moving to a new state were revealed. People described negative experiences of moving to language barriers, distance to new location, adapting to the weather, accommodation challenges, job challenges, lack of social support, transport problems including transport fare issues, loneliness, high cost of living in new state and insecurity challenges. However, majority explained that they experienced these challenges initially and with time they were able to adapt. They explained that even after settling down they still experience challenge of lack of social support due to missing family and friends. Young people who moved with their families said they had to stay at home for a while without going to school due to the challenges of settling down and finding a job and accommodation on arrival. Some participants also explained that it was difficult to make an initial decision to migrate, but it was necessary to have a better life. Some participants described their experiences as a great change from what they were used to. Finally, people described that the system and way of life of their state of origin was different from the new city and was difficult to adjust. **Participants (Collective voices) agreed with the findings, describing challenges of coping with the harsh weather and language barriers. Another participant explained that as a**

temporary migrant, had experiences intertwined with cultural networks and language. Found out that there were persistent cultural barriers between migrants and non-migrants. They also described that their place of origin is quiet, and calm compared to the place of relocation which was a busy and fast-paced city. They said people never minded their business and were always in a hurry. They described the city of relocation as not accommodating. Traffic was terrible; for example, had to leave for work at 05:30am to resume for 8am. One of the collective voice participants explained that due to the high cost of living in the place of relocation (accommodation) and inability to rent a flat in the city; the participant had to live in the outskirts of the town which led to traffic going to and from work. He had to return to his place of origin due to the high cost of living.

On the positive side, some people explained that they moved for better opportunities such as better economy, job opportunities and facilities to make a better life in the new state and that gave them the ability to endure the challenges they experienced initially on arrival. Some also mentioned that they experienced the diversity of culture in the new state. They also said that due to insecurity challenges in the state of departure, they had to move to the new city to experience security. Some participants also explained that the new city was commercially buoyant and decided to stay back. All collective voice participants agreed with the findings. They also said that the place of relocation was fun and social life was better. Thy said the city made them social, smart, independent, and lively. They also described the city of relocation as a place of opportunities.

Coping strategies

People explained that with time they were able to adapt and got used to the system and way of life in the new state. They were able to cope by learning the new language and adapting to the new weather. Attributes such as perseverance, persistence/ determination, resilient (tough) and hard work were described as terms used to cope. People also explained that religion played a vital role in coping. They also described that they got support from friends and family. They also obtained advice and met people who helped put them through. Finally, some people described that they got a job and that helped in coping and settling down while some had to engage in menial jobs to sustain self and family. Collective voices all agreed with the findings by learning the new language and adapted to the weather. Another participant (collective voice) decided to move to an area with a lower native language proficiency. Religion was also described as a good coping method especially as new migrants when distressed or struggling to adapt or settle down. They also said they had to save money to cope in the new city. The learnt to be smart and hardworking to survive in the fast-paced city. Finally, they described that when they got a job, a good network of friends and help from God through prayers they were able to cope.

Knowledge of mental health

People interviewed gave several definitions about their knowledge and views about mental health. Some of the definitions given were that mental health was psychological/ social wellbeing, state of mind (emotion) and health, status of being/ state of mind, a process affecting an individual's attitude and ability to meet social and economic needs.

Mental health was also defined as mental stability with feelings and comfort a person has. Mental health was also defined as how an individual behaves or relates with people. Mental health was also defined as how an individual perceives situations and how these situations makes a person behave or talk. They also described that moving to the new state and having a job enhanced social and economic needs and emotions. This made them able to fit into society properly. All collective voices participants agreed with the finding with concerns that mental health issues ae a growing problem especially among young people due to stress, unemployment, drug abuse and spiritual problems. It is also connected to a person's psychological and emotional well-being. A collective voice participant explained that as a young temporary migrant, had little or no temporary basis and usually associate mental health issues with distress due to being away from home. Finally, they added that it is the ability of an individual to adapt and handle life issues physically, mentally, socially, emotionally, and psychologically.

B. **Causes of mental health issues**

People gave several reasons for mental health issues in an individual. Some of the reasons given were stress, pressure, unemployment, depression, lifestyle situation and family issues such as divorce or break up, drugs, alcohol, spiritual attack, loneliness, genetic causes, accidents, migration, lack of basic necessities, smoking and poverty. They also said unemployment and economic pressure results in crime and begging among youths which impacts negatively on their mental health. Some participants also described people with mental health issues to show erratic behaviour thereby displaying signs of madness. Participants also explained that the mental capacity of an individual determines how an individual copes with stress or pressures. Some participants also said that some people used illegal drugs as coping mechanisms which can result in mental problems. They also described that mental health problems can be caused by both internal (within the individual) and external (outside the individual) factors. Some participants also explained that the inability to achieve the necessities in life due to economic hardship and unemployment affects mentally. All collective voices participants agreed that the ability of an individual to manage stress known as internal variables and various external factors which are mostly focused on poverty, having an illness, and even spiritual problems (being possessed by an evil spirit). They agreed that drug abuse is a major cause of mental health issues specially among youths.

Impact of migration on mental health

People shared various experiences about the impact moving to a new state had on their mental health. There were both negative and positive experiences. The negative experiences were that people had thoughts of returning back initially on arrival due to hardship and challenges of adjusting to the new environment. For example, some were confused if should relocate back because of non- acceptance in marriage but decide to remain. People also explained that the crisis/ violence and insecurity that occurred led to experiences of isolation and rejection, for example, an individual described encountering armed robbers while transporting goods to the new location, this experience resulted in depression and sadness. Began to question motive for relocation i.e., if making the right decision? There were also experiences of isolation and loneliness due to language barriers. The inability to understand the people in the new location also affected negatively. People described their experiences as emotionally draining especially due to lack of basic amenities and thoughts of disappointment putting a toll on mental health.

People also explained that their mode of communication and manner of speech changed and became more outspoken due to the lifestyle and way of living in the new environment. They also described that the state of affairs of the nation such as corruption, insecurity, poor infrastructure, bureaucracy and unfair treatment results in a negative state of mind and fear, for example, while travelling an individual was afraid of risk of accidents as the road are not secured. Another individual explained that the family had to move out of the apartment given after relocation because a higher official wanted the same apartment. People also explained that the high cost of living in the new state such as high cost of accommodation lead to feelings of sadness and confusion due to inability to rent a flat on arrival. They also explained that on initial arrival to the new location, they shared experiences of squatting with friends sometimes with lack of social amenities like electricity etc which had a serious impact on their mental health. People described having lack of social support from family, challenges making new friends and missing family, this impacted greatly on their mental health. Some individuals explained that they were dependent on family for some time before settling down which impacted negatively on their mental health. Some people also described missing school due to moving to a new state which impacted negatively leading to feelings of anger and loneliness. They also explained that moving to the new state felt different and had difficulty fitting in due to leaving family and friends behind. Participants expressed that surviving in an unconducive environment with difficult situations impacts on mental health especially among Nigerians. Participants gave scenarios where they became aggressive on occasions due to change in environment. Some participants described that the change in environment with security changes impacted greatly on their mood and feelings. A participant described that in the new environment, people were open and expressed themselves irrespective of the challenges. This taught her to be open and not discrete (which she was used to in her place of origin).

There were also positive experiences with regards to moving and the impact on their mental health. They all described that irrespective of the initial challenges and insecurity/ crisis experienced. They still decided to relocate and stay back because the city is a place of opportunities and a place to become economically independent. There were also experiences of the new city being an escape route from crisis/ violence and insecurity inherent in place of departure. Finally, they also shared experiences of becoming more social and independent in new city. **All participants (collective voices) agreed that negative factors as identified in the findings report affect mental health but decided to focus on purpose of migration which was for academic advancement and job opportunities. Also, when an individual moves to a place and does not experience the expected outcome on arrival can make one depressed. A participant explained that based on personal experience as a temporary migrant, it was possible that educational related pressures impacted on state of mind. Due to the fast-paced nature of the city of relocation, they found that people did not seem as 'sane' as they look due to seeing people show aggressive behaviours compared to their place of origin which is calm and civil. A collective voice participant said he had to leave due to the high cost of living which made him distressed initially. Participants said due to the fast-paced nature of the city, it can sometimes be mentally draining. They finally agreed that even though the high cost of living was initially stressful, they were able to cope after getting a job, good network of friends and through prayers.**

Appendix 19: Summary of study participants experiences

Name	Purpose of Migration	Experience of Migration	Coping Strategies	Knowledge of mental health	Impact of migration on mental health
Abdul	Education	Language barrier	Learn the new language	Psychological wellbeing	No social support
	NYSC-Corp member	Distance		Causes: stress and pressure	Isolation due to language barriers
Akin	Education	Weather	Adapted to weather with time	Status of your being	During crisis, did not relocate due to opportunities. Other who did return had properties looted.
	Work	Economic activity and opportunities good in city of relocation		Causes: pressure and stress due to economic and marital challenge	
Andrew	For better life & Greener pastures	Accommodation problems	perseverance	State of mind and degree of emotion.	emotionally draining
		Challenge finding a job	religion	Causes: social issues such as unemployment, poverty	feelings of giving up
			hope	Emotional issues; depression, family issues, divorce.	lack of basic amenities led to suicide thoughts
			determination		thoughts of failure and disappointment puts tool on mental health
			hard work		
			persistent		

Ann	Moved to join family	Weather	made new friends	State of emotional, social, or psychological wellbeing.	Became more responsible
			wearing protective clothing	Causes:	Became more sociable and independent
Ayo	Marriage	loneliness and idleness	Searched for jobs	Psychological wellbeing	First year rough due to loneliness
		no friends	Got a job	Causes; depression	Experienced depression due to loneliness
		cost of living easier and convenient in Kaduna			
Blessing	Placement (work)	Life in Lagos different in terms of housing, houses were clustered and together and bad.	Talking to people and voicing out concerns andobtaining advice	state of health which involves feelings, behaviour, and emotions	Thought of relocating back initially but changed mind due to opportunities present in Lagos.
		Lagos is a city of hustling and bustling	Build interpersonal skills	Causes: hereditary, genetically, lifestyle situation in Lagos (stressful life) frustration, lifestyle situations like bankruptcy etc, drugs and alcohol.	mode of communication and manner of speech changed and

		weather is not favourable	Resilient		became more outspoken so as not to be taken for granted.
		high crime rate and insecurity in Lagos	Perseverance persistent		
Bukky	NYSC: one-year internship in any state in Nigeria	Kaduna place of job opportunities and economic activities	Began to learn the language	She was mentally stable due to ability to meet her social and economic needs.	excited and happy to move out to another state
	Got a job at Bank of Agric (Work)	Language barriers		Causes: unemployment which has led to crime, kidnapping, and poverty	Got a job after internship and became economically independent
		Was not fully accepted at community due to language barriers			Settled down started a family and business in Kaduna.
Chris	Work	Challenge finding a job due to high competition	got used to the system and settled down	State of wellbeing of a person's mind	State of affairs of the nation could lead to depression and a negative state of mind
		Accommodation challenge	got a job in a small firm	Causes; unemployment, accidents, Black magic, and natural/ biological factors	Relocated to Abuja from Kaduna during crisis which led to fear but was an escape

					route.
		Transport problems	support from friends		
Fred	Work	Difficulty paying bills initially due to high cost of living	Learnt the language	having an issue with your mind or mental state	a bit depressed, sad, and confused due to inability to rent flat on arrival initially
		Language barrier		Causes; stress	encountered armed robbers while transporting goods to new location
		Accommodation challenge	Talking and asking questions		began to question motive for relocation if it was a right decision
		Transport problems	Associated with people who spoke the language (Hausa)		high prices of rent and finding accommodation put in depression initially
			Obtained advice		after prayers met someone who agreed they could stay together and share rent

			Prayers		
James	Work	moving from a smaller to bigger city	had support from friends	mental health is the right state of mind to live a good life/ good mental health	before relocation, used to hide and isolate self-due to high level of crime and insecurity
		ease of transport was better compared to state of departure.	with friends' support moved around and found something to do	Causes: Drugs, depression, unemployment	on arrival initially had to squat with friends with no social amenities like electricity, pipe borne water etc. this had a serious impact because was not used to that type of life
		insecurity was high in place of departure			
		had no job for a few months after arrival			
		finding accommodation not easy had to squat with friends for 2-3 years			

Jane	Moved with family	Relocated because place of departure not conducive	Due to work challenges, mum had to engage in credit to sustain the family.	When someone is not mentally stable.	During challenges, family was not happy
		Could not move all properties due to bad roads			Father was not having time with family and always thinking.
		Transport fare issues		Perceptions: when someone is imbalanced and behaving in an erratic behaviour(stig ma).	Seeing school mates going to school without her made her unhappy, isolated, and angry with parents.
		Felt like starting afresh			
		Had to stay back at home for a term before parents could find work			
Joseph	moved with family	language barrier	later moved to another location which was diverse	How you look after the body, brain, the mind, and mental state Causes: isolation/ loneliness or going through a hard time may lead to poor mental state	

Kemi	Marriage	leaving friends, social gatherings, peer groups affected mentally	family support	mental health is a state of wellbeing	the cost implications of moving were expensive
		had to leave her job and was a sacrifice that affected her mentally	searched for jobs and got a job		the roads are not secured and was scared on journey of accidents as it is a major risk
		challenge of building new friends	made new friends and colleagues		
		issue of gender: it is something meant to happen, and young single women tend to be treated differently if not married			
Lily	moved with family	accommodation challenge at time of relocation	moved with mother to relocate to meet father	it is basically stress	family had to move out as higher authority wanted apartment
		had to move from place to place before getting permanent accommodation	was able to speak language which helped communication		
		squat with relatives before obtaining permanent accommodati		Causes: stress and smoking	

		on			
		challenge finding an appropriate school learnt about the culture in the north was able to meet father			
Mathew	Work	accommodation challenge understanding culture due to different food, people, and language missed family and friends	help of friends, colleagues, and church members met friends religion - put trust in God	Causes: spiritual affairs and result of one's bad deeds life of isolation i.e. being an introvert and loneliness drugs and alcohol depression trauma e.g. divorce or breakup if it deteriorates it may not be able to control the mind	difficulties of no social support, making friends, finding a job affected mental health negatively.
Peter	family	leaving relations and missing relatives and family	family was supportive and experienced a lot	mental health means a good health of mind and behaviour of an individual	system and way of life changed (life in village was different from city)

	education	transport cost and		Causes: unable to achieve a certain goal especially in Africa where things are difficult	on arrival initially, encountered crisis which affected psychologica lly
		distance		Lack of basic necessities	remained isolated and rejected
		Kaduna is a place of labour and education so obtained qualifications			gradually picked up and began to move with people.
Philip	Greener pastures due to more opportuniti es and improved standard of living in new location	a big difference between village and city	perseverance	mental is someone who is sane, rational and makes rational decisions	felt like returning due to hardship but decided not to because was hopeful that some good will happen
		lack of effective social amenities in place of departure	persistent	Causes: Drugs and lifestyle and spiritual forces	dependent on family for everything for 6 months before settling down which impacted negatively.
		on arrival, was difficult initially			
		had to make new friends			
		had no job			

		became dependent on relative before getting a job			
		took 2-3 years to be independent			
Ruth	Marriage	movement was restricted in Kaduna	was able to adapt to the weather within one year	mental health involves a housewife having difficulties managing her home and children while battling idleness which may impact negatively	not easy because husband is posted out of state to another state while in new location
		experienced crisis sometimes leading to throwing of bombs due to terrorism			
		lack confidence to go out for business and social activities.	challenge of posting was overcome because hubby was given packing allowance		husband only visits weekends and occasionally
		economically the state is good			

		hard to adapt to the weather	was able to focus on work and manage family effectively since the aspect of idleness is eliminated		husband travels frequently and struggling to cope with his absence
		noticed on arrival the diversity in culture of the North especially in terms of food, language, and dance			
Susan	tertiary education	leaving own people/ family to join new family due to marriage	picked up menial jobs	process where an individual's psychological, mental, and social attitudes is affected either in a positive or negative way	lost items in course of relocation
	marriage	psychological and emotional problems due to leaving family behind			had thoughts running across her mind and people could not relate or understand her
		her family understood her but new family in laws) had conflict of understanding	irrespective of the challenges held on to faith because once married have to spend rest of life with the	Causes: migration by having to move to a different land to adapt to a new style, culture etc	had to adjust but not completely because of children

person

lost job after migration due to marriage		confused if should relocate back but changed her mind because marriage is a decision to remain in new family irrespective of outcome or consequences
	culture as well believe in one man/ one-woman ideology	caring for two children alone without support put a tool on physical and mental wellbeing

Appendix 20: Summary of collective voices experiences

Ade
Qualification: Community Health volunteer and Pastor
Theme 1: NYSC
Theme 2: no social life in the state of origin, became an outgoing person, transportation was expensive and accommodation challenges.
Theme 3: Got a job, support from friends, and religion.
Theme 4: causes of mental disorders: drug abuse, poverty, having an illness, and spiritual problems.
Theme 5: preferred the new city because it was less stressful. The high cost of living was stressful initially.
Ahmed
Qualification: Medical professional
Theme 1: work
Theme2: the new city was not accommodating. Hustling life was very intense. The accommodation was very expensive. Transport was inconvenient. Healthcare was not affordable. Difficulty finding a job and traffic was terrible.
Theme 3: saved money
Theme 4: Mental health is the ability of an individual to handle life issues emotionally, psychologically, and psychically.
Theme 4: no comment
John
Qualification: CEO of Non-governmental organisation.
Theme 1: the place was calmer, urban, and sophisticated. Stayed in the outskirt of the city due to the high cost of living. A lot of traffic. Could not settle due to the high cost of living and job difficulty.
Theme 2: returned to Lagos and got a job.
Theme3: Mental health is when an individual can adapt physically, mentally, and socially.
Drug abuse is a major cause.
Theme 4: Left Abuja due to the high cost of living led to distress at that time.
Johnson
Qualification: medical professional
Theme 1: Education
Theme 2: Language barriers
Theme 3: Leant the new language.
Theme 4: Ability to manage stress (internally) and external factors.
poverty is the main cause.
Theme 5: Negative factors impact mental health but focused on the purpose of migration which was for academic advancement and job opportunities.

Mike
Qualification: experienced migration researcher
Theme 1: Short term migration – for education
Theme 2: Language barriers. Cultural barriers between natives and migrants.
Theme 3: Learned the new language.
Theme 4: Had little awareness as a young migrant. Used to associate mental health issues with distress due to being away from home.
Theme 5: Discovered that educational-related pressures impacted on migration experience.
Richard
Qualification: Spiritual leader (pastor)
Theme 1: Education
Theme 2: Weather challenges. Language barriers.
Theme3: Religion. Adapted to the weather. Learned the new language.
Theme 4: Mental health problems are common among youths. Causes: stress, unemployment, drug abuse, and spiritual problems.
Theme 5: Uncertainty about the outcome of the migration experience can lead to depression.