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Abstract Refugees are exposed to extreme stressors and are therefore at risk of mental health and social problems. Other issues refugees have to cope with include the loss of their country, culture, language, profession, family, friends, and future plans. Much of the studies that have been done on refugee mental health have not attempted to explain what these experiences mean to these individuals. Thus, this study provides explorative data on the mental health and quality of life of West African refugees living in Nigeria in order to understand their views and perspectives. This study carried out in 2010 employed qualitative methods; a total of four focus group discussions (FGDs) were conducted among adult male and female refugees purposively selected at the Oru Refugee Camp, Ogun State, Nigeria. Respondents described quality of life as a major determinant of mental health status. Most of the participants believed that women were more predisposed to mental ill health due to their sensitive emotional make-up. Factors identified by respondents as affecting mental health and quality of life among refugees included poverty, unemployment, physical health, housing and environment, discrimination, stigmatization, and insecurity. Refugees rated their mental health and quality of life as poor due to the aforementioned factors. Recommendations were made to the international community, national and local governments to invest more on education, provision of vocational and entrepreneurial skills as well as adequate housing in order to improve the mental health and quality of life of refugees.

Keywords Mental health · Quality of life · Refugees · Nigeria

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Introduction

The 1951 United Nations Refugee Convention described a refugee as someone who is outside the country of his nationality due to a well-founded fear of being persecuted due to reasons of nationality, race, political opinion, religion, or membership of a social group and has sought the protection of the country s/he has fled to (UN General Assembly 1951). According to Simone Weil in wartime England, to have a place one can call home is the greatest but least recognized need of the human soul (Malkki 1992).

As at the end of 2012, there were about 10.5 million refugees globally with about 2.8 million from Sub-Saharan Africa and 268,000 from West Africa (United Nations High Commissioner for Refugees 2014). Only a few refugees are found in developed countries as most refugees flee from developing countries to other developing countries (Tribe 2002).

Due to their displacement from their usual habitat, research has shown that refugees are predisposed to a number of mental health and quality of life issues (Lindencrona et al. 2008). The World Health Organization (2014) described refugees as a population exposed to extreme stressors and therefore at risk of mental health and social problems. Some of these stressors include stigma, public humiliation, intimidation, hunger, rape, torture, death of relatives ,and other forms of hardship (De Jong et al. 2000; Hauff and Vaglum 1995; Lavik et al. 1996). Other issues refugees have to cope with the loss of their country, culture, language, profession, family, friends, and future plans (Tribe 2002).

Mental health is defined as a state of well-being in which every individual recognizes his or her own ability, can cope with the normal pressures of life, can be fruitful and productive at work, and is able to contribute to her or his community (World Health Organization 2003).

Health-related quality of life, as defined by the World Health Organization quality-of-life group, is the individual's subjective assessment of disease and impairment and disabilities (WHOQoL Group 1998). Quality of life has several dimensions including emotional well-being, social well-being, physical well-being, material well-being, and development (Felce and Perry 1995).

In a study done among Rwandan and Burundese refugees in Tanzania, De Jong and colleagues (2000) stated that about half reported serious mental health problems. Many studies have shown that the prevalence of mental ill health among refugees is high due to a number of pre- and post-migration stressors as well as the refugees' cultural background and the host environment (De Jong et al. 2000; Hauff and Vaglum 1995; Lavik et al. 1996; Lustig et al. 2004). Miller et al (2002) in a study done among Bosnian refugees revealed that exposure to war (pre-migration) and social isolation in the refugee camp (post-migration) were significant stressors associated with post-traumatic stress disorder (PTSD) and depression among the participants. It has been documented that the prevalence of PTSD may be ten times higher in some refugee populations compared to the general population matched for age (Portes et al. 1992).

A simple conceptual framework showing the interrelationship between mental health, quality of life, and physical health is presented in Fig. 1. This is supported by the conclusions of the study done by Araya and colleagues (2007) among displaced Ethiopians which revealed that when mental distress is reduced, quality of life is

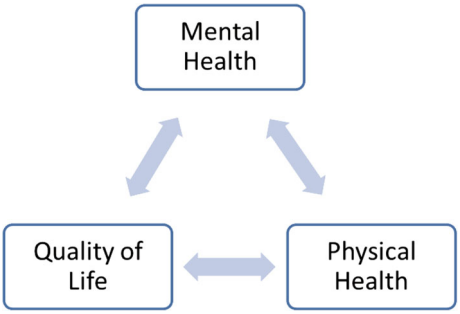

Fig. 1 Conceptual framework of the interrelationship between mental health, quality of life, and physical health among refugees

improved. Likewise, it has also been established that physical health problems may adversely affect refugee mental health as well as their social functioning (Lustig et al. 2004).

Most of the studies that have been conducted on refugee mental health have explained what these experiences mean to these individuals (Tribe 2002). Thus, this study provides explorative data on the mental health and quality of life of West African refugees living in Nigeria in order to understand their views and perspectives about their experiences in their country of refuge.

Methods

This study which is part of a larger study on refugee mental health and quality of life (Akinyemi et al. 2012, 2013) was conducted in 2010. A total of four focus group discussions (FGDs) were conducted at the Oru Refugee Camp, Ogun State, Nigeria. An FGD is a very valuable research method used to bring people of similar backgrounds and characteristics together to discuss freely an issue of interest that otherwise might not be well understood through a quantitative methodology (Krueger and Casey 2000).

Study Area

This study was conducted in Oru refugee camp located in Ogun State, south western Nigeria. Ogun State has a total population of 3,751,140 with 1,864,907 males and 1,886,233 females according to the 2006 census figures (National Population Commission 2006).

Oru Refugee Camp

The Oru Refugee Camp is located on the outskirts of Ijebu-North Local Government of Ogun East Senatorial District of Ogun State. Oru Camp is the only refugee camp in Nigeria. The camp was established in October 1990 as an initiative of the United Nations High Commissioner for Refugees (UNHCR), following the outbreak of the Liberian civil war in 1989, with the approval of the Federal Government of Nigeria in collaboration with Nigerian Red Cross Society (Ogunjobi 2004; Onakomaiya et al. 2000).

At the time of conduct of this study, there were about 5000 refugees living in the camp. More than four-fifth of the residents of the camp were from Liberia; other countries represented include Sierra-Leon, Sudan, Congo, and Eritrea. The Camp had 72 houses which were typically two-bedroom units housed in 11 residential blocks. Furthermore, there was one administrative block, one non-functional mini clinic and one primary school of eight classrooms. Most of the houses, which were overcrowded, were constructed with mud and planks.

Study Population

The study population comprised of male and female refugees aged 18 years and above who had resided in the camp for at least 1 year prior to the study. Ages of participants ranged from 18 to 67 years (M=40.5). There were two FGDs among women as well as two among men, with eight participants in each focus group. Thus, a total of 32 refugees participated in the study. Nationality and religion were not prerequisites for selecting participants for the FGDs. The description of the participants' demographics is presented in Table 1.

Study Design

This study employed qualitative methods using focus group discussions (FGDs). Four FGDs were carried out in all among the refugees: groups one and two comprised of older adult females and males, respectively; similarly, groups three and four included young adult females and males, respectively. In order to ensure homogeneity and open discussions in groups, participants were categorized based on gender and age; thus, "young adults" were persons 18–40 years old while "older adults" were refugees aged 41 years and above (See Box 1 below). Each focus group consisted of eight discussants with a moderator, a recorder, and an observer. The moderator facilitated the discussion and ensured every member of the group participated in the discussion. The recorder

Table 1 Demographics of participants

Variable	n	%
Gender		
Female	16	50.0
Male	16	50.0
Religion		
Christian	24	75.0
Muslim	8	25.0
Nationality		
Liberian	22	68.8
Sierra Leonean	10	31.2
Mean age (years±SD)		
Female	38.5±15.0	
Male	41.9±11.9	
Overall	40.2±13.4	

took notes on paper in addition to recording the discussion with a digital voice recorder while the observer took note of non-verbal expressions of participants. The FGDs were conducted mainly in English although *Pidgin English* (an adulterated form of English language spoken widely in Nigeria) was sometimes spoken by participants.

Box 1: Description of the Focus Groups

FGD 1—female, older adults (41 years and older)
FGD 2—male, older adults (41 years and older)
FGD 3—female, young adults (18–40 years)
FGD 4—male, young adults (18–40 years)

Sampling Technique

Participants for the FGDs were recruited through a purposive sampling—based on characteristics of interest (refugee status, gender, and age), availability, and ability to provide relevant information to the research question (Pope and Mays 1995; Vonk et al. 2007). No one was excluded as a result of language abilities.

Data Management

Data Collection Instruments

A focus group discussion guide was used to facilitate the discussions. The main issues discussed in the FGDs included respondents' understanding of health, mental health and quality of life, factors affecting mental health and quality of life. Other issues explored included respondents' views about mental health and how it affects the quality of life as well as roles of the community and government in improving the mental health status and quality of life of refugees.

Data Analysis

Data from the FGDs were transcribed and analyzed with the aid of NVIVO version 8 using the thematic framework approach to qualitative data analysis (Pope et al. 2000). This was an iterative process of analysis which started right after the first interview and continued throughout the research. A thematic framework was developed from emerging themes in the interviews. This was done after each interview to enrich subsequent interviews. As themes emerged, these were indexed and compared with themes from subsequent interviews until a sense of attainment of saturation was achieved (Temple and Edwards 2008).

Ethical Considerations

The University of Ibadan/University College Hospital Ethical Review Committee approved this study (NHREC/05/01/2008a), and permission to conduct the study was

obtained authorities of the Local Government Area as well as the officials of the refugee camp. Written informed consent was also obtained from every participant in the study.

Results

Introduction

The results of qualitative enquiry into the subject of mental health and quality of life among respondents are presented in this sub-section.

Respondents' View of Health

Respondents defined health in similar ways, all alluding to the fact that health includes both physical and mental well-being. According to a female refugee, "[Health] is the soundness of mind especially for the body and also the environment is very important to ensure sound health" (Female, young adult, FGD 3). Another respondent opined that health is the "Physical and spiritual well-being of the body" (Male, older adult, FGD 2).

Respondents' Opinions About Mental Health and Quality of Life

Views about mental health were similar among refugees. They were of the opinion that mental health has to do with reasoning ability and the capability to act independently. A respondent stated that "It is the way the brain function i.e. if it function well, then there is good mental health otherwise it is bad mental health" (Male, older adult, FGD 2). Another participant expressed the view that mental health "…is a situation where a person is sound, positive in doing things" (Male, young adult, FGD 4).

Respondents described quality of life in terms of the environment one lives, availability of food, and social amenities. In addition to these, the issues of security and housing were very prominent in the discourse as determinants of quality of life. According to a participant, quality of life is "having everything to one's comfort like food" (Female, older adult, FGD 1). Another respondent defined quality of life as "… Having security and living in peace" (Female, older adult, FGD 1). Additionally, one of the refugees summed up quality of life as "… having basic human needs e.g. education, housing, shelter, food, accommodation and security once all these are in place, there is good quality of life but if [there is an] imbalance then, there is bad quality of life" (Male, older adult, FGD 2).

Relationship Between Quality of Life and Mental Health

Generally, quality of life was described by respondents as a major determinant of mental health status. As narrated by one of the discussants: "…If the quality of life is bad it will affect the mental health in the sense that if the parent cannot provide the needs of the children, they start getting out of hand and do anything they like with their peers which can result to mental ill health for the parent" (Female, young adult, FGD 3). The effect of mental health on quality of life was also recognized as expressed by a

participant: "If one is mentally disturbed it will affect the quality of life because the person will not know what he is doing, the environment, food and cloth will be dirty" (Female, young adult, FGD 3).

Gender and Mental Health

Generally, most of the FGD participants believed that women were more predisposed to mental ill health due to their sensitive emotional make-up and due to the responsibilities they have to shoulder especially in the refugee camp where many of the women were single parents and many of the men were unemployed. One of the female discussants said, "We women are the ones toiling, working and thinking on how to meet all needs, our husbands don't have any work to do, more so they are refuges; even if they have skills nowhere to put it into practice. So women are more exposed to mental [ill] health due to the load on them" (Female, older adult, FGD 1). Many female refugees seem to be doing better financially than their male counterparts as many of the women were involved in sundry vocational activities like hairdressing, catering etc. Additionally, another female refugee captured the challenges facing women refugees: "Most of us are widows, so the stress is fully on us because we have to attend to our children, our home, the education and job. If a woman is not strong enough the children can't go to school and this may make them go astray which can lead to mental ill health" (Female, older adult, FGD 1).

However, a male refugee differed from the opinion expressed by the women when he expressed that men were more affected mentally by the refugee situation. He stated that "Men are more predisposed to mental [ill] health because they are responsible to care for their families and provide everything needed, if they are unable it may result to mental ill health …" (Male, older adult, FGD 2).

Factors Affecting Mental Health and Quality of Life Among Respondents

A number of factors were highlighted by participants during the FGDs as affecting the quality of life and mental health of West African refugees living in Nigeria. These are summarized in Fig. 2 and further highlighted below.

Poverty/Unemployment

Poverty, resulting especially from unemployment or underemployment was described as one of the major factors affecting the mental health and quality of life among respondents. One refugee remarked that the "…lack of job opportunity will make one not to be able to meet the demand at home which can result to mental ill health" (Male, young adult, FGD 4). The participants also reported greater difficulty in securing employment due to discrimination from employers. They reported that this situation has led to strained family relationships, difficulty in providing qualitative education for children and procuring medical care, and to many social vices like prostitution. They are also of the opinion that poverty may also result in low self-esteem especially for parents who are supposed to be bread winners. A discussant said: "…parents are unable to cater well for the children and this has resulted into prostitution (among girls), lack of discipline, depression, children not going to school because

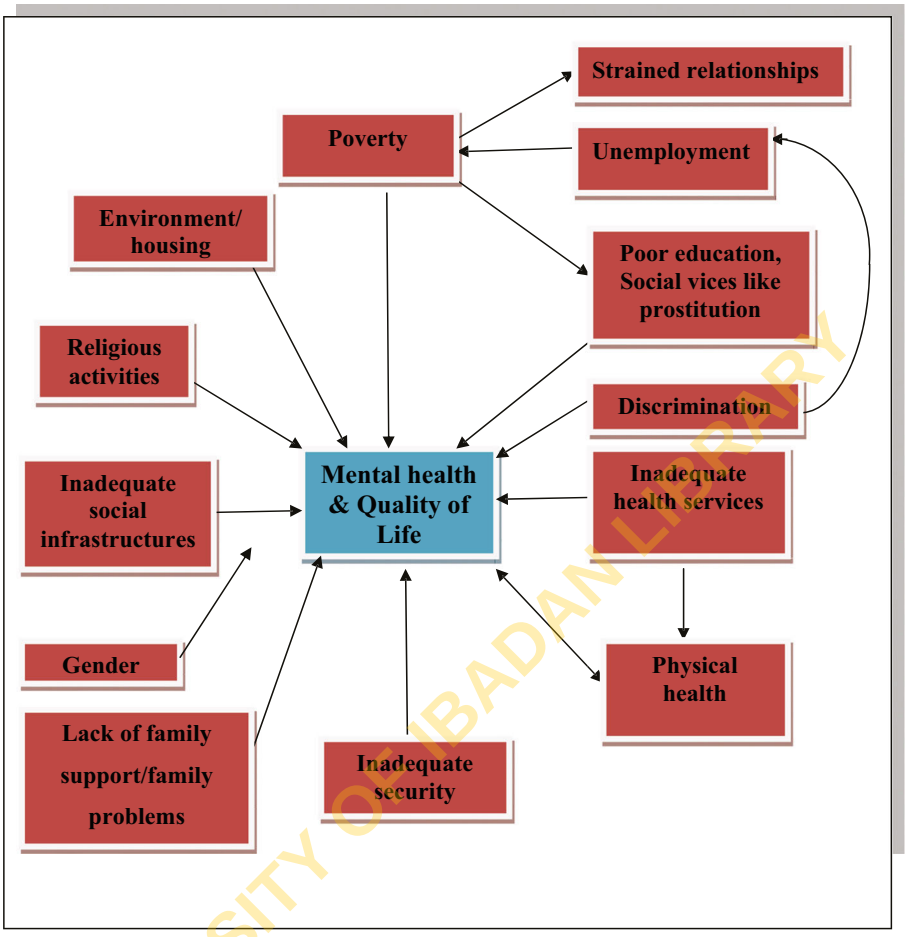

Fig. 2 Respondents' views about factors affecting mental health and quality of life

parents can't afford it and no medical attention" (Female, older adult, FGD 1). Another refugee expressed the opinion that "…because one is kept within the camp or even go out without bringing in the expected materials needed for the family or unable to satisfy the children, [poverty] can lead to disrespect at home and cause serious thinking which lead to mental ill-health" (Male, older adult, FGD 2). Lastly, a discussant alluded to the importance of proper nutrition in maintaining good mental health; his words: "…It is known that a hungry man is an angry man, if there is no food to eat, it will affect the mental health" (Male, older adult, FGD 2).

Physical Health

Good physical health was described by respondents in all the FGDs as an important prerequisite for good mental health principally because the brain is affected by whatever goes on in all the parts of the body and because physical illness may cause anxiety and isolation. A common view expressed by the discussants was that "…If one is not well, there won't be sound mind" (Female, older adult, FGD 1). In the opinion of many

respondents, this is because "If there is pain in any part of the body, it will definitely affect mental [health] because one will start thinking if the sickness or pain will result into death or not" (Male, young adult, FGD 4).

Lack of Family Support/Family Problems and Abuse Suffered in the Refugee Camp

Family disharmony, single parenting, and teenage pregnancy were other important factors identified as affecting mental health and quality of life among respondents. This view is corroborated by the experience of one of the discussants: "I have six children; with their father dead, I have to struggle and send them to school, and this can affect my mental health due to stress and inadequacy" (Female, older adult, FGD 1). Another respondent also volunteered: "…In my own case, my baby died due to lack of care and one of my daughters was impregnated in SS2 without knowing who is responsible for it, all these resulted into mental ill health and disturbed my peace because we are living a very bad quality of life in this refugee camp" (Female, older adult, FGD 1).

Religious/Spiritual Factors

Engagement in religious activities was an important factor identified by discussants as essential to maintaining good mental health and good quality of life. One of the participants asserted that "When you have Christ and every other thing is added with it like good education for your children having good finances [this] bring good quality of life" (Female, young adult, FGD 3).

Environment

The effects of the environment (particularly the type of housing) on the mental health and quality of life came out clearly in all the FGDs. A participant remarked that "When everything is well with you i.e. the environment is good, you have money, you have good work and housing and all is alright with you then you have good quality of life" (Female, young adult, FGD 3). Furthermore, the refugees described their housing units in the camp as poor and insecure. One of the refugees complained that "…In this refugee camp [there is]no good housing, the roofs are leaking, breeze are flowing in and causing cold, the house is not even good for human being to live; rats and snakes disturb. All these affect mental health" (Female, older adult, FGD 1).

Discrimination

The issue of discrimination, particularly with regards to employment, came out from the FGD with the refugees. This was reportedly one of the reasons for the poor socio-economic status among the refugees. A young refugee noted that "Being a refugee is enough a factor that can affect our mental health because from history refugees are believed to live below the standard of living of the indigenes" (Male, young adult, FGD 4). Another discussant corroborated this: "No job opportunity. Most of us engage in dirty work and some do sustain injuries or have accident at the work place and at the long run they will not pay the wages and if you apply for other

job, they will not employ. The only work available is the saw-mill work" (Female, young adult, FGD 3).

Social Vices

The refugees were of the opinion that poor quality of life among them had driven many refugees (especially the young ones) to many social vices like illicit drug use and prostitution and this has compounded mental health problems among them. The discussants were unanimous that "…Because of the fact that parents are unable to cater well for the children, this has resulted into prostitution, lack of discipline, depression…" (Female, older adult, FGD 1). Another respondent added that "… drunkenness and drug addiction (among young men) e.g. alcoholism, smoking, use of cocaine, all these disturb human health" (Female, young adult, FGD 3).

Suggested Solutions from Respondents

The study participants had suggestions for the government and the communities towards improving the quality of life and mental health of refugees. The refugees, across all age groups, suggested that government invest more in the training of refugees and that more should be done in the maintenance of the refugee camp. One participant advised that the Nigerian government should "…train the refugees and send them to school, [and] ensure security for the refugees" (Male, older adult, FGD 2). Another discussant also noted that "The Local Government should maintain the camp for the refugees and if they refused, the UN ought to take it up and do it" (Female, young adult, FGD 3).

To improve mental health and quality of life, the refugees suggested improved self-help and tranquility in the community. In the view of one of the participant, "If all of us can come out to wash and clean the environment, it will be clean even without financial [support]" (Female, young adult, FGD 3). Another discussant advised that "We must live at peace with one another, it is then we can team up together and help each other in the little way we can and make this place a little paradise till a change comes" (Male, young adult, FGD 4).

Discussion

In this study, we presented refugees' self-reports of their mental health status and quality of life. The study participants alluded to the holistic nature of health just as the World Health Organization (WHO) defined health as the state of 'physical, mental, and social well-being, not merely the absence of disease or infirmity' (Breslow 1972). Similarly, mental health was described as ability to act independently by participants in this study, a view supported by the WHO which defined mental health partly as individual's ability to recognize his/own ability (World Health Organization 2003). Likewise, respondents' definition of quality of life cuts across emotional, physical, and material well-being, as suggested by Felce and Perry (1995). These findings suggest that refugees in Nigeria are quite aware and knowledgeable of the impacts of their status on mental health and quality of life. It is very important that the perception and

views of people at risk, like the refugees, be sought on issues like quality of life and mental health because according to Calman (1984), it is only an individual that can describe these terms, and this is the only view that is important ultimately. Thus when the views and opinion of vulnerable people like the refugees are understood on issues like mental health and quality of life, it will help health managers and policy makers in planning effective interventions that will be acceptable to the people concerned.

Our study revealed that the participants considered mental health and quality of life as being interrelated and intertwined. Correspondingly, research has shown that mental ill health is significantly associated with impairment in quality of life (Ghazinour et al. 2004; Spitzer et al. 1995). Similarly, poor living conditions and poor physical health may predispose to mental ill health (Amoran et al. 2005). Thus, poor mental health may lead to poor quality of life and vice versa.

Although there were some dissenting voices, the general opinion among the respondents was that females were more predisposed to mental ill health in the refugee camp; evidence from a study done among Vietnamese refugees in Norway seems to support this view (Hauff and Vaglum 1995) and likewise a study done among refugees in Sweden (Hollander et al. 2011). However, a study done earlier among Iranian refugees in Sweden by Ghazinour and colleagues (2004) revealed that the men suffered more from depression compared with the women. Still, Rosenfield and Mouzon (2013) explained the relationship between gender and mental health better when they submitted that women internalizes mental health disorders like anxiety and depression more than their male counterparts, whereas men externalizes disorders like antisocial behavior and substance abuse more commonly. They posited that the manifestation of mental disorders among the genders depend on the context and societal expectations. The finding that some men could not provide for their household due to unemployment in such a patriarchal society, making some women double up as both breadwinner and homemaker, may contribute to elevated stress in both genders especially among women (Hollander et al. 2013; Shaver 1998; Simon 1995). According to Astbury (1999), "… gender can and does impact very markedly on the capacity of the individual, the group and the environment to attain subjective well-being, justice and equality" (p. 9). Thus, in designing appropriate interventions and policies to improve the quality of life and mental health of emergency populations like the refugees, gender roles should not be ignored (Astbury 1999).

A number of factors were highlighted by respondents in this study as affecting the quality of life and mental health of refugees—poverty and unemployment, dysfunctional families and abuse in the camp, as well as poor environment and discrimination. The "strong negative effect" of unemployment on mental health has been documented (Strandh et al. 2012). Poor mental health has also been identified as a possible reason why an individual may not get a job or find it difficult to remain employed (Butterworth et al. 2012). Furthermore, studies have shown that family support is essential to maintain good mental health (M. Cohen and Azaiza 2007; S. Cohen 1988). Ghazinour et al. (2004) argued that social support is crucial for refugees to survive the stress of life in exile and not succumb to low self-esteem due to stigmatization. Thus, providing employment and vocational skills for refugees may be pivotal to improving their quality of life and mental health.

Just as the findings of this study suggest, there is an important association between quality of housing and risk of illnesses and the quality of life. Literature supporting this

association, especially among refugees and displaced people, is abundant (Araya et al. 2007; Habib et al., 2011; Kelly et al. 2013). As a fallout of the poor housing, the participants in this study also complained about the dangers of co-habiting with rodents; Kelly et al (2013) in a similar study in Sierra Leone reflected that refugees are at risk of Lassa fever due to rodent infestation. This will not put only the health of the refugees in jeopardy but also that of the host population.

We also reported in this study that refugees were being discriminated against especially with respect to employment. Available data suggest that discrimination and stigmatization worsens the mental health and quality of refugees as these affect their access to food and housing as well as health services and employment (Henning-Smith et al. 2013; Shedlin et al. 2014). Thus, stigmatization and discrimination fuel the vicious cycle of poor quality of life and poor mental health among the refugees.

Furthermore, women refugees reported in this study that their poor economic power had driven some of them into prostitution. Robinson (2012) opined that in this age of global migrations, many women refugees are driven into prostitution due to their limited options. While the respondents in this study reported that some women engaged in prostitution because of the harsh environment they have found themselves. Codjoe et al (2013) reported that some host community members in Ghana accused Liberian refugees of increasing prostitution and other social vices like alcoholism and illicit drug use in their community. Hence, when refugees are not empowered economically, there might be increased prevalence of risky sexual behaviors, with all the resultant hazards, not only in the refugee populations but also in the host communities.

Moreover, perceived ways of improving quality of life and mental health of refugees were explored with participants in this study. Similar to the suggestions made by the participants in this study, previous research has documented that investing in the education of refugee children, increasing their access to healthcare, improving housing conditions, and providing basic needs and security in the refugee camps have markedly led to improvement in the quality of life and mental health of refugees (Fazel et al. 2012; Huijts et al. 2012; Kirmayer et al. 2011).

Limitations

The measure of quality of life and mental health provided in this study was subjective and no attempt was made to quantify these measures. Similarly, the limited number of focus group discussions might not have ensured saturation (Mason 2010) of data. Also, the cross-sectional nature of this study did not allow any claim to causality of mental health and quality of life reported; however, this study provides initial exploratory information.

Conclusion

Findings from this study show that refugees rated their mental health and quality of life as poor. Poverty and unemployment, poor physical health, lack of family support, abuse suffered within the camp, poor housing, and deficient security in the camp as well as stigmatization were some of the factors highlighted as responsible for this outcome. Therefore, there is need for all stakeholders at the international, national, and community

levels to invest more in a system that provides support for improved mental health and quality of life among refugees in developing countries. Also, more investment should be made in refugee children education probably through provision of scholarships. In addition to formal education, provision of vocational and entrepreneurial skills is needed to tackle the problem of unemployment and prostitution among the refugees. As a matter of human right, greater investments should be made to ensure that houses in refugee camps are habitable and that refugees are protected from diseases.

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Conflict of interest The authors hereby declare that there are no conflicts of interest in this study.

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