2020

How Older Nigerians View the Impact of Migration on Their Health

Jayne Nwankwo
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Jayne Nwankwo

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Joseph Robare, Committee Chairperson, Public Health Faculty
Dr. Wen-Hung Kuo, Committee Member, Public Health Faculty
Dr. Richard Palmer, University Reviewer, Public Health Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

How Older Nigerians View the Impact of Migration on Their Health

By

Jayne Nwankwo

MPA, Mercy College New York, 2011

BSc, Mercy College, New York, 2009

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

May 2020

Abstract

Migration into the United States opens windows of opportunity, but also involves difficult experiences that impact the health of migrants. In this qualitative study, the meanings that Nigeria migrants (aged 65–80) placed on their migration experiences were explored in relation to their health and well-being. Literature revealed no prior migration study on this population. The social constructivist approach provided the framework for this study. Purposive sampling was used to recruit 13 participants that fell within the selection criteria. Face to face interview was used to obtain participants' view of health; their challenges to adaptation to the United States; the impact of the American health system on them, and how the subjective meanings of their lived experiences presented to health care delivery. All interviews were audio-recorded, transcribed, and both manually and digitally coded. Findings showed that although culture and migrants' experiences played important roles in their health and health seeking behaviors, education and culturally sensitive programs have the potential to elicit behavioral changes. Study findings revealed positive social change implications in the following ways. First, health practitioners should incorporate needs assessment to promote sense of ownership among the target population, and foster active learning. Second, culturally sensitive health education programs could dispel unhealthy health habits, improve migrant health, and bridge the gap in health disparities. Lastly, health policies that improve the health of the target population could be developed. If health practitioners treat migration experience as part of the social determinants of health, this could positively enrich public health practice.

How Older Nigerians View the Impact of Migration on Their Health

By

Jayne Nwankwo

MPA Mercy College New York 2011

BSc, Mercy College, New York, 2009

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

May 2020

Dedication

This study is dedicated to the loving memory of my father, Chief, Sir J.G. Okoro, who encouraged me to get a PhD, but did not live to see his dreams accomplished. I am sure he oversees from heaven, the progress of his initiative, and is still proud of me for this achievement. May His kind soul continue to rest in the Lord.

Acknowledgments

My thanks are extended to all staff and faculty of Walden University who through their teachings and instructions have instilled knowledge in me, and enabled me advance to the status I now find myself in. Special thank you goes to my chair, Dr. Robare and my second chair Dr. Kuo who always made themselves available for guidance and directions. I am also grateful to my friends and family members, who through their patience, cooperation, understanding, and special accommodations have enabled me to reach this point in my academic career. Special appreciation goes to all my study participants who enabled me find answers to my research questions. Finally, I give thanks to the Almighty God for seeing me through all the huddles. Nothing is possible in the absence of his mercy.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

The Nature of International Migration

International migration involves the movement or permanent relocation of people from one country to another. In this project I studied the migration of older Nigerian adults (aged 65-80) from their country, Nigeria, to the United States. It is well documented that people emigrate from their native country to another country for various reasons, whether political, social, educational, or economic (Ogbaa, 2003). Being a permanent process, it requires that individuals adapt to the new environment. The practice of migration encourages interactions among peoples and countries; and it compels people to leave their social networks behind and to encounter a great sense of loss, dislocation, alienation, and isolation. These factors trigger different levels of stress and may affect migrants' health. The ability to deal with the stresses of and isolation, loss, dislocation, and the ability to settle down, depend on individual personality traits as well as the host country's acceptance and hospitality. This study will use qualitative methods to explore the meanings that migration experiences hold for older Nigerian adults (aged 65-80) living in the United States.

Migration is a usual practice of people. According to the International Organization for Migration, it is "an essential, inevitable and potentially beneficial component of the economic and social life of every country and region" (IOM, 2009). Migration can be done voluntarily or involuntarily depending on the stimulus. Generally, people who migrate voluntarily do so because they hope that migrating to another environment or place will improve the quality of their lives. Those who migrate involuntarily or otherwise are forced to leave their place of origin as a result of a hostile environment, such as bad economic conditions, war, famine, or persecution (Freeman et al., 2012). Article 13 of the Universal Declaration of Human Rights, states that "everyone has the right to leave any country,

including his own, and to return to his country" (United Nations, 1948). Thus, the decision to migrate to another country is highly influenced by people's choices.

This chapter will discuss the background information about migration of Nigerians, aged 65-80 years The chapter will also discuss the problem and purpose of the study, the general view of health as seen from the Nigeria perspective. The approach to the study, including the theoretical and the conceptual framework that guide the study, will be discussed and defended. The criteria for participation in the study, and the special audiences that will benefit from the study, will also be discussed. I will also discuss my role as the researcher and my own migration experiences.

Background Information About Migration of Nigerians, Aged 65-80 years.

Nigeria is a multiethnic nation with about 440 ethnic groups, of which 66% make up the three major ethnic groups: Hausas, Igbos, and Yorubas (Ogbaa, 2003). Despite the existence of the multiple ethnic groups, all the ethnic groups are blacks, suggesting the absence of racial discrimination in the country (Ogbaa, 2003). The country is located within the tropics and therefore has stable high temperatures throughout the year.

The quest for Western education was the primary and initial reason that influenced Nigerians to migrate to the United States (Ogbaa, 2003). Other factors included higher wages, job security, opportunities for career advancement, access to the best facilities and technologies, and political and economic instability in Nigeria (Ogbaa, 2003). Being a former British colony, Nigerians who needed to travel out of the country for Western education were formally restricted to British institutions or other institutions within the British Commonwealth; however, some Nigerians managed to get the visas that allowed them access to the United States for their education. Dr. Nnamdi Azikiwe of Nigeria, for example, was one of the pioneer Nigerians who graduated from American universities. Upon his return to Nigeria, he became a leader in the country and an ambassador for American higher education

(Ette, 2011). The talents and skills acquired by the initial migrants to the United States were fundamental to building Nigeria as an independent nation (Ogbaa, 2003; Ette, 2011). Impressed by this, many Nigerians gained confidence in the American system of education and chose the United States as their first choice over all other countries (Ogbaa, 2003). The United States and the United Kingdom (UK) are the two countries of choice for most educated Nigerians who studied outside of the country (Ogbaa, 2003).

After the Nigerian civil war, 1966 to 1970, the rate at which Nigerians migrated to the United States increased (Ogbaa, 2003). Hardships, such as socio-political instability, corruption in government, lack of good medical care, lack of access to basic necessities for living, poor environment for education, religious and ethnic conflicts among other reasons, caused the mass exodus of Nigerians. Some other Nigerians entered the United States through the Diversity Lottery Program (Ogbaa, 2003). Older Nigerian adults migrated to the country after retirement, and some came to join their relatives already in the country (Ogbaa, 2003).

In an attempt to restructure the deteriorating economy in the mid-1980s, the Nigerian government applied for a loan from the International Monetary Fund (IMF) under stringent austerity measures that included currency devaluation, lower wages for professionals, as well as poorer working conditions (Mberu & Pongou, 2010). The deteriorating economy forced Nigerian-based professionals—and even less-educated youths—to leave the country and reside in the United States in order to better their quality of lives.

The United Nations High Commissioner for Refugees [UNHCR] estimated that between the years 1996 and 2005, 13,863 Nigerians migrated to the United States (UNHCR, 2008). It is also interesting to know that even as Nigerians leave their country, some foreigners are attracted to Nigeria for various reasons such as the believe that the Nigerian oil export boom will favor them, or that they may be forced out of their own countries as a result

of some political conflicts and wars in their own countries. This is in consistent with Article 13 of the Universal Declaration of Human Rights mentioned above.

According to the analysis conducted by the Rockefeller Foundation's Aspen Institute Diaspora Program (RAD) about 376,000 Nigerian immigrants and their children reside in the United States (RAD, 2015). This represents 0.6% of all immigrants to the United States (RAD, 2015). The American Community Survey (ACS) estimated that Nigeria had a population of 206,604 in the United States, thus making it the African country with the highest population of immigrants in the United States (RAD, 2015). Statistics developed by U.S. Homeland Security in 2009 showed that 105,667 Nigerians were granted permanent resident status between 2000 and 2009, of which 15,253 were granted in 2009 alone; 60% of the people involved were immediate family members of U. S. citizens (as cited in Mberu, & Pongou, 2010).

A profile of the Nigerian adults residing in the United States presented them as being (a) highly educated, with 60.5% of the adult population having a bachelor's degree or higher; and (b) gainfully employed in management, professional, and related occupations (RAD, 2015). According to the World Bank Development Prospects Group (2007), 13.6% and 11.7% of Nigerians were employed as physicians and nurses respectively (as cited in Mberu & Pongou, 2010).

The United States is one country that placed a premium on family ties; thus, the country's policy on immigration supported the allocation of immigration visas to the relatives of U. S. citizens and immigrants already here. This policy encouraged migration of many foreigners into the United States than Americans seemed willing to accept, and compelled America to tolerate higher levels of illegal migration (Martin & Duignan, 2003). Many of these unauthorized foreigners were simply waiting for their immigration visas (Martin & Duignan, 2003). In addition, the Immigration and Nationality Act of 1965, which ended the

national origins quota system, restructured the immigration process and transformed America, to be more inclusive in welcoming foreigners. The Act also stressed family reunification as a preference, thus excluding parents, spouses, and young children from quota immigrants while allowing them the opportunity to be admitted beyond the allowable limit (Martin & Duignan, 2003).

The Concept of Health

Health was described by WHO in the 1940s as "A state of complete physical, mental and social well-being and not merely, the absence of diseases or infirmity" (as cited in Goldsteen, Goldsteen & Graham, 2011, p. 12). The international Epidemiological Association described health as "A state characterized by anatomical, physiological and psychological integrity, ability to perform personally valued family, work, and community roles; ability to deal with physical, biological, psychological, and social stress; a feeling of well-being; and freedom from the risk of disease and untimely death" (as cited in Goldsteen et al., 2011, p. 12). These two definitions portrayed health as a concept that is beyond morbidity, disability, and premature mortality, and included a sense of well-being, an ability to adapt to change, and a higher level of social functioning. Thus, good health considered virtually all human endeavors, including the pursuit of happiness (Young, 1998).

Health Beliefs of Nigerians

The health behavioral pattern of individuals is influenced by both culture and knowledge, and people's way of life affects their health-seeking behaviors (Goldsteen et al., 2011). Most underdeveloped and developing countries have poor health-seeking behaviors for diverse reasons (Meremikwo et al., 2005; Obuekwe & Akapata, 2004; Uzochukwu & Onwujekwe, 2004). The health beliefs of any group of people are fundamental to addressing their health issues effectively. Thus, in order to provide culturally appropriate care in a

multicultural setting as the United States, providers should understand the world of their clients to enable them design and implement culturally competent care (Adepoju, 2012).

Nigeria is a multiethnic country with three major ethnic groups, each of which group has distinct languages/dialects and styles of dress. Christianity and Islam are the two main religions practiced. Northerners are predominantly Muslims, whereas the southerners are mainly Christians (Oginni et al., 2010). Health beliefs are not consistent across the country, but depend largely on tribes and their religious worldviews. Each worldview shaped the people's conceptualization of, and response to, health issues.

For example, the Igbo people share a deep belief in the Supreme Being, the almighty God, called *Chi Ukwu* in the native Ibo language. In addition to the Supreme Being, there are also lesser gods, deities, and personal guardian spirits (*Chi*), and earth goddess (Agbodike, 2008). These lesser gods are believed to enforce morality on people, and bring afflictions in form of illnesses to evil-doers (Agbodike, 2008). Thus, a typical traditional Igbo man believes that illness can be as a result of a person not being in harmony with one's Supreme God or gods. There is also a deep believe in reincarnation, and any deviation of a person from the principles of the re-incarnated ancestor would result in the person being afflicted by health issues. Thus, good moral behavior is a pre-determinant of health, and ill health is a punishment for bad moral behavior (Nzewi, 1989).

To the Yoruba tribe, ill health may be magically inflicted in people by those who are hostile and jealous, through the malignant magical practices of sorcerers, curses, and witches (Adepoju, 2012). Yorubas also believe in natural causes of ill health, for example, due to inappropriate health behavior such as eating junk food, smoking, and drinking. They also believe that ill health can come from the supernatural forces of the spirit world.

A typical Hausa man attributes ill health to the work of Allah or God. In a study aimed at determining the preferred treatment for mental illness among southwestern

Nigerians (Adewuya & Makanjuola, 2017), the preferred treatment options were as follows: spiritual healers (41%), traditional healers (30%), and hospital and Western medicine (29%). This implies that southwestern Nigerians prefer alternatives to Western medicine for the treatment of mental illness and thus suggests the need to address beliefs and preferences of Nigerians in order to improve professional mental health services among southwestern Nigerians. It makes sense, therefore, to assume that the immigrant populations would be faced with the tendency to combine their traditional beliefs and that of the Western beliefs (Adewuya & Makanjuola, 2017).

Mental health disorders in Nigeria create a substantial burden, not only on the victims, but also on entire families (Ikwuka et al., 2016). These disorders also impact the economic and social functioning of the individuals and families as well as the society at large. In Africa, psychiatric disorders make up about 4% of all health disorders combined; and it was estimated that the percentage will go up to 18% by the year 2020 (Ikwuka et al., 2016). When interventions for mental health disorders are postponed, the results would be serious complications that exacerbate symptoms, poor response to treatment, poor quality social outcomes, and poor economic consequences. In the developed and developing countries, 76.3–85.4% of people with mental disorders failed to receive treatment in the previous 12 months. Of the 14.6% all people in developing countries that received treatment, Nigerians contributed to only 1.6% (Ikwuka et al., 2016).

Supernatural forces are believed to be the cause of mental illness in most African societies. This belief greatly influenced their health-seeking behavior. In general, the choices of treatment for mental health issues in Western countries sharply contrasted with those in Nigeria, where most psychiatric patients opt for nonmedical alternatives (Gureje, Odejide, & Acha, 1995).

Religion also plays a great role in most modern African societies. It is highly believed that God or Allah (for Muslims) is an all-powerful creator who has the answer to all afflictions, and who people rely on in times of need (Gureje, Odejide, & Acha, 1995; Koenig, 2008; Tepper et al., 2001; & Haan et al., 2003). Therefore, many psychiatric patients and their relations consult with religious clerics first before seeking any other alternative (Gureje, Odejide, & Acha, 1995; Haan et al., 2003).

Instrumental and ideological barriers are the main factors that underlie the gap in health-seeking behavior among Nigerians in general (Ikwuka et al., 2016). Ideological barriers consist of cultural and mental health literacy constraints while instrumental barriers concern the systemic and financial impediments to health seeking. Ikwuka et al., 2016, conducted a study to determine the relative weight of instrumental and ideological factors in causing gaps in health-seeking behaviors. These researchers used subjects from the southeastern part of the Nigeria, and determined that the ratio of ideological barriers to instrumental barriers was 84.8% to 56.6%, respectively. The result showed that improved knowledge is needed to close the gap in conventional mental health-seeking behaviors (Ikwuka et al., 2016). Delays in seeking health care creates complications and can lead to exacerbation of psychotic symptoms, poor response to treatment, and poor quality of life (Adeosun, Adegbohun, & Adewumi, 2013; WHO, 2000).

Contrary to the popular belief that good health implies the absence of illnesses, many other factors combine to influence the health of individuals, such as one's physical environment, social environment, individual behaviors, genetic inheritance, and health care (Goldsteen, Goldsteen, & Graham, 2011). Believed to be a land of opportunity, all categories of people struggle to come into the United States with hopes that coming to America will end their ordeals and provide them with the opportunities, skills, and statuses that will enable them reach their fullest life potentials. Reaching one's life potentials and having positive

outlook on lives and future are consistent with having good health (Markides & Gerst, 2011). Coming to America however, does not guarantee the attainment of good health. Even though America may provide better living environments and medical care for these older adults from Nigeria than what they got in Nigeria, migration itself is stressful because it comes with dramatic changes in living arrangements, disadvantaged socioeconomic status, unemployment, and demands for cultural adaptation—all of which bring imbalance to a migrant's health. (Friis, Yngve, & Persson, 1998; Gülşen, Knipscheer, & Kleber, 2010; Markides & Gerst, 2011). This study explored what impact the experiences of older Nigerian adults who migrated into the United States have on their health and ability to succeed.

Problem Statement

Research on international migration is well documented (Lam, Yip, & Gee, 2012; Chou, Johnson, & Blewett, 2010); however, research was still limited on the migration experiences of older adults migrating from Nigeria to the United States. There was also limited information in literature on how such experiences influenced their health. Additionally, the research completed in the United States has focused primarily on older immigrants migrating from Latin America, especially Mexico, and Asians countries such as those with Chinese populations (Lam, Yip, & Gee, 2012; Chou, Johnson, & Blewett, 2010). My research sought to explore the migration experiences of Nigerians through their culture. The meaning that participants place on their migration experiences has implications for understanding migration experiences in Nigerian culture and provides information about the development of a culturally sensitive model of health care delivery.

Purpose of the Study

Migrants are exposed to different experiences. The purpose of this study was to explore and develop a greater understanding of how this population has interpreted these migration experiences in relation to their health and well-being. The study used a

phenomenological approach to collect data from older Nigerian migrants (aged 65 to 80) residing in the Bronx county of New York City. This phenomenon was studied in a cultural and ethnic context in order to better understand the meanings placed on the phenomenon by this group of migrants. The study also explored how the Nigerian culture influence the meanings placed on the participants' experiences in order to better understand how these experiences impact on their health. The methods used for this investigation were detailed in Chapter 3.

My approach to this study was qualitative. I asked open-ended questions to better capture the essence of the phenomenon of interest. The use of open-ended questions encouraged participants to provide in-depth description of their experiences and the meaning the experiences held for them. Participants' cultural backgrounds and experiences shaped their lives; therefore, this qualitative study tapped into deeper meanings of the experiences that can be used to generate theory. A qualitative approach was most suited for this study because only qualitative data could answer my research questions. Besides, the phenomenon under study did not require any measurements of people's reactions, nor was it based on the concepts of manipulation and control of phenomena. The study only relied on the subjective nature of human experiences (Nieswiadomy, 2002; Stangor, 2011; Creswell, 2014). The research questions used in this qualitative study explored the essence of participants' lived experiences; qualitative studies typically lend themselves to a much richer and greater understanding of the phenomenon explored (Okum, 1998). It is also noteworthy that because my study is qualitative, I did not require large samples to carry out the research since my sample size was enough to answer my research questions.

Data were collected using face-to-face interviews and questionnaires. Questionnaires were only used to collect demographic information from potential participants to ensure that they met the criteria set for the study. The rationale behind the decision to use interviews and

questionnaires was that the data needed from the participants could not be obtained by mere observation, but only by getting the participants to verbalize or write out their concerns. The decision to use questionnaires in particular was because my units of analysis, individuals who may have cultural inhibitions, do not permit free discussion of the topic. Questionnaires can be completed without a face-to-face interaction with a researcher. The qualitative researcher seeks to contextualize, interpret, and understand perspectives (Salazar, Crosby, & DiClemente, 2006). Data were collected at the participant's chosen setting, using interviews with open-ended questions. The use of open-ended questions provided me the opportunity to probe into Participants' responses and permitted me to gain a better understanding of the phenomenon of interest.

Research Questions

This study was designed to answer the following four research questions:

1. How and to what extent has living as an immigrant affected the self-understanding of health/health care for older Nigerian immigrants?
2. How do study participants interpret their immigration experiences?
3. How does culture in the United States influence the participants' interpretation of their migration experiences?
4. What implications do the subjective meanings of the lived experiences of the migrants in this study present for health care delivery in the United States?

Theoretical Approach

This research was informed by the social constructivist approach to the qualitative study. The approach was based on the premise that human perceptions of things are shaped by cultural and linguistic constructs (Patton, 2002). It makes sense therefore; to argue that concepts, beliefs, and ideas are better understood through a process of discovery rather than being organized into prescribed conceptual categories before a study begins (Lewis, 1996).

There is, therefore, a need to understand participants' lived experiences when researching a concept.

How Social Constructivism Shaped the Research Approach

In order to understand the world where people live and work, the subjective meanings of people's experiences have to be developed. Since the meaning assigned to a concept may vary for each participant therefore, this research looked at the complexity of ideas and views (Creswell, 2014). Posing open-ended questions to the study participants enabled the participants construct the meaning of a situation. These subjective meanings were formed through interaction with others as well as through the historical and cultural norms that they were exposed to (Creswell, 2014).

Using the social constructivism approach, an understanding of the world in which the Participants live was sought by developing the Participant's subjective meanings about their migration experiences. Since Nigeria is a multi-ethnic nation with various cultural backgrounds, it was fundamental therefore, to use varied and multiple views of the experiences of Participants from various cultural backgrounds while seeking to identify factors that influenced their adjustment to the United States.

In consistent with the concept of the social constructivism approach, the research relied on the participants' views of situations, taking into consideration the Participants' subjective meanings of experiences formed through interaction with others and through historical and cultural norms that have operated in their lives (Creswell, 2013). The questions that I asked of the participants were open-ended, broad, and general. This provided me the opportunity to do further probing into their experiences, life activities and values. Further probing enabled me to obtain clarifications and construct the meaning of situations.

Social constructivist orientation posits that people desire to understand the environments they live in, and that people's experiences direct their way of living (Creswell,

2014). Consistent with the social constructivism approach, this research relied on the participants' experiences as they encountered a new environment. Since migration involves interaction among people, the social constructivism approach provided a better understanding of the subjective experiences of the participants and how they connected such experiences to their health. Social constructivism also allowed me as the researcher to use my own background as a Nigerian to shape my interpretations (Creswell, 2014). Consistent with the social constructivism, data collection technique was rigorous.

Conceptual Framework

Literature revealed that little is known about the population of interest; therefore, the conceptual framework will be used to approach this study, the aim being to explore and discover more about the topic (CourseMedia, 2010f). Based on the conceptual framework for this study, consideration was given to the participant's experiences; thus, the experiences of the study participants were sought though interviews with the participants (Verstraeten et al., 2014).

The participants consisted of adults, aged 65 to 80, who migrated from Nigeria to the United States and who have lived in the United States for at least two years. The core assumption that guided this study was that people form their own perceptions about their migration experiences and how their experiences affected their health. And people's experiences hold different meanings for different people. Therefore, how a participant perceived the impact of his/her migration experiences on his/her health can be described only from own viewpoint.

A vivid imagination about the new county, promising expectations of the host country, and high aspirations about oneself have encouraged the decision to migrate (Minghuan, 1999; Theo, 2003). Although migration into the United States can open a new window of opportunity for increased earnings and savings (Gathman, 2008), it can also be a difficult

experience for migrants. The risks and costs of border crossing, poor paying jobs, irregular and hazardous jobs, poor living/housing conditions, lengthy family separation, politically hostile climate, and change in weather conditions are all difficult situations that can affect the health of migrants (Hovey, 2000; Massey & Sanchez 2010; Ullmann et al., 2011). As one gets older, the risk of getting chronic diseases increases (Anderson & Knickman, 2008; Lam & Gee, 2012). Older Nigerian migrants are also confronted with changing cognitive capacities associated with old age.

Philosophical Assumptions

These are knowledge claims made by a researcher when planning a study, it is fundamental to identify the philosophical assumptions that are brought into the study, and such assumptions should be the most appropriate for the design of choice as well as the methods and procedures that translate the research into practice (Creswell, 2014).

The Health Status of Participants

The health status of the study Participants were collected based on the participants' self-assessed health, chronic disease and functional limitations both in Nigeria and in the United States. Self-assessed health can be collected from the participants by asking each to describe his or her general health. Chronic disease status was obtained from the participants by asking them to describe their regular and long-term illnesses and health issues, or health problems that had lasted or were expected to last for 6 months or longer. Asking the participants to describe their daily activities and what interferes with such activities would assess functional limitations.

Migration Status

The participant's migration status was based on how long a participant has stayed or lived in the United States, and whether or not the person participant was employed, had access to healthcare or had medical coverage (Jolivet et al., (2012).

Operational Definitions

Gender Role.

This is a social role assigned by one's culture in terms of Personality traits, mannerisms, interests, attitudes, and behaviors that are considered more appropriate to one gender as against the other. Gender role does not have to conform to one's gender identity (Wienclaw, 2013). Through socialization one learns what is acceptable or not acceptable in a society, and gender role may change to meet the needs of the society (Wienclaw, 2013). The Nigerian society assigns premium importance to men than women. The Nigerian society believes that it is the primary responsibility of the men to work and provide for the family while the women be totally submissive to the men and have the primary responsibility of rearing the children, cooking and feeding the family (Ogbaa, 2003).

Marginalization.

This is a socially constructed phenomenon that embraces the behaviors, activities and attributes that assigns more importance to one gender or group while ignoring the needs and desires of the other. The process of marginalization pushes someone or a group to the edge considered to be less important, and ignores their needs and desires while making the marginalized group a target of negative beliefs, behaviors, or judgments from others. (**http://counselingcenter.syr.edu/social-justice/impact-of-marginalization.html**).

Culture

There are several definitions of culture, and the concept of culture continues to be debated among anthropologists (Huff & Kline 2007). Generally speaking, culture is the traditional unique way of life of people that distinguishes one community from the other and guides all decisions making. Culture is a dynamic framework used by a group to view, understand, behave, and pass on its unique characteristics and way of life to each succeeding generation (Huff & Kline 2007). The 18th century anthropologist, Edmund Tylor, defined

culture as “that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities acquired by a man as a member of a society” (Tylor, 1871). According to Slonim (1991), five basic criteria define culture of a group: having a common pattern of communication, sound system, or language unique to the group; similarities in dietary preferences and preparation methods; common patterns of dress; predictable relationship and socialization patterns between members of the culture; and a common set of shared values and beliefs. Institute of Medicine 2002 identified the common concepts in culture as: shared ideas, meanings, and values; socially learned, not genetically transmitted; patterns of behavior that are guided by these shared ideas, meanings and values; often exists at an unconscious level; constantly being modified through lived experiences. Since lived experiences influence people’s beliefs and behaviors (Garro, 2000,2001), culture is not a static concept. Thus, migration allows for cultural change as it compels people to move to different settings and acquiring different experiences as conditions change around them (Scrimshaw, 2006). The culture of people influence their ideas, beliefs and behavior including health behaviors. Based on the assumption that the beliefs and values of people within any particular society influence their health behavior, cultural themes will be used to provide explanations for certain experiences and behavior of the population that influence their health. The role of culture in health behavior of people is fundamental to understanding what influences the health of individuals. This study identified the cultural models shared among members of this study population in terms of the components of behaviors and beliefs, including their common ways of thinking and acting.

Assumptions

Assumptions are the basic beliefs that inform and direct a study. The following assumptions were made:

- It is assumed that the study participants were sincere and responded to interview questions based on how they actually felt about their experiences.
- Generalization of the study results was limited to the older Nigerian Adult migrants to the Bronx, United States.
- People migrate for different reasons and each ethnic group may adjust differently to migration experiences.
- Differences exist between nations in terms of culture.
- People who decide to migrate to a different country understand that they are exiting their social network and may be encountered by a great sense of loss, dislocation, alienation, and isolation.

Limitations

This study is a qualitative research and relied on the subjective experiences of the Participants. Being a qualitative research, the study did not yield precise statistical statements about the population. The subjective nature of qualitative research would make it almost impossible for two researchers to arrive at same conclusions (Rubin & Babbie, 2011). Generalization of the result of this study is therefore not feasible.

The study was limited to the older Nigerian Adult migrants to the United States therefore cannot be generalized to all Nigerians in the United States or to the public. The study only used participants that live in the Bronx, New York. This limited the participants' exposure to other experiences that would have been important to this study. Nigeria is a country with about 440 ethnic groups with various cultures (Ogbaa, 2003). The study population did not comprise of all the ethnic groups. Although the participants of this study come from the three major ethnic groups, there is no even distribution of the ethnic groups

used for this research. Also, although the age criterion for this study was 65-80 years old; only one participant attained the age of 80. This study could not even be generalized to Nigerians.

Being that I, the researcher came from the same background as the participants, the study participants could be uncomfortable expressing their sincere beliefs and experiences, and this could introduce bias to the study. However, I alleviated this concern by assuring the participants that there were no right or wrong answers to any questions, and that they also had the right not to answer any questions they did not want to answer. I advised them that they had the right to participate or not participate in the study. I also assured them that they could decide to withdraw from the study at any time or stage they want to. Some of the participants knew me as a Child Protective Specialist Supervisor. This could also provoke a suspicion that the answers they provide to me could be used to judge their relationship with their minor children and grandchildren. This could trigger the fear of having their children removed from their care as a result of the answers they provided. I assured the study participants that in the context of this study, I was not acting in the capacity of a Child Protective Specialist Supervisor and this helped to dissipate these suspicions.

Scope and Delimitations

The criteria for eligibility for the study are:

(1) The Participants must be born in Nigeria, raised in Nigeria, and stayed in Nigeria to adulthood.

(2) The Participant must be a Nigerian immigrant to the United States

(3) The Participant must be aged 65 to 80 years.

(4) The Participant must have resided in the United States for at least 2 years.

(5) The Participant must live in the Bronx county of New York City.

The purpose of the study, as well as the risks and benefits of the study were discussed with the Participants. I provided all participants the opportunity to ask questions about the study and make informed decisions. All Participants provided me with signed written consents prior to participating in the study.

The theory that informed this research is social constructivism, which is based on the premise that human perceptions of things are shaped by cultural and linguistic constructs (Patton, 2002). The conceptual framework assumed that little was known about the subject of the study, thus the need to explore and discover more about the topic. The study was not meant to the generalized to the public.

My Migration Experience

I was born and raised into a humble Nigerian family with high value for education, religion, and high respect for culture. From the time I was a child, my parents, just as other parents did with their children, saw it as their responsibility to take care of my needs, which included providing my day to day needs as well as sponsoring my education to the university level irrespective of my age at the time. On the other hand, it was highly believed that when parents get old, it became the responsibility of their offspring to provide and support them. As a female, the custom of my people demanded extra protection by parents and elders of the extended family until I was given away in marriage. In addition, it was not the responsibility of females to provide for the household. There was great believe and respect for the extended family system, and emphasis was always placed on ‘seniority’ and male tended egoistic values. The burden of providing for immediate family members was placed on males who were the heads of households while the wives were expected to stay home and raise the children in God-fearing manner as the religion permits. Thus, males assume premium importance over the female due to their primary rights to both family inheritance and extension of family lineage. The extended family structures provided support structures for

the Nigerian people, and intervene in time of crises. I was also born into the catholic faith where attending masses on Sundays was mandatory, and working on Sundays considered sinful. The only acceptable reason for missing Sunday masses was ill health, which was beyond one's control.

I spent a good part of my adult life in Nigeria; therefore, my personal values and worldview were influenced by the custom and beliefs of the Igbo culture I was born into. These were the values and beliefs that I hold as truth in my life, and these values, beliefs and worldviews differ from those of the United States.

My decision to move to the United States was prompted by my marriage to Nigerian man who settled in the United States for good. My then husband migrated to the United States but still maintained ties with his home country, Nigeria. However, he was more accustomed to the American culture because he migrated as a teenager. He initially came to the United States to get his education but decided to settle for good in the United States, having built a comfort zone in his new country. The hardships he experienced in Nigeria during his one-year trial return to Nigeria after getting his masters' degree in the United States compelled him to go back to the United States. In Nigeria, marriage was considered a sacred institution, and divorce was considered a taboo and victims were looked down on. Every partner in a marriage in Nigeria understood the role to play in a relationship. Even on rare cases where there were differences and difficulties, the extended family intervene and settle the differences. This was made possible especially because there was great respect for elders of the community, and people listen to their wise counsel.

As a new migrant to a foreign land, I encountered some challenging experiences. I totally lost physical touch with my network of friends and relations. Although I had enough knowledge of English to navigate the system, communicating with people was still not smooth because I was described as having ascent. I was looked upon as a person who did not

speak good English despite my knowledge of English. Although Nigerians have their own vernacular, the language of instruction was English, since Nigeria was a former British colony. Communication in writing was not a challenge at all. Getting a job was not easy because I did not have the necessary working papers. Subsequently, I was compelled to stay indoors most of the time. My staying home was not only because I did not have anywhere to go but also for fear of being arrested and deported by the immigration department officials. I continued to live in fear of deportation until I was able to legalize my stay. Unemployment, weak social support and weak social integration became the norm, and subjected me to severe loneliness and depression. Due to financial barriers, communicating with my extended family in Nigeria was not as frequent as desired, and this further complicated issues.

Even before I legalized my stay in the United States, I was able to get a job where I worked 'under the table', which earned me limited income to be able to support myself, yet a very tasking job because I was really subjected to hard labor, long hours of work with no matching pay. In addition, I was compelled to work even on Sundays, which prevented me from going for my Sunday masses and instilled some guilt in me. Before migrating to the United States, I was already used to Nigerian traditional diet with the promising freshness. Even though there are few African/Nigerian stores where one can get Africa/Nigerian food items, these foods come in processed in order to withstand the distance of travel and length of stay. I found myself, feeding mainly on processed foods, which I believed was not as healthy as the organic food I cherished and was used to.

To crown it all, the marriage that brought me to the United States ended up in divorce; leaving me as a single mother with all the stresses and responsibly associated with it.

The experiences I encountered as a result of migrating to the United States really impacted my personal values, beliefs and worldviews; and I certainly had some biases in regard to migration. However, I held my biases in suspension while conducting this research

in order not to allow my personal beliefs and biases interfere with the interpretation of the data I collect from the study participants, who themselves have their own migration experiences and interpretations. I find it fundamental therefore, to give my study participants the opportunity to tell their stories the way they felt about it in order for me to capture the essence of their experiences with migration, and be able to understand their interpretation of how their experiences influence their health.

Significance of the Study

Migration of an older population is associated with certain experiences and stressors that could affect the health of the migrants. Individuals migrate for different reasons and the rate of adaptation to a new environment depends on the reasons for migration, the experiences encountered, and how the host country welcomed the migrants. This study explored the cultural background of the participants, their interpretations of their migration experiences, the socio-economic factors of the migrants, and their interpretation of the relationship of these factors to the health of the Participants. The study sought to enrich an understanding of the strengths, resources, adaptation, and needs of these migrants in order to guide the formulation of effective interventions and policies on elderly migrants. It could be rightly assumed that migration involves changes in the physical, socioeconomic, and cultural environments of the migrants. This study sought to fill the gap in the literature about the experiences of migration and how such experiences impact health, especially the health of Nigerian immigrants. It sought to enable older Nigerian migrants to better manage their health and live more fulfilling lives. It also sought to guide program development. As a result of this study, the scope of public health practice would be expected to be enriched by the inclusion of migration experiences as part of health determinants.

Summary

This study used interviews to elicit descriptions of participants' migration experiences and their subjective interpretation of the impact of the experiences on their health and well-being. The research had its foundation on social constructivist approach which assumed that individuals seek to understand the world in which they live and work by developing subjective meanings of their experiences directed towards objects and things (Creswell, 2003). The conceptual framework assumed that little was known about the population of interest, thus, the need to explore and discover. 18 questions were asked the 13 study participants and the answers they provided were used to answer the four research questions developed for the study. All interviews were audio-recorded and professionally transcribed. I used both manual methods and software to analyze my results. The next chapter reviewed the prior studies done by various researchers on migration or other related issues.

Chapter 2: Literature Review

Introduction

In this study, the meanings that older Nigeria migrants (aged 65–80) placed on their migration experiences were explored in relation to their health and well-being.

The study used the phenomenological design to collect data from Nigerian migrants in the Bronx area of New York City. This chapter discussed the pre and post factors associated with migration, the meaning of health, age and migration. The chapter also provided explanations of important issues associated with migration such as accommodation and acculturation, healthy immigrant effect, language proficiency, education, socioeconomic factors, culture and beliefs, and social support. .

To identify prospective, peer-reviewed articles (as well as books and grey literature), the following electronic databases were used: CINAHL, PubMed, ProQuest, Sociological Abstracts, Psycinformation, and Google Scholar. Government websites such as the United Nations, World Health Organization, United States Health and Human Services resources and Department of Homeland Security websites and Textbooks were also used. The reference lists of the selected articles were searched for additional articles. Most literatures that provided these data were less than 10 years while some such as textbooks are more than 10 years old. Literature searches were conducted using the general topic of migration as well as the specific subject of older Nigerian migrants to the United States. There was no limit placed on the timeframe of the search. I used the following keywords: migration, migration experiences and health, Nigeria immigration and health, elderly migration and impact on health, migration and health consequences, and international migration.

International Migration

Mobility was been described since ancient times, as a marker of the human species (Hausmann-Stabile & Guarnaccia, 2015). The United Nations (UN) defines an international

migrant as one who leaves his/her country of origin and relocates to another country for at least 1 year (United Nations Department of Economic and Social Affairs, 1998). About 3.2% of the populations across the globe were migrants and this percentage comprised 232 million people of the world's population (Batalova & Terrazas, 2015). United State attracted approximately 20% of the migrants across the globe. In 2013, there were over 41 million immigrants living in the country (Batalova & Terrazas, 2015). A quarter of the U.S. population consisted of immigrants and their children combined (Batalova & Terrazas, 2015). These migrants were more diverse than ever, and present with diverse reasons and purposes for migrating. According to the Migration Policy Institute (2015), never before in the country's history has United States witnessed such number of migrants. People of Mexican origin make up about 28% of the immigrant population in the U.S., followed by Chinese (5.6%), and Indians (4.8%) (Migration Policy Institute, 2013, 2015). The Department of Homeland Security (2011) reports that since 2005, over 1,250,000 immigrants have obtained legal permanent residence in North America annually of which the United States alone admit over 1 million annually. According to the Migration Policy Institute (2015), the population of Nigerian immigrants and their children residing in the United States was about 376,000; thus, highlighting Nigeria as the largest source of African immigration to the United States, and the figure accounted to about 0.6% of the United States' overall foreign-born population (Migration Policy Institute, 2015).

Whether or not a person migrated to another country depended on the person's motivations, which were influenced by political, social, economic, legal, historical and educational factors in the original country as well as the host country. The effect of migration experiences on the health of migrants depends on what actually triggered the decision to migrate, the conditions in the destination country including the healthcare systems (Freeman et al., 2012). Although people who migrate to other countries hoped to invest on their well-

being, however, it did not always work that way because the investment would not yield good mental health return (BodvarssonVan den Berg, 2009). The conditions of livelihood in the original country that triggered the decision to migrate, and the host countries' degree of acceptance and reception, influenced a migrant's mental health status. For example, refugees who were forced out of their country as a result of life-threatening risks that were beyond their control faced a more compromised mental health status than those who migrated voluntarily for reasons under their control, such as those migrating for economic gain (Hausmann-Stabile & Guarnaccia, 2015). Illegal immigrants from Latin America always lived in fear of deportation, which predisposed them to increased risk of emotional distress (Cavazos-Rehg, Zayas, & Spitznagel, 2007).

Pre and Post migration Factors

The pre-migration factors include (a) the traumatic events experienced or witnessed by migrants either before or during migration**;** (b) individual background characteristics such as age, education, ethnicity, gender, and marital status of the migrant (Nicholson, 1997). Post migration factors are the conditions encountered by migrants at the destination countries, and have a lot to do with how the migrants adjust and are welcomed at the host country. Both of these factors could impact on the mental health status of migrants. It made sense therefore, to assume that older Nigerian adult migrants (aged 65–80 years) to the United States face peculiar experiences and stresses that may interfere with their adaptation into their host country.

Description of Health

A healthy individual is characterized by being in a state of anatomical and physiological integrity; having the abilities to participate in the activities he/she values; being able to deal with the physical, biological, psychological and social stresses encountered in daily living, and having the feeling of contentment that he or she is a productive member of

the society he or she belongs to (Longest, 2006). In addition, good health is associated with a feeling of well-being and freedom from diseases and untimely death, and having the ability to adapt to change and social functioning. The health of an individual is determined by a combination of many factors, which include the individual's environment and circumstances (Longest, 2006). For example, the genetic make-up of people, which predisposes people to certain diseases; the physical and mental health that people acquire during life processes, all have parts to play in the health of people. Aging, injury and violence can cause the emergence of new biology in people that affects health (Longest, 2006). According to Longest (2006), behavior, which refers to people's reactions or responses to both internal stimulus and external conditions, has reciprocal relationship with biology because both can react to the other. For example, an individual who realizes the potential to having heart diseases due to his or her genetic make-up may resort to taking preventive measures as improving his or her diet, avoiding smoking, and maintaining an active lifestyle.

The physical environment where individuals live and work, or where they perform their daily activities, can either have positive or negative influence on people. People can also shape the physical environment positively or negatively. Longest (2006), posited that although less tangible elements such as radiation, ozone, etc. are part of the physical environment, the physical environment in most cases could be seen, touched, heard, smelled, and tasted, therefore can have influence on the health of people. Thus, exposure to the toxic substances, irritants, infectious agents, and physical hazards in homes, school or work places could harm the health of individuals and community. On the other hand, the physical environment could enhance the health of individuals and community if it provides clean and safe places for people. The social environment, which consists of all human groups, social systems, and institutional settings that one belongs to and interacts with in life also, has affect on the health of people. The social environment could be at micro, or macro levels. The

micro level involves interactions with family, work groups, friends, and community organizations while macro level environments involve interactions with professional associations, government agencies, social institutions, and the society at large (Coreil, 2010). Other components of social environment include but not limited to housing, public transportations, and the presence or absence of violence in the community. The social environment influences the health of individuals and communities. On the other hand, individuals and communities influence the quality of a social environment. The social environment is particularly unique because it involves interaction with culture, customs, and language, religious or spiritual beliefs. Elements of the social environment include social support, social capital, family systems and gender role. Migration also involves change in one's social environment, which ultimately influences the health of the migrants (Coreil, 2010).

Since migration involves movement from one environment to the other, and different circumstances trigger the decision to migrate, migration would more likely subject migrants to different experiences, which may impact on the health of the migrants in various ways. For example, the pre and post-migration stresses encountered by migrants have negative effects on the health of migrants, and aging declines the physical and cognitive functions of people (Wu et al., 2015).

Pre-migration Living Difficulties

Pre-migration factors are the traumatic events experienced or witnessed by migrants either before or during migration**,** as well as individual background characteristics such as age, education, ethnicity, gender, and marital status of the migrant before migration (Nicholson, 1997). According to Nicholson (1997), people's needs that cannot be readily obtained from their original countries, such as the need to pursue economic opportunities, to escape from totalitarian governments, stresses encountered in their original countries, and the

changing needs of employers and governments benefiting from immigrant labor (e.g., cheap labor, skilled workers) are all instrumental to the decision to migrate. Violence and instability in Nigerian economy continue to force the people of the country to flee their homes in search of a better living. Some younger ones who are solely responsible for their aged or aging parents and relatives find it more convenient to bring their relations into the United States for ease in discharging their responsibilities towards the parents and relations (Nicholson, 1997). It has been documented that the cumulative impact of pre-migration traumatic exposure, and the stressors encountered during migration subject people to physical and psychological stresses (Bentley et al., 2012).

In a study conducted by Roodenrijs, Scherpenzeel, and de Jong (1998) on the mental health status of Somali refugees, the incidence of post-traumatic stress disorder (PTSD), depression, and anxiety were found to be high. It was well documented that almost 1 million Southeast Asian refugees flee from their country of origin (much against their will and without proper planning), due to experienced dangerous conditions and political upheaval (Carlson & Rosser-Hogan, 1994; Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984; Kinzie et al., 1990; Kleinman, 1990; Lee & Lu, 1989). In addition to grieving the multiple losses intrinsic to the upheavals in Southeast Asia, these migrants also continued to be exposed to more difficult conditions, which undermined their capacities to adjust successfully to a new environment. The health and welfare of migrants were better when they readily adapt to the new country and blend with the values and norms of the host society (Bernier, 1992; Bromley, 1987; Eisenbruch, 1991; Gorst, 1992). However, adapting and adjusting to the new environment after migration suggests that migrants could be forced to learn the language of the new host country, seek employment, rebuild social supports, and redefine gender and work roles as well as integrate the values and norms of the host society. Their experiences with these acculturative tasks unfortunately created more stress as well as hindered the

process of adaptation, with a cumulative effect of triggering mental health issues (Nicholson, 1997; Gong-Guy, Cravens, & Patterson, 1991; Le-Doux & Stephens, 1992; Mayadas & Elliott, 1992).

Post-migration Stress

Post-migration factors have to do with the current stress that migrants are exposed to after migration. These are all believed to be potential predictors of mental health outcomes (Nicholson, 1997). While at the host country, migrants could continue to grieve over the pre-migration factors that lead to their decision to leave their counties of origin. Such factors may include the loss of family members, loss of material possessions, homeland, culture, role, status and social supports. All these losses delay the process of adaptation to the new environment and exacerbate the trauma of migration (Boehnlein, 1987; Eisenbruch, 1984, 1991).

Refugees from the Southeast Asian suffered loss of homeland, culture, role, status, and material possessions, which rendered their process of acculturation even more difficult (Bernier, 1992; Gorst, 1992). They also faced the challenge of adapting to a new country with cultural norms and values that were significantly different from those of their homeland without the support of their prior indigenous social networks (Canda & Phaobtong, 1992; Matsuoka, 1993; Mayadas & Elliott, 1992). Such adaptation process included learning the language of the host country, redefining gender and work roles, rebuilding social networks, and integrating the values and norms of the host society.

Most difficulties generally encountered by migrants to the United States or migrants in other host countries had to do with cultural, linguistic, health literacy and socio-economic issues. While migrants expected some degree of support and cooperation from the host country, such expectations could not be met due to some presenting hostile conditions of reception that add stressors to the already challenging migration process. This condition

creates tensions between the individual migrants and host society's needs and wishes that will most likely diminish the sense of well-being among the migrants, and exacerbate latent vulnerabilities for mental health disorders (Hausmann-Stabile & Guarnaccia, 2015).

The global economic crises besieging nations had pushed unemployment rate to the highest level. The situation is even made more complicated for undocumented or illegal migrants who came into the country without meeting up the national regulations that would permit them to enter and work in the host country. This class of migrants are generally prone to being exposed to high risk working and living environments, yet are not eligible to receive the social and health benefits and services available to the rest of the population. (Rechel et al., 2013). This further added to post-migration stress for some immigrants. Subsequently, migrants who were undocumented were also more at risk of developing mental health issues than those who have legal status in the host country; and the situation became unbearable when compounded by violence in the country of origin and the stress encountered at the host country (Lindert, 2009).

It was well documented that post-migration stressors like unemployment, weak social support and weak social integration contribute to an increase in PTSD symptomatology, psychiatric morbidity and in the severity of the symptoms (Nicholson, 1997). Despite the mixed evidence of mental health issues among migrants. Certain migrant category, such as those who left their countries of origin in search for asylum, refugees, and migrants who were undocumented in the host country, were more prone to mental health problems. In a study conducted by Milenkovic et al. (2010) using participants from the Kosovo war, the authors established an inverse relationship between social support and post-traumatic stress. An inverse relationship also existed between social integration and good mental health based on a study conducted with immigrants from Norway (Dalgard & Thapa, 2007). In another study done with Serbian participants exposed to war, unemployment and lower social support

among other factors were found to be predictors of PTSD (Nelson et al., 2004). In a study conducted with migrants seeking asylum in Australia, post-migration stressors, such as unemployment and loneliness were found to be associated with PTSD (Silove et al., 1997). Bentley et al. (2012) posit that refugees who are older, female, more educated, and of higher socioeconomic status are adversely effected by post migration stress; and that migrants from rural areas and those migrating from countries with unresolved sociopolitical conflict were more prone to poorer outcomes. Worrying about left-behind relations and friends, and difficulties adjusting to life in the host country were the main triggers of psychological stress (Teodorescu et al., 2012). It had been documented that when migrants were confronted with unemployment, weak social network, weak social integration in the host country they became further stressed and the compounded stresses made immigrants susceptible to psychological problems (Teodorescu et al., 2012).

Age and Migration

Migration at older age were particularly more stressful because the more one aged, the more the physical and cognitive functions declined, suggesting the need for increased family support or consideration for moving to care settings for the elderly (Wu et al., 2015). Wu et al. (2015) also posits that older people age better when they remain in their local environments; and that changing the environment of the elderly may lead to maladaptive behaviors. Nigerians were particularly skeptical about the elderly being placed in facilities due to the availability of close and extended families who are willing to live with and support their older relatives. They consider being put in the elderly home an abandonment, which readily made those being placed in elderly homes develop depressive symptoms. On the other hand, the American system supported the use of elderly homes, and no one frowned at it. It made sense, therefore to assume that migration at older age into a different environment and culture, like from Nigeria to the United States, could bring culture clash that eventually affect

health. In general, when migrants are not adequately adjusted to the culture of the host country, the migrants' health would be adversely affected. In a cross-sectional investigation of the health of migrants based on age at migration, length of residence, and self-rated health among young immigrants, Leao, Sundquist, Johansson, & Sundquist (2009) found that people who migrate at older ages are more prone to poor health outcomes than those who migrate at younger ages. The study also showed that poorer health outcomes exist for migrants who had lived in Sweden less than 15 years than the health for those who had lived more than 15 years in the same country (Leao, Sundquist, Johansson, & Sundquist, 2009).

Accommodation and Acculturation

Acculturation is a complex, multidimensional process with no descriptive marker faced by people when they leave their original countries and migrate to other countries. It is a theoretical approach to the study of immigrants' cultural change and has been widely studied by psychologists interested in the mental health of immigrants. It is however, assumed that as one remains in the host country, they integrate more with the host country and the impacts of acculturation will be minimized (Ritsner & Ponizovsky, 1999; Ryder et al., 2000). The behavior and way of life and skills of individuals, which includes how immigrants adjust to the social life and culture of the host country, are factors that play important roles in the health of migrants. Irrespective of whether or not the individuals are employed, one's ability to communicate with people in the host country is fundamental to acculturation (Ryder et al. 2000; Lieber et al. 2001).

Mui & Kang (2006) established a negative relationship between acculturation and depression using Asian immigrants. Social workers will surely benefit from these concepts when they incorporate them in program planning for elderly Nigerian migrants in the United States. The cultural orientation of the United States supports individualism and freedom of expression. This runs counter to the Nigerian culture where family members influence

individual decisions, suggesting the possibility of cultural clash and its implications to healthy living.

Healthy Immigrant Effect

When people migrate, the population of the host country not only increases but also there will be more ethnic diversity and the consequential demand for cultural change. All theses issues impact on the health of the migrants (Zou & Parry, 2012). It is well documented that people migrating from relatively poor countries have the poorest socio-economic situation but relatively better health (Newbold, 2009; Malmusi, Borrell, & Benach, 2010; Mathee & Naicker, 2015). Healthy immigrant effect describes a pattern of better health for immigrants than individuals born in the host countries; however, the health of the migrants steadily declines after immigration (Newbold, 2009; Mathee & Naicker, 2015). The transitory nature of the health of immigrant can be attributed to culture-based healthier lifestyles and stronger social bonds and support they enjoyed in the country of origin that initially exert a protective effect on immigrants' health.

In addition, the process of migration usually requires those migrating into a country to meet a standard health status before being admitted into the host country; therefore, migrants are often, at least initially, relatively healthier than the non-migrant population in the host country (Rechel et al., 2013). However, with some lag in time, these migrants soon face some challenges that subject them to vulnerability to certain communicable diseases, occupational health hazards, injuries, and poor mental health. According to Newbold (2009), 4 years after arrival to the destination country, self-reported unhealthy migrants to Canada tripled in percentage.

Some migrants may be more at risk to certain diseases than the others; and the genetic make of some people or their lifestyles may also make them more susceptible to certain types of diseases (Rechel et al., 2013). An immigrant's region of origin, gender, pre-migration

experiences and conditions, acculturation stressors, community fragmentations, as well as sociocultural and socio-economic characteristics explain the differences and variations in chronic and NCDs such as cancers, cardiovascular diseases, chronic respiratory diseases, diabetes, mental illness and musculoskeletal diseases. Cigarette smoking, physical inactivity and unhealthy diets contribute to this increasing burden of chronic and NCDs.

In a study conducted by Gee, Kobayashi, and Prus (2004) among Canadian immigrants it was established that the phenomenon of "healthy immigrant effect" where immigrants are healthier than their host counterparts, is more consistent with younger immigrants aged 45-64 years than with the older immigrants aged 65 and above.

Language Proficiency

One of the greatest barriers to effective health communication is health literacy. Health literacy describes not only one's ability to read, or to understand information about health, but also one's willingness to act on such health information (Zou & Parry, 2012). According to Statistics Canada (2003), of the 164 200 immigrants aged 15 years and older who were granted permanent residency and landed in the country between October 2000 and September 2001, 18% were not able to communicate in English or French. When migrants lack literacy skills it interferes with their ability to communicate and understand the basic health information (Borovoy & Hine, 2008; Jackson et al. 2000; Reitmanova & Gustafson, 2009; Wang et al., 2008). The implication is that migrants fail to make proper use of health resources for the simple reason that they are not able to communicate with the rest of the population (Zou, & Parry, 2012). Therefore, fluency in English enhances communication and enables easier transition to the host culture. Migrants who are deficient in English proficiency or otherwise migrants with limited English proficiency (LEP) have limited access to health. Since language barrier reduces the effectiveness of communication, there will be increased risk of non-compliance in taking prescribed medications, less likelihood to follow up with

appointments, and decreased ability to navigate Western healthcare systems (Zou & Parry, 2012). Lack of communication also affects efficiency in data collection from migrants, which may present conflicts in managing confidentiality issues. When migrants do not understand the need to disclose some personal information they tend to withhold some important medical issues that otherwise may be necessary for improving their health (Zou & Parry, 2012).

Education

The more educated a person is, the more likelihood that the person will understand the implication of not seeking health care. For example, an educated migrant who understands the biomedical concepts of prevention and self-care is more likely to seek preventive care than a migrant who is less educated and may not understand the biomedical concepts of prevention and self-care (Hubbell et al., 1995; Jackson et al., 2000). Billings & Cantor (2008) posit that lack of education also interferes with the ability of migrants to adhere to medical regimen, and seek care in the early course of an illness. Immigrants with limited background in education generally have lower overall health care utilization (Billings & Cantor, 2008). They are usually not able to follow directive on prescriptions; diagnostics test instructions, or treatment directives. Chiswick and Miller (1995) posit that the level of education one has affects the person's earnings, which subsequently impacts on the spending ability of the migrants.

Socioeconomic Factors

It is well documented that the socio-economic status (SES) of immigrants are usually lower than that of the host country due to difficulties presented by unemployment, reduced income and deskilling. Although Asian Americans, on average, have higher household income, research with Cambodian Americans indicated that Cambodian migrants to the United States generally have low socioeconomic status than the rest of the population, which makes them seek survival rather than health (Jackson et al. 2000). For the same reason, low-

income Koreans immigrant women, rather than manage their menopausal health, tend to pay primary attention to employment and financial problems (Im & Meleis 1999).

Culture and Beliefs

Culture is a way of life of a particular group of people describes the attitudes, values, goals, historical experiences and traditional practices shared within a group of people (Zou & Parry, 2012). When migrants leave their countries of origin, they encounter new political and social systems in the host country, which are quite different from what obtains in their countries of origin (Zou & Parry, 2012). In addition, the United Stated culture supports individualism, autonomy and choice. This personal initiative and responsibility found in the American culture runs counter to many migrants' culture and belief. The Russian Jewish immigrants to America, for example, are not used to the concepts of autonomy and choice, therefore find it difficult to manage their own health. Subsequently, they are not motivated to pay attention to their own health as well as assume the responsibility to provide care for their selves (Zou & Parry, 2012; Borovoy & Hine, 2008; McEwen et al., 2007; Wheat et al., 1993). The situation is more complicated with Africans who have high confidence in home remedies and at the same time have limited education because these issues affect their decision to seek health care.

Nigerian culture supports an enmeshment of individuals in a dense network of social ties with the extended family. Migration to the United States definitely diminishes the benefits derived from extended family. It is however, also worth mentioning that bonding deeply with the extended family can also generate undesirable social patterns that negatively impact on health (Rook, 1992). Due to the availability of the support from the extended family system, most Nigerians do not support the elderly being placed in facilities as these close and extended families are willing to live with and support their older relatives. They consider being put in the elderly home an abandonment, which readily places them into

depression. Wu et al. (2015) posits that older people age better when they remain in their local environments; therefore, when supporters of family and extended family bonding are exposed to a different environment, maladaptive behaviors which impact on health will manifest.

Older people who migrate from Nigeria into the United States definitely face chances of losing relationships and being detached from their culture or regular way of life, thus increasing the risk of depression and other mental health conditions through stress, coping and social support.

Healthy immigrant effect posits that new migrants tend to have better health when they initially arrive to the host country; but the health of the migrants steadily declines with time. The decline in health is attributed to the immigrants being more at risk for various chronic and non-communicable diseases (NCDs), being more deficient in health knowledge, and being less likely to receive adequate health education (Zou, & Parry, 2012).

Some migrants are also more prone to a particular disease than the other (Wiking et al. 2004; Sungurova et al. 2006). For example, female immigrants from Finland and Eastern Europe are at greater risk of developing coronary heart disease than the Swedish-born women (Sundquist and Johansson (1997a). Many studies have also documented that that migration not only increases the risk factors for coronary heart disease but also increases the mortality and morbidity due to the disease (Worth et al. 1975; Salmond et al. 1989; and Williams 1993).

Chinese immigrants to North America were shown to have substantially higher rates of chronic hepatitis B infection than the general population and, yet only 25% of them had received information on the physician recommendation for hepatitis B serologic testing, and fewer than 60% had been tested for hepatitis B (Taylor et al., 2008). Hispanic women also are at an increased risk of having heart diseases, yet did not receive adequate health education

(Zarate-Abbott et al. 2008). It is also well documented that migration also increases the rate of mental disorders (Eitinger, 1960; Eitinger and Grunfeld, 1966; Hitch and Rack, 1980; Sundquist, 1993; Cantor-Graae et al., 2003; Saraiva Leao et al., 2005; Saraiva Leao et al., 2006). Bhugra (2001) posits that that the rates of schizophrenia among Norwegians who had migrated to the United States were higher when compared with Norwegians who had stayed back in Norway.

Social Support

Social support is the use of social relationships and interpersonal transactions to obtain social benefits. Social support can be obtained through "the exchange of advice, information, and resources in response to life problems" (Pearlin, 1989). Social support provides a support system that is needed by migrants in managing the uncertainties imposed by movement into a foreign land. Social support minimizes the negative effects of stress (Rains & Young, 2009). Individuals obtain social support through their own social networks irrespective of the presence or absence of stresses. In the event of stress impacted by migration, socially supportive peer networks can act as a buffer and insulate an individual against the negative effects of stress (Cohen & Wills, 1985).

Social support can have both positive and negative implications. It can be emotional, instrumental, informational, or appraisal (Coreil, 2010). Emotional support is the type of social support that can be expressed through empathy, love, trust, and caring. By giving someone tangible aid and services, instrumental support can be provided. Informational support is expressed through giving advice, suggestions, and information. Appraisal support is expressed by providing one with information that can enable self-evaluation of the person concerned.

Social support has a positive impact on health outcomes. In a study conducted by Nuckolls, Cassels, & Kaplan (1972) on the level of support received by pregnant women and

complications during delivery showed that women who received fewer supportive relationships and exposed to stressful conditions have more complications during delivery. It has also been documented that married people (irrespective of gender and age), who get social support, have fewer morbidity and mortality. Coreil, (2010), however, posits that the strength of the relationship between social support and health varies with types of communities and gender; and argues that the effect is stronger for those who live in urban areas than those who live in small communities. Williams (2003) argues that the health benefits of social support are much stronger among men than women.

This study will enrich the existing literature on the impact of social support on health by examining the health impacts of social support on elderly migrants from Nigeria into the United States. The study will examine the bio psychological processes that mediate the association between health and social support, which will provide a better understanding of the phenomenon.

Migration and Health

Although the change in the environment may likely impact the health of the migrants, Gülşen, Knipscheer, and Kleber (2010) posited that all subgroups of immigrants do not have equivalent health status and that different migrant populations experience different degrees of risk to diseases and infections. This is because factors such as the environment, economic, genetic and sociocultural factors related to time of migration, the original country and the living conditions there, reason for migration, how they migrated, and the post migration factors existing in their host country, all combine to influence the health of migrants. The challenges faced by adults-in-migration are further influenced by the choice of place they migrate to. For example, migration to rural or urban centers in the United States has both negative and positive consequences to both the rural or urban communities involved, as well as the migrants themselves. An understanding of the implications of these patterns is

fundamental to the planning of the health needs of the older adults in-migration (Reel & Lauder, 2006). The development of rural or urban older adult health service has implications to healthy aging. Older adults residing in rural areas have less accessibility to health services than those residing metropolitan centers. In addition, it cost more to deliver such services in rural areas than in urban areas (Reel & Lauder, 2006). Some necessary resources such as advances in technology for healthy aging may not be accessible to older adult migrants in the rural areas.

Although the United States is one country that recognizes the value of community-based older adult care, implementation of such strategies vary by state as well as local communities. Despite the fact that there is no universal health coverage for all citizens, older adults enjoy national health care coverage through Medicare. The services provided by Medicare however, do not cover some prescribed medications. Compounding the above issues are the facts that immigrants in general are vulnerable to socioeconomic inequalities, have limited medical coverage and are limited by language barrier and other stresses associated with relocation. All these obstacles lead to the underutilization of health care services that are otherwise available to them (Lam & Gee, 2012). As one gets older, the risk of getting chronic diseases increases (Anderson & Knickman, 2008; Lam & Gee, 2012). Older Nigerian migrants are also confronted with changing cognitive capacities associated with old age.

Some older Nigerians entered the United States through the Diversity Lottery Program. Other older Nigerian adults migrated into the country after their retirement. The Nigerian value for extended family system also causes some elders to relocate and join their family members who already settled in the he United States. Some Nigerians who leave their country of origin do not do so because of hardships but because they want to attain a status quo based on their high regards for the country. There are therefore cases where individuals

who are financially stable in Nigeria have decided to migrate to the United States just to attain the "American Dream." An average Nigerian desires to live in or visit the United States; however, migrating into the United States as older adults within the ages of 65 and 80 are particularly associated with stressful conditions that impact the abilities of these migrants to achieve their desired ends. The migrants' vulnerability to health is shaped by constraints posed by experiences involving legal, social, cultural, economic, behavioral, and communicational issues. Employment, education, poverty, accessibility and responsiveness of health practitioners as well as that of the United States health care system to immigrant health needs, all influence the health of migrants (Gülşen, Knipscheer, & Kleber, 2010). My study will identify the differences in socio-economic status and health of these migrants while they were in Nigeria and while in the host country. The information will guide program development tailored to the specific needs of each migrant, which will ultimately close the gaps in health disparity.

Hyman, Vu, & Beiser (2010), posit that the post migration stresses encountered by Asian Refugee Youth in Canada subject them to developing mental health problems such as addiction to drugs and alcohol, delinquency and depression, post-traumatic stress disorder, and psychopathology. In the same way, adults who migrate out of their native country for one reason or the other encounter post migration stressors such as unemployment, family separation, loneliness, all of which negatively impact on the mental health of those involved. Identifying the particular stressors associated with each particular situation will better guide the development of programs that will promote the health of the older Nigerian migrants in the United States. Silvone et al., (1997) posits that the immigration procedures undergone by migrants predict the stress level that each migrant is exposed to. Elderly migrants encounter transitional stressors such as lack of social support, which they enjoyed from the extended family system in their original country, language barriers, reduced dependence on their adult

offspring for economic support, unemployment and perceived discrimination. All these stressors elicit anger, which ultimately has implication to health. My study will compare the effect of these stresses on both genders in order to provide interventions tailored to individual needs.

The reason, planning and timing of migration influence the psychological distress experienced by migrants. Evidence shows that migrants with clear and strong reasons for migration have less chances of suffering mental health conditions than those who have no set goals to achieve in the host country and have been forced to leave their country of origin without adequate planning (Gong et al 2004). The study by Gong et al., (2004) also posits that when migration is well planned, the stresses encountered by acculturation are less than when migration is not planned, and having multiple strong reasons for migration has a buffering effect on stresses of acculturation. On the other hand, a study conducted by Angel, Angel, Diaz, & Bonazzo, (2010) argue that migration at older age is associated with lower risk of death.

Summary

In this Literature review, I identified the peculiar factors that influence the health of migrant into the United States so that such factors will be put into consideration when developing health services, to ensure that the services being developed will meet the identified needs of the population. My study will add to the existing literature by exploring how Nigerians migrants, aged 65-80 perceive how their experiences immigration influences health. In the next chapter, I will discuss the methods I will use to answer my research questions.

Chapter 3: Research Method

Introduction

This study explores the migration experiences of older Nigerian adults and how they interpret the experiences in relation to their health. This chapter discusses the appropriate research method used to answer the research questions.

When people migrate, they carry with them their knowledge, experiences and distress. However, in order to adapt to a new environment, migrants need to identify with the new culture they find themselves in. This is called assimilation or acculturation (Bhugra, 2004). The coping mechanisms they use depend on their reasons for migration, whether they were prepared for the process, and the social support that was and is available to them (Bhugra, 2004). According to Veiel and Baumann (1992), social support refers to people, behaviors, relationships, or a social system that provide an environment that can help compensate for environmental stress. My study used NVivo for data analysis.

Research Methodology

Research can be approached in one of three ways: quantitative, qualitative and mixed methods. These approaches are strategies of inquiry available to a researcher in answering research questions; however, each approach provides a different perspective to understanding the problem of interest, and each design has its own strengths and limitations (Salazar, Crosby, & DiClemente, 2006). The basic difference between them is the philosophical assumptions that researchers bring to the study, the type of research design used (such as experimentation and surveys for quantitative studies, case studies, phenomenology, for qualitative research, and a blend of both qualitative and quantitative designs for the mixed method research) and the methods used for data collection (Creswell, 2014). Each method of data collection, analysis and interpretation of research findings has unique steps. Ethical issues, cost, feasibility, and accessibility to the study population are factors to be considered

when making the choice of a research design and strategy; and making the right choice is fundamental to the success of a study.

The qualitative approach is better suited for research that aims to (a) explore and get a better understanding of a phenomenon as well as (b) understand the meanings that individuals or groups have of social or human problems (Creswell, 2014). In qualitative design, the variables are complex, interwoven, and not easily measured (Salazar, Crosby, & DiClemente, 2006). I collected data from participants using open-ended questions, which allowed probing by me, and enabled a better understanding of the experiences of the migrants and their subjective interpretation of how their experiences affect their health. It is worth mentioning that although the aim of this study was not to form theories, the qualitative approach could be an inductive process because the responses of participants can be used to form a theory about the subject matter. I probed into the answers provided by the participants by asking them more questions based on their responses. Thus, I was able to search for patterns in the results of the study (Salazar, Crosby, & DiClemente, 2006).

Qualitative research is focused on observing and describing events as they occur, with the goal of capturing all the richness of everyday behavior, and hoping to discover and understand phenomena that might have been missed if only a more cursory examination had been used.

As the researcher using the qualitative design I was the key instrument for data collection, which I accomplished by interviewing participants and audiotaping responses without relying on other instruments developed by another researchers (Creswell, 2014; Rubin & Babbie, 2011). Thus, while quantitative design uses formal instruments for data collection, I was the instrument for data collection because I did not use any developed instrument to collect my data. The data that form the basis of qualitative research are in their original rich form- descriptive narratives such as field notes, audio or video recordings—done

by the researchers themselves, based on their own observation (Stangor, 2011). Qualitative research does not take the form of numbers, but consists of verbal responses to both structured and unstructured questions.

Considering the characteristics described above, my research benefited from the qualitative method of inquiry. My interest in this study was in the meaning of the experiences of the subjects than in generalizing the results to other groups of people. The study was not meant to test any hypothesis as demanded by the quantitative approach; however, hypothesis could be generated from this study (Creswell, 2014; Nieswiadomy, 2002; Stangor, 2007).

By this study, I formalized experiential knowledge as well as promoted quality health among the elderly Nigerian migrants. This qualitative approach also helped me gain an insight and understanding of the cultural factors that influence people's health through the participants' subjective experiences and interpretation of the relationship of the experiences to their health. Thus, a qualitative approach is better suited for a research that aims to explore and have a better understanding of a phenomenon as well as understanding the meanings that individual or groups have of social or human problems (Creswell, 2014).

Qualitative research does not take the form of numbers but consists of verbal responses to both structured and unstructured questions. Although both qualitative and quantitative methods of inquiry use interviews and questionnaires to collect their data, however, qualitative methods use open-ended questions while quantitative studies use closed ended questions (Creswell, 2014; Rubin & Babbie, 2011).

Given that my study required insight into and understanding of the cultural factors that influence people's health, the qualitative method was a better approach (Nieswiadomy, 2002). My study also relied on the subjective nature of human experiences, which made my choice of qualitative design a better option for the study (Creswell, 2014; Nieswiadomy, 2002). Although my sample size was small, the participants that make up the size of my

sample provided me with rich information on their perceptions of migration and the impact on their health. The rich information they provided enabled me to answer my research questions.

I used open-ended questions to better capture the essence of the phenomenon of interest and, via my interview questions, sought in-depth descriptions of the participants' subjective experiences. I assumed that the experiences of individuals and the cultural backgrounds shaped their lives; therefore, this study approach tapped deeper meanings of the participants' experiences Also the phenomenon under study did not require any measurements of people's reactions, nor based on the concepts of manipulation and control of phenomena (Nieswiadomy, 2002; Stangor, 2011; Creswell, 2014).

Although the qualitative method of inquiry is relatively inexpensive and may not demand expensive staff and equipment; however, it has the disadvantage of not yielding precise statistical statements about a large population. Also generalization is made difficult because the subjective nature of qualitative research makes it almost impossible for two researchers to arrive at same conclusions (Rubin & Babbie, 2001).

Research Design

Of the different types of qualitative research design, which include phenomenological, ethnographic, narrative, case study, and grounded theory, phenomenology best suited my data. As the scientific study of how things appear in our consciousness, phenomenological study aims to uncover meanings of the phenomena being studied, with no regard to factual matters. Phenomenology describes the meaning of lived experiences for individuals experiencing a particular phenomenon or concept (Creswell, 1998). In this type of study, experiences are described without providing any explanations or analysis, and the questions posed to participants provided direction and focus to meaning, and in themes that sustain

inquiry. In phenomenological studies, the phenomenon of interest is examined thoroughly from all angles until a unified vision of the essence of the phenomenon is achieved.

The phenomenological perspective puts into consideration all perceived objective and subjective phenomena, including using my personal subjective experiences. Since the phenomenon of interest is the migration experiences of the elderly, and the participants' interpretation of these experiences in relation to their health, I did my exploration with participants who have lived the experience, including their subjective and objective experiences of something in common with other people (Creswell, 2013). I collected my data from 13 participants in the Bronx section of New York City who fell within the scope of the study. I also examined the phenomenological perspective experiences of the participants through the descriptions provided by the participants who had lived through the experiences. I aimed to capture the meaning that the experiences hold for each participant. The use of this phenomenological approach helped me capture the common meaning of the lived experiences of the concept or phenomenon of the study participants and reduced the individual experiences to a description of the universal essence (Creswell, 2013). While carrying on the research processes I, as the researcher put aside my own ideas about the phenomenon of interest and that enabled me see the experiences from the eyes of those who have lived the experience. I developed themes and patterns from the data I collected, and I collected and analyzed my data simultaneously (Nieswiadomy, 2002). The phenomenological approach allowed me to make a comprehensive observation at the outset before attempting to winnow out any elements that originated in my own worldview rather than that of their participants. In this way, the participants' experiences, as well as how they made sense of their experiences were discovered. At the end, I was able to understand how each participant assigned meanings to the experiences and related such experiences to their health. The significance of this type of study to public health is that researchers and practitioners can view the

experiences and health of older adult migrants in the context in which it occurs (Nieswiadomy, 2002).

In this study, I looked for patterns and themes in the data I collected. Through interviews the study participants provided me with their lived experiences, as they perceived them; and I examined such experiences and described the meaning that the experiences hold for each participant. I believe that this type of design is appropriate for my research because health is enmeshed in the life experiences of people, their beliefs and cultures (Nieswiadomy, 2002). I put aside what I expected to discover and that enabled me understand the experiences of the study participants from the advantage point of the participants.

My Role as a Researcher

The role of a qualitative researcher is that of personal involvement and partiality. As a qualitative researcher, I was the key instrument for data collection, which I accomplished by examining documents, observing behavior, interviewing participants and audiotaping responses without relying on questionnaires and other instruments developed by another researcher (Creswell, 2014; Rubin & Babbie, 2011). As a qualitative researcher I used descriptive write-up in presenting study results (Salazar, Crosby, & DiClemente, 2006). As a researcher, I really considered my personal history, my personal views about the phenomenon of interest, what others felt about the subject as well as the ethical and political issues surrounding the subject of interest. I addressed the processes of interaction among individuals to enable me understand the historical and cultural orientation of the study participants. My study focused on the specific content in which people live and work. By thinking through the philosophical worldview assumptions, I was able to choose a research design that is related to the worldview, and the specific methods or procedures of the research that translate the approach into practice (Creswell, 2014).

Participants of the Study

Study participants were male and female Nigerians, aged 65–80 years, who migrated from Nigeria to the United States as adults, and who had lived in the United States for at least 2 years. I used purposive sampling to select my participants. The unique and distinct characteristic of qualitative research is that its sampling strategy assumes that the researcher or the chosen expert has enough knowledge about the population of interest to select specific subjects for the study (Nieswiadomy, 2002). In purposive sampling therefore, I selected participants that I believed would yield the most comprehensive understanding of the subject of interest (Patton, 2002; Rubin & Babbie, 2002).

Sampling Strategy and Sample Size

Prior to initiating this qualitative research, I already determined the purpose of the study, realizing that the purpose of the study would guide my approach to the study including the decisions on the sampling strategy and sample size (Patton, 2002).

Patton, (2002) posits that in a qualitative inquiry, there are no set rules guiding the sample size needed for a study; and that the sample size for a particular study depends on the in depth and richness of information that can be obtained to satisfy what a researcher intends to find out, why the researcher needs the information, how the findings will be used, the credibility of the study, the resources available for the study as well as the time frames permitted by the study (Patton, 2002). Creswell, (2006) recommends that a phenomenological study require at least 10 participants in order to make assertions regarding the phenomenon of interest. The samples that I used in this qualitative study, analysis, and the presentation, were judged on the ability to provide rich information on the subject matter of interest. I also used my personal knowledge of the community to hand pick key people, such as those I knew fit within study category specified for the study (Rubin & Babbie, 2002).

Unlike in probability sampling, which aims at generalization, purposive sampling does not aim at generalization but focuses on collecting rich information that will benefit the study. The sampling strategy that benefited this study is purposive sampling because the aim of this strategy is not to generalize to the larger population, but to get rich information that would support the purpose of a study. The samples I selected were based on my judgment and purpose of study.

There are different types of purposeful sampling, some of which includes extreme or defiant case sampling where the focus is on the unusual manifestations of phenomenon; intensity sampling, which relies on information-rich case that intensively, but not extremely manifest the phenomenon; maximum variation sampling which utilizes a wide range of cases in order to get variation in the dimensions of interest; homogeneous sampling which focuses on reducing variation, simplifying analysis, and facilitating good interview; typical case sampling which highlights what is typical; critical case sampling, where generalization and application of information is permitted; snowball sampling, and criterion sampling.

The type of purposeful sampling that benefited my research was criterion sampling because my unit of analysis consisted of individuals who met certain criteria; In this case, the participants in the study consisted of Nigerians who are 65 to 80 years old residing in the United States for at least 2 years. Because of their lived experiences, they were able to help the me answer the research questions (Rubin & Babbie, 2002).

Answering a research question therefore does not depend on volume, but on the usefulness and richness of information that I collected. It is also important that I collected this sample from the setting of interest. Since my research focused on older adult Nigerians in the Bronx section of New York City, it was a benefit to my research to collect information from this group of people because the information they provided was more useful than collecting large samples from other settings that would not benefit the study (Creswell, 2014).

Another determination for my sample size was the design of my study. My approach to this study was phenomenological, therefore, only those who were within the bracket described by the study provided the information that benefited the study. Saturation is another factor that influenced sample size in qualitative study. I stopped collecting data when categories or themes were saturated (Creswell, 2014). I used a sample size of 13 participants.

Data Collection

In order to ensure that the study participants met the criteria required for the study, and for me to have baseline information for my study, I asked the participants to provide their demographic information such as their birth dates, town of residence, country of birth, language spoken, parent, and parents' occupation in a quick screening questionnaire. I used face-to-face interview to get the participants' understanding of their health status while in Nigeria and while they were in the United States. By interacting directly with the study participants I gained a deeper understanding of the phenomenon in question, which in turn provided the basis for future qualitative or quantitative research (Rubin & Babbie, 2001). In recognition that participants' behaviors were influenced by their culture, I used open-ended questions, which provided me with an opportunity to explore and make meanings of the participants' view on the issues of concern. It also gave the participants the freedom to provide answers in an unstructured manner as well as gave them the opportunity to expand their discussion, thus I was able to capture the essence of the study.

My decision to study participants who spent a substantial amount of their lives in Nigeria helped to avoid participant bias in data collection. To avoid the participants providing socially desirable answers that could bias the study, I informed the participants that there were no right or wrong answers, and assured them that the answers they provide would be confidential.

I communicated with the participants in plain, simple English language that they easily understood in order to enable them make informed decision about participation in the study. In addition to providing consent forms to all participants, only those who signed and returned the forms participated in the study. Also, I obtained ethical approval for the study was from the Walden Human Research Ethics Committee Institutional Review Board.

Research Instruments

As a qualitative researcher, I was the key instrument for data collection, which I accomplished by interviewing participants and audiotaping responses without relying on instruments developed by other researchers (Creswell, 2014; Rubin & Babbie, 2011). I collected data using face-to-face interview and questionnaires. I also used questionnaires to screen the participants and ensure that they fall within the criteria described by the study. The rationale behind my decision to use interviews and questionnaires was that the responses expected from the participants could not be obtained by mere observation, but by getting the participants to verbalize or write their concerns. The decision to use questionnaires in particular was because my unit of analysis consisted of individuals with cultural inhibitions that may not permit free discussion of some topics, such as their ages. My role as a qualitative researcher is that of personal involvement and partiality. I used descriptive write-up in presenting my study results (Salazar, Crosby, & DiClemente, 2006). See Appendices E and D, for the interview questions, demographic questionnaires respectively.

I, the researcher, come from one of the major ethnic groups, and I sometimes attend common functions with some of these participants, and may have had pre-established relationship with some of them. In realization that this relationship could make the study participants uncomfortable in expressing their sincere beliefs and experiences, I assured the participants that there were no right or wrong answers to any questions. Some of these participants knew me as a child protective specialist supervisor, which may also provoke a

suspicion that the answers they provide could be used to judge the participants relationship with their minor children and grandchildren, and trigger fear of having their children/grandchildren removed from their care as a result of the answers they provide. I, therefore, assured the study participants that in the context of the study, I was not acting in the capacity of a child protective specialist supervisor in order to dissipate this suspicion.

I asked the study participants 18 interview questions (see Appendix E), which enabled me to better understand the phenomena and capture the essence of the study (Moustakas, 1994).

Data Analysis

Data analysis is an interconnected activity that includes data organization, preliminary review of database, coding and organization of themes, data representation and interpretation (Creswell, 2003). In qualitative studies, the first steps in data analysis involves transferring the text data into transcripts, or image data into pictures; coding to reduce the data into themes, condensing the codes, and representing the data in figures, tables, or discussions (Creswell, 2003).

I collected a great deal of oral data. In realization that the volume of data could be overwhelming I started interpreting data as I collect them. I created categories of the data I collected and developed rules for coding them (Creswell, 2014; Nieswiadomy, 2002).

The first part of my analysis began with the description of my personal experiences as a migrant from Nigeria to the United States and then I shifted the focus to the experiences of the participants themselves. I developed and noted a list of significant statements, including non-repetitive and non- overlapping ones. Each statement was treated as having equal worth (Creswell, 2003). I also developed groups of themes according to the units of information they contained. I described the experiences of each study participant in a narrative form. I also described how, where, or when the experiences happened. With the textural and

structural description of the participants' experiences, I developed a composite description of the phenomenon of interest (Creswell, 2003).

It is fundamental to code data to enable readability in computers because computers are at their best with numbers. Therefore, since computer could not understand the responses from open-ended questions posed to participants, I translated the responses through coding (Rubin & Bobbie, 2001).

I looked for the similarities and differences in data collected from the participants, and the commonalities in patterns of interaction and events. I identified the norms of behavior and commonalities in behaviors. I questioned the universal behaviors as to the reason why it should be and what functions they serve. I also tested my expectations based on these conditions. I looked for deviations from the norm and the reason for such deviation and the characteristics associated with such deviations. Once a health problem was identified, I made more sense of the observation by identifying the frequencies of occurrence, the magnitude or level of the health issue, the different types of the health issues, (such as physical or mental health issues and whether or not they are related), what the participants believed caused the health issues, were such issues more common with a particular gender or ethnic group. I also associated the health issues with season, and the short and long-term patterns of interaction and events that are generally common to what was being studied. I noted what patterns of behavior that all participants share. These observations enabled me discover universal and commonalities among the participants and the reasons for such (Rubin & Babbie, 2002). I also paid attention to differences such as deviations from the general norms. I noted that some similarities and differences might not be clearly defined; therefore, I created an organized list of classified behaviors, and sought to discover other characteristics associated with the different types of behaviors (Rubin & Babbie, 2002).

Rubin and Babbie posit that data analysis involves establishing patterns; therefore, the analysis of my study benefited by establishing patterns associated with migration of this study populations.

NVivo 12 plus version of Computer Assisted Qualitative Data Analysis Software (CAQDAS), is an ideal statistical analysis software that I used to classify, sort, organize and arrange information as well as examined relationships among data. The advantage of using software for coding is that unlike hand coding, software coding shortens data processing time. The software was used to sort and search information in text or image data (Creswell, 2014). The software was also more efficient and faster to store and locate data than with hand coding. I also used the software to make comparison of different codes (Creswell, 2014).

I guarded against personal bias by articulating my own biases before the research began, tracking my interpretations as they change.

Measures

The aim of this study is to explore the subjective and objective experiences of the participant's and how they relate these experiences to their health. I put into perspectives the migrant's socioeconomic status, age at migration, social networks, length of residence, acculturation. These participants must have functioned as adults in Nigeria and arrived and lived in the United States for at least 2 years for effective comparison to be made.

Ethical Protection

Ethical conduct in research is a valuable tool that guarantees the IRB's requirement to protect human subjects when conducting research. It demands that researchers demonstrate transparency, honesty, integrity, and fair treatment and protection throughout all stages of the research process. In recognition of this, I considered all potential risk and protection for human subjects, and adhered to all ethical demands of this study. I presented to all

participants the research aims, risks and benefits involved in the research as well as how I plan to protect them through the research process (Santelli, 2006).

My research protocol was reviewed by IRB prior to commencing my study, and all plans intended to protect human subjects was based on ethical principles of respect for persons, beneficence, and justice; and should be in compliance with stipulated regulations. I recognized that if I need to deviate from this protocol, I would seek a waiver of informed consent; I would be required to provide ethical rationale to justify such request (Crosby, DiClemente & Salazar, 2006).

In compliance with the ethics demanded by this research, my participants were in the age bracket described by this study and they were able to make the decision as to whether or not to participate in the study. Although the study does not present any major harm to the participants, however, if any participant experiences any harm during the research process a referral to local services would be made. All participants completed the consent and confidentiality forms, and all files, audiotapes, and transcripts used for the research were properly and securely kept in a way that does not permit access to others outside the researcher. Having satisfied all ethical demands of IRB, I was approved to proceed with the study under IRB Approval No. 03-21-19-0298495.

Procedures

The steps I took in recruiting the study participants were as follows:

1. I secured a partnership with community organization specifically designed for Nigerians and introduced myself and the proposed study. I collected and secured the participants' contact information to ensure sustained contact with the participants.

2. I sent letters to the study participants explaining the nature of the study and I asked them to refer other people who they know to fall under the bracket covered by the study.
3. Once I have identified the study participants, I organized and help meetings with them and presented the proposed study as well as provide them with a copy of the letter describing the study.
4. I then scheduled interviews with the participants based on each participant's availability. I followed up each participant with phone calls if there was no contact within one week of informative meeting.
5. I gave a copy of a letter describing the proposed study to every participant in advance for review, and all participants signed the Informed Consent Form prior to commencement of the study.
6. I transcribed all transcripts verbatim.
7. I advised the professional transcriber of obligation to adhere to ethical standards demanded by the research.

I discussed and addressed all participants' concern before they signed the informed consent. I presented all information on the benefits and likely risks of participation to all participants to give them the opportunity to make informed decision. In addition, I gave them the opportunity to ask questions to enable them clarify their concerns. The consent forms I gave to the participants were readable and communicated in an unsophisticated language consistent with the reading and understanding level of the subject (Santelli, 2006). All communications with the IRB were clearly presented. I maintained confidentiality during data collection and analysis, and I removed identifiers from such data as soon as they are no longer needed (Santelli, 2006).

Since my research involved the health of study participants, it is expected that the process will involve multiple therefore I strictly complied with the code of ethics and guidelines required for any study involving human subjects. Thus, the rights and confidentiality of the research participants were protected in my research.

Ethical Considerations

The importance of protection of human rights in all research involving human subjects is the basic principle that governs all research in recent years, therefore, cannot be overemphasized. The primary responsibility of ethically managing research in the healthcare field, including public health, resides with Institutional Review Board (IRB). The role and history of the IRB, centered largely on response to human rights' violations that occurred during the World War II (Steinbock, Arras, & London, 2009). Other stimulus that drew attention to international standards in research is the Tuskegee Syphilis study of 1932-1972 (Steinbock, Arras, & London, 2009)

In 1978, the National Commission adopted the Belmont Report, which was guided by three ethical principles of beneficence, respect for human dignity, and justice, for protection of human subjects of biomedical and behavioral research in the United States. The three principles played important roles in shaping the ethical and regulatory standards for acceptable research in the Unites States. Here is a further explanation of these principles:

- Beneficence demands that the research must be critically analyzed, and the risks and benefits involved in the research be favorably assessed (Steinbock, Arras, & London, 2009).
- Respect for human dignity implies that the consent of the participants should be obtained while recognizing and respecting their personal dignity, and autonomy as individuals (Steinbock, Arras, & London, 2009).

- Justice implies that when selecting subjects for a research, equitable procedures should be applied in order to ensure that the vulnerable populations are protected and do not bear disproportionate burdens of the research (Steinbock, Arras, & London, 2009).

Guided by these three ethical principles, the IRB is therefore specially set up to monitor, review, approve, or disapprove research using human subjects, and they are found in almost every hospital or healthcare setting, and other institutions where research is conducted with human subjects. However, settings that do not have their own IRB often rent from the outside institutions.

On the principle of beneficence, the board defines the nature of the research, systematically assesses the risks and benefits; and at the same time provides researchers with the opportunity of seeking and using other alternatives that will favorably balance the risks to benefits ratio. While the research is in progress, IRB continues to communicate with the investigator and insists on direct answers to questions regarding the research. The board ensures that the researcher provides clarity as to the validity of the presuppositions of the research. The risks and benefits determine whether the investigator's estimates of the probability of harm or benefits are reasonable based on verifiable evidence (U. S. Department of Health & Human Services, Office of Human Services, 2009).

The assessment of benefits and risks has its own rules:

- It is never acceptable to treat human subject in an inhuman manner.
- The use of human subjects should be avoided if possible especially if the benefit does not outweigh the risk.
- The direct benefit to the subject should be a primary consideration of IRB that justifies any research involving significant risk of serious impairment.

- The appropriateness of any research that involves a vulnerable population must be demonstrated.
- While seeking the consent of a participant, all relevant risks and benefits must be completely disclosed.
- The elements of informed consent demand that participants observe the information, understand and comprehend the information, and are given the freedom of choice of whether or not to participate in the research.
- The researchers should make sure that subjects are given enough information for them to make a decision as to whether to participate in the research or not.
- It is not enough to discuss the purpose, risks, benefits of the research, they should also be given the opportunity to ask questions, and/or withdraw at any time in the process of the research.
- The benefits to be expected from the research, the fact that participation should be voluntary, and the range of the risk involved should be clearly stated to the understanding of the subjects (U. S. Department of Health & Human Services, 2009).

The only acceptable excuses for incomplete disclosures are:

- When full disclosure will obstruct the goals of the research.
- When the risk that is not disclosed is minimal.
- When the subjects are debriefed and provided with the research result.

The IRB functions in such a way that information are given to the subjects in a manner that they will understand. They do competency testing on their subjects if warranted. For subjects that have limited capacity to understand, opportunity should be extended to them to choose whether to continue or not, and their opinion should be respected. Third-person

consent is required in special situations where the subject has impaired mental capacities, terminally ill, comatose, or a minor (U. S. Department of Health & Human Services, 2009).

The responsibility of the IRB regarding the principle of justice mandates that the procedure for selection of research subjects include the following:

- Exhibiting fairness to the subject as an individual with social, racial, sexual or ethnic orientations.
- The order of subject selection should be adults before children; and the choice of subjects should not be made just because the subjects are readily available, or easy to manipulate due to illness, or socioeconomic condition (Steinbock, Arras, & London, 2009).

It was my duty to assess and eliminate ethical violations in the research prior to commencement of the study. In recognition that the participants in my research are human beings, I was careful to avoid any ethical dilemmas, and I followed the right steps to ensure the participants are well protected and their rights not violated. I got the consent to proceed with the study from Walden IRB prior to the commencement of this study. I explained the purposes of my study to all participants taking into consideration the cognitive level of understanding of the participant, to ensure that the participants fully understand the meaning and implication of what they are doing. I made the study participants understand their right to withdraw from the study whenever they want to. I understood that my failure to communicate the information is unethical. As a researcher I abided by elements of informed consent and I was fair when I selected subjects for this study.

Summary

In this chapter, I described the research plan for this study and the reasons for the choice. I also discussed my choice of participants, data collection methods and how I analyzed the data I collected. I intended to use a sample size of 10 to 15 participants;

however, only 13 participants fell within the study criteria and participated in the study. I was the sole instrument for collecting data. I used face-to-face interviews to advance the study. The ethical considerations in research were also discussed in this chapter. In the next chapter will present the results of the study.

Chapter 4: Results

Introduction

This qualitative research explored the meanings that older Nigeria migrants (aged 65-80) placed on their migration experiences; and their interpretation of how the experiences impacted their health. and well-being. This chapter will discuss the findings and results of the research.

The sample size for this study was intended to be between 10 to 15 participants; however, 13 potential participants met the inclusion criteria for the study and participated in the study. The two participants who did not meet the criteria for the study had not resided in the United States for at least two years. Creswell, (2013) recommends that a phenomenological study require at least 10 participants in order to make assertions regarding the phenomenon of interest. Patton, (2002) posits that in a qualitative approach to a study, there are no set rules guiding the sample size needed for a study; and that the sample size for a particular study depends on the in-depth and richness of information that can be obtained to satisfy what a researcher intends to find out, why the researcher needs the information, how the findings will be used, what information is credible, the resources available for the study, as well as the time frame permitted by the study. Thus, the data I collected from the 13 study participants in this qualitative approach to the study reached saturation and continued collection of fresh data would not spark new insight or reveal new properties (Creswell, 2014).

This chapter will list the research questions, the setting of the study, the demographics of the study participants; and how the data were collected and analyzed. The results of the study are also being discussed in this chapter.

Research Questions

This study was designed to answer the following research questions based on the participants' responses to the 18 interview questions:

1. How and to what extent has living as an immigrant affected the self-understanding of health/health care for older Nigerian immigrants?
2. How do study participants interpret their immigration experiences?
3. How does culture in the United States influence the participants' interpretation of their migration experiences?
4. What implications do the meanings of the lived experience of the migrants in this study present for health care delivery in the United States?

Setting of the Study

This study took place in the Bronx, New York City. It has been documented in the earlier chapters that Nigerians decide to leave their original country and come to settle in the United States for various reasons, which included the desire for Western education, higher pay wages, job security, opportunity for career advancement, access to better health and technologies, political and economic instability, hardships and sociopolitical reasons. Migrants are also attracted to a particular setting by various factors, which directly and indirectly influence their migration experiences and coping skills. Such factors include but are not limited to going into cities and towns where relatives and friends are already settled in, where immigration laws are not so strict on the migrants, where one can be better guided on adapting to the new environment, where medical care is not strictly limited to people who have medical insurance, and accommodation is made for emergency treatments. Some older Nigerian migrants live where their families need/want them to stay.

Migrants also settle in towns and cities with populations of other migrants with similar or the same cultures. In New York City for example, there are many African culture

stores that are licensed to import and sell African foods, making it possible for migrants to still enjoy the type of food they were already used to in their original country. This accessibility to African traditional dishes eased the adaptation and coping skills of migrants.

I arranged to meet with participants at a time convenient for them and at a convenient venue determined by the participants. I also explained to the participants that the venue convenient for them should be free of distraction. Although I suggested using a private room in a public library of their choice, and offered to provide tokens for their transportation, all participants declined the offer and opted to be interviewed in the privacy of their homes. They all believed that there is no privacy outside the confines of their homes. For the retirees, interviews were scheduled at times that other household members had gone to work. Participants residing with children were interviewed at the time the children were in school. Prescreening questionnaires to ensure compliance with inclusion criteria, explanations of the study, explanation of the voluntary nature of participation, and obtaining consent from participants were completed prior to the actual interview in order to minimize the time spent during the interview. Interviews lasted between 15 to 30 minutes.

Demographics of Study Participants

A participant's demographics are the background information of that participant that identifies his or her characteristics, and help in locating that participant in relation to the others (Paton, 2002). The eligibility criteria for this study required that participants were born in Nigeria, raised in Nigeria, and stayed in Nigeria to adulthood; the participant must be a Nigerian immigrant to the United States; the participant must be aged 65 to 80 years; must speak and write in the English language; the participant must have resided in the United States for at least two years, and must currently live in the Bronx county of New York City. In order to ensure that study participants met the inclusion criteria specified for the study, participants were asked to provide their demographic information such as their birth date,

current address, country of birth, language spoken, the Nigerian tribe they belonged to, how long they have lived in the United States, and date of migration. Average age of study participants was 70.3 years and their average length of stay in the United States is 3.8 years

Table 1

Demographic Characteristics of Study Participants (N =13)

Study participant	Age	Gender	Place of birth	Tribe in Nigeria	Length of stay in United States	Marital status
A	***80***	Female	Nigeria	Igbo	3	Married
B	***78***	Male	Nigeria	Igbo	7	Married
C	***70***	Female	Nigeria	Igbo	5	Married
D	**69**	Female	Nigeria	Housa	3	Married
E	**69**	Male	Nigeria	Housa	6	Divorced
F	**69**	Female	Nigeria	Igbo	4	Married
G	**68**	Female	Nigeria	Housa	3	Married
H	**68**	Male	Nigeria	Yoruba	2	Divorced
I	**70**	Male	Nigeria	Igbo	5	Married
J	***69***	Male	Nigeria	Yoruba	4	Married
K	**67**	Female	Nigeria	Yoruba	2	Married
L	***69***	Male	Nigeria	Igbo	3	Married
M	***68***	Female	Nigeria	Yoruba	2	Married

Data Collection

The data for this study were collected between April and August of 2019. I was the key instrument for data collection, which I accomplished by interviewing participants and audiotaping responses without relying on questionnaires and other instruments developed by another researcher (Creswell, 2014; Rubin & Babbie, 2011). A professional transcriber transcribed all interviews. I reviewed all transcripts against recorded interviews, and shared the transcripts with the respective interviewees to ensure accuracy of the data provided. By interviewing each participant, I was able to better capture each participant's migration experiences and how each person viewed the world. By interviewing each participant, I was able to enter each person's perspectives and experiences, and I recognized that the perspectives of others were meaningful, knowable, and could be made explicit. As a qualitative researcher, I sought to establish contextualization, interpretation and understanding of perspectives (Salazar, Crosby, & DiClemente, 2006)

Data collection started soon after Walden University IRB granted approval to precede, Approval No. 03-21-19-0298495. I contacted a Nigerian Community Organization for assistance and cooperation in conducting this research by helping to identify Nigerians, irrespective of gender that met the research inclusion criteria.

The contact information for all eligible participants was provided to me by this community organization upon official request in writing. I explained in the letter of request what my study was about, the eligibility criteria, and what I will use the information provided to me for. I also explained in the letter that the provision of the information being requested is strictly voluntary and they have the right to stop the interview at any time, and that all information provided was confidential. I provided my contact information to the organization as well as the individual participants for the purpose of facilitating communication. I explained the intention to audio record the interview to better capture the interview for accuracy. All information provided to me was coded and stored in a locked cabinet that was only accessible to me. All information obtained from study participants would be destroyed 5 years after the study was completed.

I used the contact information provided to reach out to the individuals referred via a letter and telephone call. I met with each interested participant and I introduced myself as a student carrying out a study on the migration experiences of older Nigeria adults aged 65-80 years old, and their interpretation of how their experiences impacted on their health. I provided the participants the opportunity to ask questions that would enable clarification of any concerns and be sufficiently informed about the study. The consent form was readable and communicated to each potential participant in a simple English language consistent with the reading and understanding level of the subject (Santelli, 2006).

Answering a research question does not depend on volume, but on the usefulness and richness of information collected. Since my research focused on older adult Nigerians in the

Bronx County of New York City, I figured that it would benefit my research to collect information from this group of people because the information they provide would be more useful than collecting large samples from other settings that would not benefit the study (Creswell, 2014).

Data were collected from 13 participants consisting of males and females selected from the three major tribes of Nigeria, who meet the eligibility criteria for the study.

I used the standardized open-ended interview approach to collect data. All participants were asked the same questions. Some individual experiences differed, and there were rooms for inconsistencies, which illuminate the study and provide more insight into the individual experiences and the study phenomenon (Patton, 2002). The use of standardized open-ended questions minimized variations in the questions asked the participants and limits flexibility in probing, and in relating interview to particular participants and circumstances. In recognition that participants' behaviors were influenced by their culture, the use of open-ended questions provided an opportunity for me to explore and make meanings of their view of the issues of concern. It also gave the participants the freedom to provide answers in an unstructured manner, thus expanding their discussions and providing an opportunity for me to better capture the essence of the study. By asking each participant the same questions, the responses provided by the participants were compared. Asking the same questions ensured that data was complete for each person on the subjects addressed in the interview.

Data Analysis

The analysis of my data started with verbatim transfer of the interview data into transcripts, checking the transcribed data against the audio-recorded interviews to ensure accuracy and quality. The data were imported into NVivo 12 plus version of Computer Assisted *Qualitative Data Analysis Software* (CAQDAS). This software denoted the data into groups for ease of management and analysis. Coding was done to reduce the data into

themes. The codes were condensed, interpreted and the presented in figures, tables, and/or discussion (Creswell, 2003).

Evidence of Trustworthiness

I conducted this research with strict adherence to the ethical standards demanded by the research. Having originated from the same cultural background as the participants I also encountered my own migration experiences which really impacted my personal values, beliefs and worldviews; However, I held my biases in suspension while conducting this research in order not to allow my personal beliefs and biases interfere with the interpretation of the data I collected from the study participants. I gave my study participants the opportunity to tell their stories the way they felt about it in order for me to capture the essence of their experiences with migration, and be able to understand their interpretation of how their experiences influence their health. The transcripts of each participant's interviews were clarified with the participant to ensure the accuracy of the transcript.

By interviewing 13 different participants using the same exact questions for each participant, I applied the principle of triangulation to collect my data. Each participant answered a particular question in a different perspective that could be compared from different points of view. Although this could lead to inconsistencies in findings, such inconsistencies could also illuminate and strengthen the study, and offer opportunities for deeper insight into the phenomenon of interest. I also checked the responses from the participants against evidence from literature to enable me corroborate what the interview respondents reported. I used questionnaire to screen the participants in order to ensure that each participant falls into the criteria described by the study.

Results of the Study

All transcribed data were imported into NVivo 12 plus version of Computer Assisted Qualitative Data Analysis Software. Through the thematic analysis of the information

gathered during the interview, which included going through the data and coding information that relate to the research questions, I was then able to generate three main themes that I used in answering the research questions.

Theme 1: Nigerian Health Culture

This theme described how Nigerians see and approach health issues in their original country. The data collected from this interview contained many references to Nigerian culture. The participants discussed how much they perceive the differences in culture in the United States versus Nigeria. According to a Participant:

> Nigeria is a country where you can walk into a pharmacy, buy drugs, even the prescription drugs, and you could get around to buy it over the counter, not prescribed, as if you were buying candy. Sometimes you became your own doctor. This could cause more problems to someone. So, coming here in the United States, I noticed that most drugs were prescription drugs; especially those ones t that have adverse effects, your doctors must prescribe. (Participant F)

The participants appreciate and miss their culture of respect for elders, which they think they did not get any respect from their grandchildren here in the United States, and they felt sad about it. Participant F also shared that:

> In my country, our children and grandchildren see you in the morning say good morning. In America, they will say hi, or call you by your name. Initially when I saw it I had goose bumps all over me. Because where I come from, you not only greet seniors, you prostrate when you are greeting them. And we appreciate all these a lot. And when your elders are talking, you don't talk back or argue. But here it is the opposite. (Participant F)

Another challenge to adjustment to the new country was based on food culture. This population of migrants misses the organic food grown in Nigeria. They thought the food

produced in Nigeria is better for them. Participant J shared that: "The food in America is different from the food in Nigeria because the food in Nigeria was more organic than the food in America."

Communal living is another challenge to adjustment in the United States. In Nigeria, extended family system was the norm. This system supported co-living among the extended family members in distinct communities under one governance. Members of such communities shared the same ideas, socialized with each other, and consulted one another for important decisions. Thus, communal living promoted mutual support, understanding, respect, security, and mental wellness. Participants did not enjoy communal living in the United States; subsequently, they felt isolated and not plugged into the community compared to when they were living their life in Nigeria. A Participant shared that:

> When I initially migrated to the United States, it was not easy for me to fit in. Every day was like just a struggle because here you didn't have relations. Even if you had relations, everybody was on their own, trying to make life meaningful, you know. So, the struggle was like, you really had to go out there and fend for yourself, you know. (Participant C)

Another Participant expressed that:

> Nigeria believes in extended family system, and respect for elders. In Nigeria also, there is interaction between neighbors. Nigerians also believe that it takes a village to raise a child. Here in America, we live in isolation and everybody minds his or her own business. (Participant B)

According to a Participant:

> We live communal life in Nigeria and people look out for each other's back. Here in the United States, you are on your own, even with your next-door neighbor, and one is

> a stranger in a foreign land. When you have problems in Nigeria you confide in families, friends and relatives. It is not like that here. (Participant C)

Theme 2: Change in Approach to Health

The respondents discussed and compared Nigerian and United States health approaches and culture many times. The migrant health experiences and cultural background guide their approach to health and health-seeking behavior. The participants discussed their perception of health before and after migrating to the United States, and how the migration experience affected their health. Participant A shared that: "I have better diagnosis and genuine medications in the United States. In Nigeria, I may not go to the doctor but do self-treatment. Sometimes they give wrong and fake medications in Nigeria." This participant also shared that: "My daughter helps me interpret my communication to the people because of differences in accent. Like when I go to see my doctor, my daughter is the one who explains my symptoms to them." Participant C shared that: "In Nigeria, there is self-medication and people do not usually go to the hospital." All participants expressed that the cold winter was too harsh on them. Another Participant shared:

> The only challenge I have was weather. Nothing more. The country is beautiful. I love everything here. The summer is good for me. And the style of living is very good, is very nice. Oh, the weather is not good for me at all. It's too cold. It makes me weak. And it's not good. Because we have no experience of this type in my country. So, it's too cold. I mean, it's not good to me. (Participant E)

Participant J expressed that: First of all, climate in America is different from the climate in Africa, where I come from." According to a Participant:

> The cold here is too much. So, because I have like three daughters here, one lives in Florida, another one in California. So, when the weather in New York is too cold, like in winter, I will go to the one in California to help out. I mean, the weather there is not

> as cold as the weather in New York. Then I come back after. In fact, I rotate because three of them need assistance. (Participant K)
>
> Another participant also expressed that:
>
> It is not easy at all. The Nigeria system of government, family life, and weather are totally different. In Nigeria, there is no snow, and I am not used to this harsh weather. The political system in Nigeria is corrupt; there is no freedom of speech there. Sometimes you work for the government and will not be paid. It is really frustrating." (Participant M)
>
> Participant L expressed that: "My greatest challenge is language and weather."

All the participants discussed having issues with access to health, like lack of insurance, out of pocket payment for doctors. They all talked about how they view Nigerian versus American Health culture. They discussed the health services available to them that they appreciate and think would influence their health and health-seeking behaviors. They compared both cultures and discussed their preferences. They discussed the activities available to them before and after migration, and how they feel these activities impacted on their health. Participant L shared that: "I had no access to health care. My children were paying out of pocket until they filed for me to have green card, then I was able to get Medicaid." Participant C expressed that: "I still have problem with the food. I still miss my Nigerian food." Participant B stated that: "The type of food that I was used to in Nigeria was not available I had to figure what to use as a substitute for a dough."

Theme 3: Aging Population

Many of the participants talked about their age as a reason for their health challenges. Participant B stated: "I am older now. I was in excellent health in Nigeria because I was younger then." Another Participant expressed depreciating in health due to age and weather:

> Well, like I said, the cold is worse on me as a result of aging. I think almost everybody; many people feel pains due to the cold over here by winter period. So sometimes I do feel pain too, like body pain with arthritis, body pain, waist pain, Arthritis pain. (Participant E)

Participant M stated that: "Age is the main factor. The harsh winter weather is unbearable. The bones are chilled here as a result of weather, my arthritis is worse."

Participant A stated that: "In Nigeria, I was very active and engage myself in so many activities in church and community. Here I only stay home caring for my grandchildren. I do not make my own money here."

Participant B stated: "In Nigeria, I was functioning very well. I was going to parties and I had less responsibilities. Here I stay indoors most of the time."

These participants linked the difference in their health status with their aging. In some cases, their social situation had rendered them with a decreased health status because they were so dependent on their children and lack other means of keeping themselves engaged. The premise here was that social engagement could result in an increase in health status. The respondents reported less socialization in the United States than when they were in Nigeria.

The above themes were aligned to the theoretical and conceptual framework of this study in order to answer each research questions.

The theoretical framework of this research was informed by the social constructivist approach to the qualitative study. This approach is based on the premise that human perceptions of things are shaped by cultural and linguistic constructs (Patton, 2002), The way people interpret things depends on their own experiences and background. It makes sense therefore, to assume that in order to understand the world in which people live, it is necessary to develop people's subjective meanings of their experiences towards the subject matter of this study (Creswell, 2013). The implication is that concepts, beliefs and ideas are better

understood through a process of discovery rather than organized into prescribed conceptual categories before a study begins (Lewis, 1996). The participants' lived experiences were obtained by interviewing participants who have had such experiences. My interview therefore, explored the subjective meanings of the participant's experiences, relying only on the views of study participants.

Thus, the social constructivism approach relies on the participants' experiences as they encounter a new environment. This study was guided by the core assumption that people form their own personal perceptions about their migration experiences and how their experiences impact on their health. Since the experiences encountered by people hold different meanings to different people, the perception of a participant's migration experiences on their health can only be described from the viewpoint of the migrant who is directly involved with an experience.

The conceptual framework of this study assumes that little is known about the migration process of this population of Nigerians under study, therefore it was necessary to explore and discover more about the topic (Course Media, 2010f).

Research Questions (RQs)

RQ1: How and to what extent has living as an immigrant affected the self-understanding of health/health care for older Nigerian immigrants?

Responses to the questions that spoke to the migrant's health culture in terms of the self-understanding of their health prior to their migration, and after settling to their new host country, provided the answer to the research question.

The migrants' self-understanding of health emphasizes self-medication and use of herbalists while they were in Nigeria. Participant I said: "Yeah. You see, where I come from, reliance on health care from the institutions is not a common thing, you know." Participant L

shared: “Sometimes, I am lazy going to the doctor and want to self-medicate because that is what I am used to.” Another participant expressed that:

> My culture in Nigeria, you know, believes in consulting a herbalist when sick. Sometimes we will want to consult the spiritual doctor for everything. And sometimes we just believe that illnesses don’t just happen; that somebody, maybe in the family is doing some things bad to you. Anything that happens, we want to consult a spiritual doctor. That’s what we call the oracle, you know. We want to consult the native doctor. (Participant F)

According to another Participant:

> In our culture, for instance, when you are sick, the first thing is to see a native doctor. They will tell you to go and take herbs. So, we are not used to going to hospital all the time. We do not even know the dosage of herbs we take. To be honest with you, at times it works so well, but not all the time. Because whichever sickness you complain of, they give you the same herbs. And because it’s our culture, we’ve been doing it over years. That’s how my parents and grandparents have been dealing with it. So, I grow up to follow the same suit. (Participant K)

Participant M said: “Self- medication was the norm while in Nigeria. We just go to the pharmacist/chemist to buy medication we think will work for us. We also used herbalist, traditional doctor for treatments. There was no proper diagnosis before treatment.” Some participants also expressed that the hospitals in Nigeria lack the needed infrastructure. Participant B also said: “In Nigeria, you do not even rush to hospital until you become so sick. In Nigeria, we don’t normally go for checkups, you know.”

Despite their culture of self-medication, some participants still acknowledge that self-medication is not good. According to participant A: “Nigeria culture believes in self-medication and assumptions. Now I know better and there is no room for self-medication and

improper diagnosis." This population now understands the need for an annual checkup, and they now acknowledge the importance of consulting a doctor at the first instance of their bodies not feeling well.

Another Participant shared:

> Like when we are sick in Nigeria, may be because of the culture, and because you don't even have all these things that you need in order to rush to the hospital, sometimes when we are sick we try to stay home for some time and see whether we're really sick before we go to hospital. Now I understand the need for proper diagnosis and treatment. (Participant A)

Some participants however, are still stuck to their original culture of self-medication. For instance, participant D still expressed the desire to self-medicate: "I still wish I can go to the chemist and self-medicate. Here, they give long appointments and things will be worse."

Most participants understood the importance of insurance in United States health context. The migrants appreciate the United States health infrastructure when compared with what they have in their original country. They appreciate the government support. They also appreciated preventative medicine (annual check-ups). A Participant expressed her preference for the United States medical system:

> Sometimes they have to write you and remind you that you have to come for mammogram, checkup, dental checkups, and the rest of them. In Nigeria, we don't normally go for checkups, you know. Here, because they call or send you letters to remind you. So, we go to the hospital. You do not wait until you are sick before going for a checkup. I prefer and am more in agreement with the system here. (Participant C)

Some participants argued that they were more active in Nigeria than in United States. These participants now understood that inactive lifestyle is not healthy. Participant L

expressed that: “Here in America, I stay home and watch TV and eat and be taken care of by my children. I have limited places go to. My children take me to the doctor when the need arises.” Participant M expressed having limited time in the United States for socialization: “Here in United States, I work every day with limited time for socialization. I work on weekends too. Here you stay on your own.”

Participant I expressed that: “Socializing was minimal in the United States because of helping my children and grandchildren with schoolwork, homework, and then having to go to work. Now I have to fend for myself to some degree.” Another Participant stated:

> In the United States, I took care of my children and grandchildren. I took them to school and brought them back home. And then I went to my job. I took care of more activities because we don’t have house help. So, I did the laundry–more chores. There were more house chores to do than when I was in Nigeria. (Participant G)

Some of the migrants talked about food quite a bit. They missed the type of food they were used to and they believed that lack of organic healthy food, availability of food that is not nutritious, and the stress associated with life in the United States affect their health. According to Participant D: “I had problems, adjusting to the American food. I still miss the organic Nigerian food. That is a major challenge.” Participant J stated: “The food in America is different from the food we ate in Africa. The food in Africa was more organic and healthier than the food in America.”

Another, Participant expressed:

> In Nigeria, we are used to organic food. In America, I eat mostly processed food. This has a great impact on my health because organic food is more natural, with fewer chemicals. Processed food has a lot of chemicals that may be detrimental to health. My social network is also limited in United States. I had a lot of relatives and friends in Nigeria who kept me company and assisted me in time of need. (Participant, B)

The above statements indicate that these participants now have self-awareness of health.

RQ2: How do study participants interpret their immigration experiences in context of their health?

The participants' responses to the research questions that asked about their challenges as they adjust to the host country; activities performed prior to migrating to the United States and after migration; questions that ask about their health status before and after migration and what they think attributed to the differences in health; questions that were asked about their functional status before and after migration, and how they think living as a migrant affected their health, provided the answers to the above research question. Most of the study participants interviewed identified that as they got older they became weaker and less active. One of the Participant stated:

> Here in America, I am much older. I do not have that much interest in going out. I am less active and I do not have the strength to do many things. There is less time for socialization here. There is language barrier too. (Participant A)

Participant H stated:

> "Now my health is no more excellent, because I'm 67 years old going to 68. I don't look my age. That's okay. But then, inside me I feel my age."

The participants argued that they lost their social network of friends and relatives they had in Nigeria as a result of migration. According to another participant:

> It was not easy, you know, to fit in. And every day is like just a struggle, you know. Because here you don't have relations. Even if you have relations, everybody is on his/her own, trying to make life meaningful, you know. So, the struggle is like, you really have to go out there and fend for yourself, you know. So, it was not easy. (Participant B)

Participant M identified that: “Here in United States, I work every day with limited time for socialization. I even work on weekends too. Here you stay on your own.”

Another Participant went further to say:

> Because when you come over here, you miss your childhood friends, your schoolmates. You miss your parents also and your relations. So it takes a lot of toll at the beginning. And although it does not go away completely, the effects lessen a lot. (Participant M)

Another Participant stated:

> One thing is fighting for acceptance. When I initially arrived to the United States, I lived in Alabama and most of the people around me had not seen black people from Africa before. When I talked, they laugh at me. They said they did not understand. They said I had a heavy accent. I also had problem understanding them too. If they spoke slowly and I listened carefully, I understood them. But communication was difficult then. Another challenge that I had was food. The type of food that I was used to in Nigeria was not available, and I had to figure what to use as a substitute for a dough. (Participant D)

All participants understood that socialization was important in relation to their mental health. Having had the opportunity to socialize and find community affiliation could have a positive effect on how they coped up with their health challenges as well. Most of these migrants stayed indoor most of the time and lack companionship. They understood that inactive lifestyle is not healthy.

Another health-related experience identified by most migrants was the type of food they eat in United States. They believed that the organic food they ate in their original country were healthier than the processed food they usually were exposed to in the United States. They were concerned about lack of availability of organic healthy food, availability of

food that was not nutritious, and the stress associated with life in the United States. All these showed that the migrant population showed self- awareness of health. Participant E expressed having too many challenges with adjusting to the host country: "I had so many challenges because since I came, my number one biggest challenge is the language due to differences in accent. When they spoke, I didn't fully understand. And when I spoke to them, they didn't fully understand me."

All the Participants spoke so much about the barrier in communicating with health care providers because of the differences in accent. The participants talked about how they were dependent on their children for accessing, and communicating their health needs to the providers. According to a Participant:

> Oh, there's a lot of differences between life in Nigeria and life in the United States. Even though there have been some improvements from the time I came, I faced challenges like my accent was difficult for people to understand me, so I had to say things over and over again. And you know, I felt judged. Some people had the perception that I was from the jungle you know, to the extent that I was asked questions like: do you live in houses or in the bush, in the forest? They asked me so many depressing questions. It's not until they started mixing up with me that they started realizing that I grew up in a place where I had shelter and stuff like that. That on itself impacted me so much that I had to spend more time trying to relate with people that came from the same background as me – you know. But over time when, I worked with people from United States, who were born in United States, things started opening up and got better. I got to know them more, and then they got to know me more from the work environment. (Participant I)

RQ3: How does culture in the United States influence the participants' interpretation of their migration experiences?

The premise of the question is to investigate the influence of United States culture on the interpretation of the participants' migration experiences. This question evokes the ideas that line up with comparing the Nigerian health culture and U. S. Health culture, and how each culture impact on their health. The questions from the interview protocol that asked about the participants background and how they grew up; the challenges they face in their host country, and how they deal with such challenges; the differences in culture and how they deal with the differences, how it feels to be far away from home; how the culture in the United States affected their health, all provide the answers to this research question.

All participants spoke about being more active in Nigeria and having a strong network of family and friends who provided them with strong social support. They were not happy to lose this Support System as they settle in the United States. A Participant shared that:

> Nigerians believes in extended family system, and a general believe in respect for elders. In Nigeria also, there is interaction between /amongst neighbors. Nigerians believe that it takes a village to raise a child. Here in the United States, we live in isolation and everybody minds his or her own business. (Participant H)

In terms of how overall culture influence the participants' interpretation of their migration experiences and challenges faced, most respondents spoke about not understanding what Americans speak. Participant K noted that she did not even understand her own grandchildren when they spoke. All participants complain about scarcity of the type of food they desire to eat, difficulty fitting into the new society, and fighting for acceptance. Participant M spoke about being laughed at when he spoke.

All respondents talked about the Lack of respect for elders, and the isolated life they are exposed to in the United States. They talked about community in Nigeria and how important they feel about the role they play in the community.

Participant K stated: “In Nigeria, we have more respect for elders. The men work and support their children. The women mainly stay home and care for the children and ensure they cook for the family. Here in the United States you share responsibilities.” This confirms the gender role and marginalization discussed in the earlier chapter.

This participant also stated that:

> In our Nigeria culture, for instance, when you are sick, the first thing is to see a native doctor. They will tell you to go and take herbs. So we are not used to going to hospital all the time. We do not even know the dosage of herbs we take. To be honest with you, at times it works so well, but not all the time. Because whichever sickness you complain of, they give you the same herbs. And because it’s our culture, we’ve been doing it over the years. Our parents, our grandparents, that’s how they’ve been dealing with it. So I grow up to follow suit. Coming to the United States, it is quite different. The culture here, when you are sick, you must go to hospital. They will examine you before giving you medication. I believe the American system is better and reliable more reliable. (Participant K)

Another participant, D shared that: “United States has better hospitals and medications. They even remind you to go for your appointments.”

Participant, J, stated: “I have better diagnosis and genuine medications here in the United States. In Nigeria, I may not go to the doctor but do self-treatment. Sometimes they give wrong and fake medications in Nigeria.” According to another Participant:

> Here in the United States, you have to go to hospital and be taken care of, you know. In the United States you have the health insurance, which you don’t have in Nigeria. And the insurance helps a lot. Also the hospitals in the United States are well equipped too. (Participant A)

A participant expressed experiencing better health in the United States:

> Oh, I attribute that to being in a developed country. It's quite different. You know, Nigeria is still developing. And some of the things we find here is not there, you know. Like the hospitals here are well equipped, just like I said. But in Nigeria it's not like that. And although we have doctors there, they might be trained, you know, but they do not have the facilities that help them do their job. (Participant E, personal communication, May 7, 2019)

During the interview, most participants talked about the change in their health attitudes after migration:

> Like when we were sick in Nigeria, maybe because of the culture, and because you don't even have all these things that you need in order to rush to the hospital, sometimes when you are sick you try to stay home for some time and see whether you're really sick before you go to hospital. Now I understand the need for proper diagnosis and treatment. (Participant J)

Participant M shared that: "Everybody knew that the United States and Nigeria do not have the same culture. In United States they live by the rule of law. But Nigeria is reckless at that. Participant G shared that adjusting in the United States was quite a bit tricky for her, knowing her Nigerian cultural values, coming from the northern part of Nigeria where most times the women are behind the scene." According to this participant:

> You hardly hear us speak. It is our husbands that go out. But coming here, I saw a different setting. Everybody has equal playing ground in terms of work, in terms of earning income. Here in the United States the bills keep coming every day in the mails. (Participant G)

The participant went further to share:

> Yeah, both countries have different cultures. First of all, back home in Nigeria, there – we don't have a coordinated structure. That is a country where you can walk into a

> pharmacy; buy drugs, even the prescription drugs as if you are buying candy, because sometimes you become your own doctor. And you know buying without prescription will create more problems for you. So coming here in the United States, I noticed that most drugs are prescription drugs, especially those ones that have adverse effects, your doctors must prescribe. They also monitor –not only monitoring – they also remind you through your mails, even sometimes calling your phone to remind you of your upcoming checkup. These go a long way, you know – nipping some illnesses in the bud before they spring up. (Participant G)

Participant J stated that the medical system was well structured in the United States and that one dare not just walk into a pharmacy to buy any drugs, especially the prescription drugs. "There are a lot of regulations and laws around them. And that has gone a long way to help me in particular because I used to abuse prescription drugs a lot."

While comparing the medical cultures of the two countries, a Participant stated:

> My culture in Nigeria, you know, we believe in herbalist. Sometimes we will want to consult the spiritual doctor for everything. And sometimes we even believe that illnesses don't just happen; that somebody, maybe in the family is doing some things to you. Anything that happens, you want to consult. That's what we call the oracle, you know. But here in the United States, all that has changed. When once you are sick, you are taken to the hospital and then the doctor sees you – and even after you are treated, you are given opportunity for regular checkups. I believe the United States way of treating people is better and has really changed my thinking. (Participant B)

Participant E shared that **"**Here in the United States I have health insurance. And I see my doctor often. More than when I was in Nigeria."

All respondents acknowledge the availability of good doctors and medicine in the United States, the availability of specialist care, and well-structured medical services.

However, some participants were constrained by money, lack of access to care through medical insurance. The participants also appreciated the custom of the doctors sending reminder notices to their patient to keep their appointment. The participants acknowledge and appreciate through the responses provided by them, the availability of health care services in United States, they emphasize on self-care, annual visits, and use of health insurance to access health.

RQ4: What implications do the meanings of the lived experience of the migrants in this study present for health care delivery in the United States?

Interviews with this population of migrants showed that they came into the host country with their original cultures, causing intermix of cultures in the host country that present adjustment challenges to the migrants themselves as well as the health care industry, in their health care delivery. In addition, migration also brought with it variety of new and old health problems that challenged the health care industry to think and act in the best appropriate way to effectively address the presenting issues, in order to achieve equity in health care delivery, and bridge cross-sectional divide.

Being a multicultural City, New York City is faced with the challenge of achieving health equity within another culture. For this reason, health care delivery should put into consideration the existence of individual differences while planning, implementing and evaluating health delivery and promotion. Adjustments to the challenges faced by migrants in this population of study hold lessons for health care system to call for philosophical commitment, cultural knowledge, human sensitivity, and open communication while administering care. It is therefore fundamental that health practitioners should learn to avoid over generalization in their practice guidelines, and be guided instead by the needs of each population and individual. The cultural background of a migrant should always be taken into consideration while providing care; and each migrant should be treated with dignity and

respect. Also, the different circumstances of each individual within the same culture should be put into consideration while delivering health care. Health care delivery and promotion should therefore, be from within the culture of the intended consumer, and in the spirit of participatory research. This implies that both practitioners and consumers of health care should work in collaboration with each other. Practitioners and consumers should be involved in self-study, co-learning, and mobilization. It is by having in-depth understanding of a targeted cultural group that health practitioners would understand their immigration patterns, cultural values and norms, health beliefs and practices. For example, the participants' responses to interview questions on their health challenges and adjustments would enable practitioners get a better picture of the participants' history and be guided by their specific needs in their health care delivery.

Coping with weather was a big concern for a lot of respondents. Participants complain about the United States weather being too harsh on them. Participant I stated: "My arthritis was worse." Participant A cited age and weather as a hindrance to adjusting to the United States. According to this participant: "Age and weather. Well, like I said, the cold. I think almost everybody; many people feel pains due to the cold over here by winter period. So sometimes I do feel pain, like body pain with the Arthritis." Participant F stated: "Oh, the weather is not good for me at all. It's too cold. It makes me weak. We do have no experience of this in my country. So it's too cold. I mean, it's not good – to me." When participants share their experiences with the practitioner, a more appropriate guide will be used to address the participants' concerns. When practitioners are culture competent, they are more likely to address issues effectively.

A participant shared that the main thing that affected his health over the years was the climate in United States.

> In the United States, you have four seasons. You have the winter, you have the summer, and you have the fall and the spring. So with these changes in weather there are changes in temperature. And I have found that I have become more susceptible to being ill during the wintertime with the flu. And in the summertime sometimes it gets hot and humid, in the sense that, when it gets hot and humid, I find that my appetite is compromised. I eat less during the summer. I eat more during the winter, for some reason unbeknownst to me. But I see that I've had some issues with illnesses such as the flu, especially during the wintertime. And the changes in the weather and temperature negatively impact my health in dry season. And these seasons didn't have many changes in temperature. But in these fluctuations in temperature affect my health in a negative way. (Participant K)

Another participant, J also shared his health had been compromised by the fluctuation in the climate here in America and that his body sometimes struggled to adjust to these fluctuations in Temperatures. "I find that I have a lot of sinus problems. The flu comes and goes. I would say that my health has been compromised not severely, but to some extent, since my migration to the United States".

Health care delivery for this population should consider encouraging this population to always dress warm at winter times, and also to limit their exposures to the fluctuating weather as much as they can. Efforts could be made to ensure that the homes of this elderly population have enough heating during the winter. This can be achieved by subsidizing the cost of heating to the population in order to encourage them. This population should also be provided with transportation to enable them keep their medical appointments and yet, minimize exposure to harsh weather. Nursing care visits to the home of this population should also be encouraged during bad weather. This population should be educated on preventive care, such as encouraging them to take Flu Shots prior to commencement of the

winter season. In recognition that New York City has extremes of weather, this population should also be encouraged to use air conditioners when the weather permits its use and to drink a lot of fluids during summer to reduce excessive heat and risk of dehydration. Another participant expressed concern for language barrier

> My daughter helps me interpret my communication to the medical providers. Like when I go to see my doctor, my daughter is the one who explains my symptoms to them. During the winter season, I hardly go out. The food we eat here is different from what we eat in Nigeria. (Participant C)

Knowledge of language barriers would alert practitioners to use translation services to communicate with participants and not assume that everybody understands English. If health consumers are more comfortable using their children to do the interpretation, they should be encouraged to do so. I recommend educating migrants with Basic English skills and concepts in order to enhance their communication skills as well as help them socialize and build community ties. Having such skills and concepts will definitely help them have a feeling of belonging and be part of community they live in. This also will improve their mental health status because they now have the ability to openly communicate with anyone. Participant K reported learning Spanish language to enable her interact better with her church members. Others can be encouraged to do the same if their situation permits them to do so.

All participants pointed that they have to be careful about their health as they age. Eleven out of 13 respondents did not use any services while adjusting to United States. Migrants should be encouraged to participate in community activities being offered in their neighborhoods, such as attending the senior centers and recreation centers to socialize with peers. A Participant complained, about the hospital bill in the United States being too much:

> My daughter takes me to the doctor. The bill is too much, so I'm dealing with the toothache. It's paining me. But my daughter is still saving money to pay for me to see

> the doctor. So it will be fine if there is a way they will include people like me that come and stays in the health insurance program. At the moment I do not have insurance and that would be of help. (Participant J)

Providing medical insurance coverage or subsidizing their coverage will encourage this population to seek proper health care and discourage their tendency to self-medicate. Reducing long appointments and waiting times for medical appointments will discourage self-medication and reluctance in seeking prompt care.

Out of the 13 participants, 10 spoke about missing the organic food in Nigeria.

> I am older now. I was in excellent health in Nigeria not only because of my current age, but because I was eating organic food in Nigeria. Here in America, most of their food is processed. Also the winter here is very harsh on me. I always get sick during the season. (Participant B, personal communication, April 22, 2019)

It is well documented that migrants' behavioral patterns is rooted in their culture. However, migrants' behavior patterns could be influenced by knowledge and awareness. Knowledge and awareness could be instilled in these migrants by providing them health education. Education can influence them to dispel some primitive beliefs. Nutrition education can make migrants get used to the food available in the United States. Since most participants, complained of being deprived the opportunity to bring in certain food they are used to. A change to the in policy that give the migrants the right to import certain foods from their country will help in alleviating this situation. In addition, the government could grant license to grocery stores that are interested, to import ethnic foods to better suit the needs of the migrants.

Summary

This study described the lived experiences of 13 participants who met the eligibility criteria described by the study. The research was informed by the Social Constructivism

Approach, which relies on the participants' experiences as they encounter a new environment. The conceptual framework of this study assumed that little is known about older Nigeria migrants' (aged 65 -80) perception of how their migration experience impacts their health, and well-being. This research was conducted with strict adherence to the ethical standards demanded by the research. In this chapter, I identified the research questions, the setting of the study, the demographics of the study participants; how data is collected and analyzed, evidence of trustworthiness, and how the research questions were answered. The results and summary of the study was also discussed in this chapter. The findings from the interview were described under three themes, which were aligned to the theoretical and conceptual framework of this study in order to answer each research questions. Through this study, I provided insight into how the participants feel their health is impacted by their lived experiences as migrants to the United States.

In Chapter 5, I will describe the relationship of this study with the theoretical and conceptual framework; discuss the study implications, limitations as well as make recommendations for improvising the health of migrants, and also make recommendations for further studies.

Chapter 5. Discussion, Conclusions, and Recommendations

Introduction

This study explored the meanings that older Nigerian migrants (aged 65 -80) place on their migration experiences; and how they relate these meanings to their health and well-being. The study has its foundation on social constructivism, where learning is approached based on a participant's subjective views of their experiences (Creswell, 2013). The conceptual framework of this study assumed that little was known about the migration experiences of the study population. By interviewing 13 participants, I was able to learn about their background and culture, which influenced their health and health-seeking behaviors. In this final chapter, I presented the key findings of this research, interpreted and reflected on the findings, discussed the limitations, and provided recommendations. I also discussed the implications of the study for future research.

Key Findings

The findings from this research were in consistent with the assumptions that culture and people's subjective experiences play important roles in their health and health-seeking behaviors. The study also supported the role of knowledge in changing the behavioral patterns of individuals. The interviews with this population revealed the challenges that the migrants faced as they adjusted to the new country, and the ways these challenges affected their health and health-seeking behavior. The participants spoke so much about the harsh weather in New York City, missing their culture of self-medication, missing the organic food they were used to eating in Africa, the language barrier, limited access to health care due to lack of medical coverage, difficulties associated with aging and loss of their social network of friends and family.

Despite these complaints, the participants still appreciated United States health care and recognized the danger of self-medication. They recognized and appreciated the

importance of being active, and the role that activities play in their health. The participants' appreciation of the United States health culture showed that they have health awareness and that they were willing to welcome change.

With this population, participants migrated to the United States for different reasons. Some respondents mentioned having more than one reason for migrating into the United States.

Table 2

Reasons for Migration

Reasons for migrating	Number of respondents
Health issues	1
Political instability	5
Move closer to family	6
Economic opportunities	8

According to Table 2, and based on the responses of the participants, only one participant cited health issues as the reason for migrating to the United States. According to Participant F: "Medically, my husband and I were not getting better after all our children left to the United States. I wasn't getting the best medical care so; my husband and I decided to quickly join our children in 2014." Five participants mentioned political instability in their own country as one reason for migrating to the United States. According to this Participant:

> I had to move to the United States due to the political instability in Nigeria. My husband lived in the United States at the time I got married to him. After our marriage, we decided to keep two homes and to raise the children around our cultural values. But when things became unbearable I joined him. My children, the eldest moved long before I did, followed by the younger ones. And then I had to move when there was a lot of discrimination in my job. The security situation was also being threatened. (Participant F)

Another Participant shared that:

> I came to further my education. Yeah, because in Nigeria the school system is not all that good. – It's better in the United States. In Nigeria, it took longer to graduate because of the problems, so many problems. Schools were always going on strike. I just wanted to get it over with. A degree that would take me four years to earn in the United States would take me like eight years to earn in Nigeria. So, I decided to come here. (Participant M)

Participant I expressed: "Well, the intention was to come here, to further my education. And on furthering my education, I also wanted to – at the end of furthering my education – to go back home and impact on my community." Another Participant stated that:

> I came to the United States for the sole purpose of attending college. There were colleges in Nigeria, but I decided not to go to university in Nigeria because I wanted to visit other parts of the world. Another reason was that most of my friends from high school back home also migrated abroad to Europe and United States to go to school. So, because of that, I didn't want to be stuck in Nigeria. I wanted to see other cultures. I wanted to see the world. So, I decided, with the blessing of my father, to migrate to United States to go to the university. (Participant J)

These participants believed that United States education yields better economic value.

Six participants mentioned the desire to be closer to their family as one reason for migrating to the United States. According to a participant:

> I migrated to the United States just because I have been hearing about United States. I love the country and my children happened to be here. They invited me to come and stay with them. I was here on vacation. I was here on holiday and after that I made up my mind to come over. I migrated to the United States in 2005. (Participant E)

Participant G stated: “My husband was over here, and I had to join my husband with my children too.” Participant K stated: “I came because my daughter wants me to come and help her take care of my grandchildren. Since I was retired in Nigeria I came to help out.” Another Participant stated:

> I came to United States to be with my children upon their request. I was living by my myself in Nigeria and no body to care for me or keep me company as my wife already passed, and all my children are in the United States.” (Participant L)

Eight participants mentioned that one reason why they migrated to the United States was as a result of the economic opportunities afforded by United States. This reason is the most common reason given by the participants for migration into the host country. Participant A expressed coming into the United States to be with her children as the economy in Nigeria was bad. Another participant stated that:

> “The economy in Nigeria was getting worse and worse that I could not make ends meet. It was difficult for me to maintain my family, both immediate and extended, and to take care of my elderly parents, there was no job. I decided to leave and look for a way to survive. (Participant B)

Another Participant shared that:

> “I decided to move to the United States because I wanted to give my children better life, and to be there for them, and provide guidance to them as they grow to adulthood. I went back to Nigeria after I had my first child. I stayed and thought in Nigeria for a while, had some more children in Nigeria, then came back with all the children to settle in the United States for good.” (Participant C)

Participant H stated:

> Two things that made me to migrate. One, that name America; and secondly, there was the notion back home in Nigeria that people who studied in America do very

well. Because they have good education system in America, in. So those two factors led me to come.

Participant B stated: “The economy in Nigeria was getting worse and worse that I could not make ends meet. It was difficult for me to maintain my family, both immediate and extended, way to survive.” The second most common was the desire to be closer to family. Participant A simply stated: “I came to be with my children.” Participant E stated: “I migrated to the United States just because my children happened to be here.”

These discoveries from the interviews supported and corroborated the findings from the literature that different forces drive migrants to leave their original country and settle in the new country.

Table 3

Perception of Health Status with Migration

Respondent	Health status before migrating	Health status present	Change in health status
A	Good	Very Good	Positive
B	Excellent	Good	Negative
C	Good	Very Good	Positive
D	Good	Very Good	Positive
E	Very Good	Very Good	No Change
F	Good	Good	No Change
G	Good	Excellent	Positive
H	Excellent	Not Excellent	Negative
I	Good	Fair	No Change
J	Very Good	Good	Negative
K	Good	Very Good	Positive
L	Good	Good	No Change
M	Very Good	Good	Negative

Five respondents reported a positive change from their health status prior to migrating to the United States. According to literature, the transitory nature of the health of immigrant can be attributed to culture-based healthier lifestyles and stronger social bonds and support they enjoyed in the country of origin that initially exert a protective effect on immigrants’

health. Four respondents reported no change in their health status, while four reported a negative change in health status after migrating. Literature indicated that migration challenged subject migrants to vulnerability to certain communicable diseases, occupational health hazards, injuries, and poor mental health.

Table 4

Self-Reported Health Status Change Due to Migration

Health Status change with migration	Number of respondents	Percentage Change
Positive	5	38%
Negative	4	31%
No Change	4	31%

Prior to migration, the migrants did not have any basis for comparing the two health systems. However, once they experienced the United States health system they were able to compare and showed their preference for the health system of the United States. Another Participant shared that:

> In Nigeria, from time to time, I was always sick due to mosquito bites. We have a lot of mosquito in Nigeria because there is no drainage. So, once it rains, mosquito breeds. Then the pollution, and the environment were not even friendly. Yes. In Nigeria, it's like every two weeks I get sick with malaria, because as you are treating, another mosquito will bite you. Every time it was always malaria. I have not had any Malaria since I settled here in the United States. (Participant K)

More Participants reported having better health status with migration. This suggests that migration influenced this population of migrants to be more aware of their health. Migration also exposed most migrants to have better attitudes and behaviors towards health. This population of migrants showing improved health status may have adjusted well to the United States. The minority of the respondents found it more difficult to adapt to the culture of the United States. This population of migrants needed more education to help them dispel

some of their superstitious beliefs that block their approach to health. This should be approached with respect while recognizing the existence of individual differences. By interacting with these participants, I was able to discover their various and specific problems and issues that interfered with or molded their beliefs, ideas, and behaviors. This spoke to the recognition that every individual had unique characteristics, and that each individual saw the world differently based on the experiences and culture they were exposed to. It is therefore necessary that practitioners and programs should not overgeneralize but deal with each person based on the person's needs. For example, participant L expressed that: "My greatest challenge is language and weather. I also had no access to health care. My children were paying out of pocket until they filed for me to have green card, then I was able to get Medicaid." It is only by interacting with people that the people's needs are discovered, and the most suitable way of meeting such needs devised. A health care practitioner who discovers the need of interpreter services would then use the services while dealing with the patient.

The study also brought to light the role knowledge plays in changing the health behavioral patterns of individuals. Self-medication was the norm amongst this population of Nigerians migrants under study. By interacting with these migrants and discovering this unacceptable and destructive habit they have based on their culture, practitioners will better help the migrants through health education.

Sample Analytical/Graphical Output

The following analytical output was developed based on the interviews.

Figure1. Word cloud: Health-seeking behavior.

A word cloud or word frequency was generated from the interview regarding the participants' health-seeking behavior.

In figure 1, the most frequently occurring words in the node, health-seeking behavior, were coded from respondent interviews. The words hospital, better, healthy, cultures were the prominent words used by respondents. Alongside were insurance, money, and diagnosis. This graphic shows that respondents were thinking about a culture of health behavior where they access hospitals and were healthy; but they also echoed issues of money, and insurance.

More male than female respondents complained about socialization and community as presenting barriers to adjusting to the host country. This could be attributed to the Nigerian culture, where men socialized more than women due to gender role and religion. It was therefore expected that the men would miss their social networks more than the women. Another Participant shared that:

> Oh, adjusting here was quite a bit tricky for me, knowing my family's cultural values and coming from the Northern part of Nigeria consisting of mainly Muslims. In the north, most times the women at the background. You don't, you hardly hear us speak.

> It is our husbands that go out. But coming here, I saw a different setting. Everybody has equal playing ground in terms of work, in terms of earning, income, everybody. And here in the United States the bills keep coming every day in the mails. Most times when you see the mails coming, you are not happy, because I knew my husband will come in, look at those mails and frown, you know. So, I needed to really start doing something to be able to bring my pennies to the table. (Participant F)

As mentioned in Chapter 1, the Nigerian society believed that men were the primary providers for every family while the women be totally submissive to the men and have the primary responsibility of rearing the children, cooking and feeding the family.

Study Implications to Practice and Policy

When people migrate they carry with them their knowledge, experiences and expressions of distress. However, in order to adapt well with the new environment, and have some degree of belonging, migrants would have to identify with the new culture they find themselves in (Bhugra, 2004). The coping mechanisms used by individuals would depend on their reasons for migration, whether or not the migrants prepared for the migration process, and the social support available to them (Bhugra, 2004). Veiel and Baumann (1992), posit that social support, which is an abstract characteristic of persons, behaviors, relationships, or social system, provide an environment that compensate for environmental stress. Migration brought with it the existence of multicultural settings that posed some challenges and implications to the study participants and health practitioners. Practitioners should therefore, not overgeneralize in their approach to health care delivery; rather, they should approach health within the cultures of the intended consumers. Health care practitioners should be aware of the differences and limitations of each individual health consumer in their approaches to health care and delivery. This calls for cultural awareness and competence, and collaboration amongst people. Practitioners should therefore deliver health with moral and

ethical conduct, applying the highest level of professional competence, honesty, respect, and confidentiality. The experiences of migration posed big challenges to health practitioners who are subsequently compelled to seek to be more culturally competent and sensitive, always working towards improving and increasing their abilities to work with a different culture (Kline & Huff, 2007).

Practitioners would be faced with the task of educating these consumers with respect and understanding, to dispel some of their superstitious beliefs that block their attitudes towards health. The consumers of health care should be educated on the need for proper diagnosis prior to dispensation of medications. Practitioners should also offer Nutrition Education, which would seek to ask the participants to dispel their belief that only organic food from Nigeria is good for their health. They should be made to understand that there is also organic food in United States and that they should seek to obtain a balanced diet instead. Advocating for changes in the attitude of the participants towards their health-seeking behavior would make a positive impact on the health of the population that could lead to the development of policies that would improve the migrant experiences.

While educating this population of people, practitioners should be attentive to the views of the target population. In recognition that the differences in culture could bring about conflict in health care and health care delivery, practitioners should always strive to improve their communication skills and at the same time be patient and persistent. In addition, practitioners should be mindful of the fact that changing one's health behavior is not easy and requires the acceptance of the need for change, motivation, commitment to the change, and a guided, sustained effort (Kline & Huff, 2007).

Participants in this study demonstrated their appreciation for a culture of health behavior where they access hospitals and health care services. However, they also echoed issues of money, and insurance that limits their access to health. Providing medical insurance

coverage or subsidizing their coverage would encourage this population to seek proper health care and discourage their tendency to self-medicate. Some participants complain that long waiting time for medical appointment discourage them from seeking care and reverting to self-medication. Health care practitioners should therefore, devise means of reducing long appointments and waiting times for medical appointments. This will discourage self-medication and reluctance in seeking prompt care.

The participants complained about the effect of weather on their health. Nigeria has tropical climate with no cold winter seasons. Since they were not used to weather fluctuations while in Nigeria, they easily fell victim of illnesses associated with weather fluctuations. Health care delivery for this population should consider educating and encouraging this population to always dress warm during winter times, and also to limit their exposures to the fluctuating weather as much as they can. Efforts should be made to ensure that the homes of this elderly population get enough heating during the winter. This can be achieved by subsidizing the cost of heating for the population. This population should also be provided with transportation to enable them keep their medical appointments and minimize exposure to the harsh cold weather. Nursing care visits to the homes of this population should also be encouraged during bad weather. This population should be educated on preventive care, such as encouraging them to take Flu Shots prior to commencement of the winter cold season. In recognition that New York City has extremes of weather, this population should also be encouraged to use air conditioners when the weather permits its use during hot seasons, drink a lot of fluids during summer to reduce excessive heat and risk of dehydration, and to always dress warm during winter.

Language barrier was another challenge that this population faced. The participants complained of the differences in accents, which obstructed their abilities to process the American English. Practitioners working with this group of people should use translation

services to communicate with participants and not assume that everybody understood what they speak. If the health care participants /consumers were more comfortable using their children for translation, they should be encouraged to do so. Participants could also be provided with the opportunity to learn other languages that could enhance their communication skills as well as help them socialize and build community ties. This could also help them have a feeling of belonging, and improve their mental health status,

In terms of policy implications, since this population of migrants valued and echoed communal living and respect for elders, providing opportunity for the population to connect to each other will surely enhance their well-being. Such could be in form of creating recreation centers where migrants could meet and interact with each other. Having the opportunity to socialize and find community affiliation would have a positive effect on how they cope up with their health challenges as well. Most of these migrants stayed indoors most of the time and lacked companionship. They understood that inactive lifestyle was not healthy.

Some of these participants also complained of being deprived the opportunity to bring in certain food they were used to. A change to the government policy regarding the restriction in food importation could alleviate this concern. In addition, merchants who are interested in the importation of Nigerian food should be encouraged by providing them licenses that would enable them import such food and make the foods available to the migrant population.

Participants also pointed that they had to be careful about their health as they age. Most respondents did not use any services while adjusting in United States. Participants would be encouraged to participate in community activities being offered in their neighborhoods, such as attending the senior centers and recreation centers to socialize with peers.

Implementation of the recommendations mentioned above would surely help the target population adapt to the host country, improve their general heath, bridge health disparities, and create positive social change for the migrant population.

Study Limitations

Although these participants expressed vividly their cultural beliefs and the challenges they encountered as they adjust to the host country, however, the findings from this study cannot be generalized to other populations. This study relied on the subjective experiences of the participants, therefore cannot be generalized to the public. The study used only participants that lived in the Bronx, in New York City, which limited the participants' exposure to other experiences that would have been important to this study. Nigeria is a country with about 440 ethnic groups with various cultures, the most populous and politically influential being Hausa, Yoruba, and Igbo. These three major ethnic groups make up 66% of the Nigerian population (Ogbaa, 2003). Although the participants of this study come from the three major ethnic groups, there was no even distribution of the ethnic groups used for this research. Also, the age criterion for this study was 65-80 years old; however, only one participant attained the age of 80. The implication of the above shortcoming was that this study could even be generalized to Nigerians.

I, the researcher, being a member of one of the major ethnic groups in Nigeria; and attending common social function with the participants suggested that the researcher and some study participants could have pre-established relationship. This relationship could make the study participants uncomfortable in expressing their sincere beliefs and experiences, and introduce bias to the study. I alleviated this concern by assuring the participants that there were no right or wrong answers to any questions. Some of the participants knew me as a Child Protective Specialist Supervisor. This could also provoke a suspicion that the answers provided by the participants would be used to judge their relationship with their minor

children and grandchildren, and trigger the fear of having their children removed from their care as a result of the answers they provided. I assured the study participants that in the context of this study, I was not acting in the capacity of a Child Protective Specialist Supervisor and this helped to dissipate this suspicion.

Recommendations/Social Change Implication

The findings from this research would benefit the migrant population by creating awareness to the health care systems/industry of the complexity of explaining health and diseases. By recognizing the influence of culture on migrant health-related beliefs and behavior, understanding and appreciating the differences in health beliefs and behavior, the practitioners would be able to identify the specific health needs of the migrants and approach health care delivery in the context of a migrant's culture. In order to help migrants overcome the challenges they face while adjusting to their host country, practitioners should seek to use strategies that have been demonstrated to be effective in overcoming migrant barriers. Such strategies would include but not limited to explaining the Western concepts of health, disease prevention and treatment in terms that are culturally relevant to the migrants. The materials used in educating this group of migrants should be culturally appropriate, and health educators should be well-trained, bi-lingual staff. The health of this population would be improved if their access to health and healthcare should be improved. Also, when the migrants are educated to the extent of dispelling their negative attitudes towards health, their health would improve and they would be functional members of the society they belong to. Thus, the gap in health disparities would close.

Dissemination of the results of this research to practitioners and key stakeholders in health care delivery system should guide the planning, design and implementation of programs that would benefit the migrants in adjusting to United States.

Although the qualitative method of inquiry was relatively inexpensive and could not demand expensive staff and equipment; however, it has the disadvantage of not yielding precise statistical statements about a population. Generalization was made difficult because the subjective nature of qualitative research made it almost impossible for two researchers to arrive at same conclusions (Rubin & Babbie, 2011). In view of the above limitations, I would recommend that further research be done on this phenomenon using a different theoretical framework, using a different approach, and expanding the population of participants beyond the Bronx County of New York City, to strengthen, confirm or disprove these research findings. The use of quantitative research for further studies on my topic of dissertation would encourage the generalization of the result of the research to other population of migrants.

Conclusion

Bridging the health divide across cultures must be within the target culture that needs to benefit from the intervention, but requires collaboration between the target population and the practitioners administering the intervention, in the spirit of participatory research (Kline & Huff, 2007). This approach should start with assessing the needs of the target population, which is fundamental to promoting sense of ownership among the target population and foster active learning.

References

Adepoju, Joseph A, 2012). A Study of Health Beliefs and Practices of Yoruba. *Journal of Cultural Diversity*, 19(2), 36-43. Retrieved from https://search-proquest

Adeosun II, Adegbohun AA, Adewumi TAal. The pathways to the first contact with mental health services among patients with schizophrenia in Lagos, Nigeria. 2013;2013:769161. Epub 2013 Dec 31.

Adewuya, Abiodun, F.W.A.C.P., F.M.C.Psych, & Makanjuola, Roger, F.W.A.C.P., PhD. (2009). Preferred treatment for mental illness among southwestern Nigerians. *Psychiatric Services*, 60(1), 121-4. Retrieved from https://search-Proquest-com.ezp.waldenulibrary.org/DocView/213103925?accountid=14872

Aghukwa, C. N. (2012). Care seeking and beliefs about the cause of mental illness among Nigerian psychiatric patients and their families. *Psychiatric Services*, 63(6), 616-8. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/1370133394?accountid=14872

Akinlua, J. T., Meakin, R., & Freemantle, N. (2017). Beliefs about hypertension among Nigerian immigrants to the United Kingdom: A qualitative study. *PLoS One*, 12(7) [make sure there is a period before any DOI number] http://dx.doi.org.ezp.waldenulibrary.org/10.1371/journal.pone.0181909

Anderson , G.F., & Knickman, J.R. (2008). Chronic Care. In A.R.Kovner, J.R.Knickman (Eds.). *Health Care Delivery in the United States* (pp. 221-238). Springer Publishing Company

Angel, R., Angel, J., Díaz Venegas, C., & Bonazzo, C. (2010). Shorter stay, longer life: Age at migration and mortality among the older Mexican-origin population. *Journal of Aging & Health*, 22(7), 914-931.

Batalova J, Terrazas A, [Internet] Migration information source. Washington (DC): 2015.

[2015 May 1]. Frequently requested statistics on immigrants and immigration in the United States. Available from

Bhugra D. Acculturation, cultural identity and mental health. In D. Bhugra , R. Cochrane (Eds.) Psychiatry in Multicultural Britain. London: Gaskell, 2001; 112–36

Bhugra, Dinesh. (2004). Migration, Distress and Cultural Identity. British Medical Bulletin (2004) 69 (1): 129-141. DOI:10.1093/bmb/ldh007.

Bentley, J. A., Thoburn, J. W., Stewart, D. G., & Boynton, L. D. (2012). Post migration Stress as a Moderator Between Traumatic Exposure and Self-Reported Mental Health Symptoms in a Sample of Somali Refugees.

Bodvarsson ÖB, Van den Berg H. *The economics of international migration: Theory and policy*. Springer; New York: 2009.

Borovoy, A. & Hine, J. (2008) managing the unmanageable: elderly Russian Jewish émigrés and the biomedical culture of diabetes care. Medical Anthropology Quarterly, 22 (1), 1–26.

Bos V, Kunst A.E, Keij-Deerenberg I.M, Garssen J, Mackenbach JP: Ethnic inequalities in age- and cause-specific mortality in The Netherlands. Int J Epidemiol 2004, 33:1112–1119.

Bryant, C.A. (2010). Community-based approaches to health promotion. In J. Coreil (Ed.), *Social and Behavioral Foundations of Public Health* (pp. 273-289). City, State: SAGE Publications, Inc.

Cantor-Graae, E. et al. 2003. Migration as a risk factor for schizophrenia: a Danish population-based cohort study. British Journal of Psychiatry, 182, 117 -122.

Cavazos-Rehg PA, Zayas LH, Spitznagel EL. Legal status, emotional well-being and subjective health status of Latino immigrants, 2007. J Natl Med Assoc.; 99:1126–1131.

Chiswick, B., & Miller, P. (1995). The endogeneity between language and earnings: International analyses. Journal of Labor Economics, 13, 246–288.

Citizenship and Immigration Canada (2010) Canada facts and figures: immigrant overview permanent and temporary residents 2009. Ottawa, Ontario, Canada.

Cohen, S., & Wills, T. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98, 310–357.

Coreil, J. (2010). The Social Environment and Health. In J. Coreil (Ed.), Social and *Behavioral Foundations of Public Health* (pp.109-126). City, State: Sage Publications Inc.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (pp. 3-21). Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J. W. (2013). *Qualitative inquiry and research design choosing among five approaches*. Thousand Oaks, CA: Sage Publications Inc.

Dalgard, O. S. & Thapa, S. B. (2007). Immigration, social integration and mental health in Norway, with focus on gender differences. Clinical Practice and Epidemiology in Mental Health, 3, 24.

Dean, J.A, & Kathi, W. (2010). "My health has improved because I always have everything I need here": A qualitative exploration of health improvement and decline among immigrants. Retrieved from www.elsevier.com/locate/socscimed

Department of Homeland Security (2011) 2010 Yearbook of Immigration Statistics. Department of Homeland Security, Office of Immigration Statistics, Washington, DC.

Eitinger, L., (1960). The symptomatology of mental disease among refugees in Norway. Journal of Mental Science, 106, 947 -966.

Eitinger, L. & Grunfeld, B., (1966). Psychoses among refugees in Norway. Acta Psychiatrica Scandinavica, 42, 315 -328

Felipe, G.C., Hector, B., & Marya, C. (2007). *Health Promotion in Latino Populations*. In M.V.Kline & R.M.Huff (Eds.) *Health Promotion in Multicultural Populations* (pp222-253). SAGE Puplication, Inc.

Fleming, P. J., Villa‐Torres, L., Taboada, A., Richards, C., & Barrington, C. (2017). Marginalisation, discrimination and the health of Latino immigrant day labourers in a central North Carolina community. *Health & Social Care In The Community*, 25(2), 527-537. DOI:10.1111/hsc.12338

Freeman, M., Baumann, A., Blythe, J., Fisher, A., & Akhtar-Danesh, N. (2012). Migration: a concept analysis from a nursing perspective. *Journal Of Advanced Nursing*, 68(5), 1176-1186. DOI:10.1111/j.1365-2648.2011.05858.x

Gathmann, C. (2008). Effects of enforcement on illegal markets: Evidence from migrant smuggling along the southwestern border. Journal of Public Economics, 92, 1926–1941.

Goldsteen, R.L., Goldsteen, K., & Graham, D.G. (2011). *Introduction to Public Health*. Springer Publishing Company.

Gong F, Xu J, Fujishiro K, Takeuchi D. (2011). A life course perspective on migration and mental health among Asian immigrants: The role of human agency. *Social Science & Medicine* [serial online]. Dec. 2011; 73(11): 1618-1626 9p. DOI: 10.1016/j.socscimed.2011.09.014

Gülşen, C., Knipscheer, J., & Kleber, R. (2010) The impact of forced migration on mental health: A comparative study on posttraumatic stress among internally displaced and externally migrated Kurdish women. *Traumatology*, 16(4), 109116. doi.org/10.1177/1534765610388306

Guven, C., & Islam, A. (2015). Age at migration, language proficiency, and socioeconomic outcomes: evidence from Australia. *Demography*, 52(2), 513-542.

DOI:10.1007/s13524-015-0373-6

Hausmann-Stabile, C., & Guarnaccia, P. J. (2015). Clinical Encounters with Immigrants: What Matters for U.S. Psychiatrists. *Focus (American Psychiatric Publishing)*, 13(4), 409–418. Doi.org/10.1176/appi.focus.20150020

Hubbell, F.A. et al. (1995) From ethnography to intervention: developing a breast cancer control program for Latinas. Monographs National Cancer Institute, 18, 109–115.

Hyman, I., Vu, N., & Beiser, M. (2010), Post migration Stresses Among Southeast Asian Refugee Youth in Canada: A Research Note. *Journal of Comparative Family Studies*. Vol. 31, No. 2 pp. 281-293.

Ikwuka, U., Galbraith, N., Manktelow, K., Chen-Wilson, J., Oyebode, F., Muomah, R. C., & Igboaka, Anuli. (2016). Ideological vs. instrumental barriers to accessing formal mental health care in the developing world: Focus on south- eastern Nigeria. *Journal of Health Care for the Poor and Underserved*, 27(1), 157-175.

Im, E.O. & Meleis, A.I. (1999) A situation-specific theory of Korean immigrant women's menopausal transition. The Journal of Nursing Scholarship 31 (4), 333–338.

International Organization for Migration (2004). International Migration Law: Glossary on Migration. International Organization for Migration, Geneva.

International Organization for Migration (2005). World Migration 2005: Costs and Benefits of International Migration. International Organization for Migration, Geneva.

International Organization for Migration (2009). Facts and Figures Retrieved from http://www.iom.int/jahia/Jahia/about-migration/Facts-and-figures/lang/en on 14 June 2009.

Jackson, J.C. et al. (2000) Development of a cervical cancer control intervention program for Cambodian American women. Journal of Community Health, 25 (5), 359–375.

Kang, S., Howard, D., Kim, J., Payne, J. S., Wilton, L., Kim, W., & Maramba, D. (2010).

English language proficiency and lifetime mental health service utilization in a national representative sample of Asian Americans in the USA. Journal of Public Health, 32,431- 439.

Lam, J., Yip, T., & Gee, G. (2012). The physical and mental health effects of age immigration, age, and perceived difference in social status among first generation Asian Americans. *Asian American Journal Of Psychology*, 3(1), 29-43. DOI:10.1037/a0027428

Laureate Education, Inc. (Executive Producer). (2010e). *Doctoral research*: *Preparing for qualitative research*. Baltimore: Author.

Leao, T., Sundquist, J., Johansson, S., & Sundquist, K. (2009). The influence of age at migration and length of residence on self-rated health among Swedish immigrants: a cross-sectional study. *Ethnicity & Health, 14*(1), 93-105 13p.

Leão T.S., Sundquist J., Frank G, Johansson LM., Johansson SE., Sundquist K. (2006). Incidence of schizophrenia or other psychoses in first- and second-generation immigrants: a national cohort study. Journal of Nervous and Mental Disease, 194, 27-33

Leão T.S, Sundquist J., Frank G, Johansson LM, Johansson SE, Sundquist K. (2005). Incidence of mental disorders in second-generation immigrants in Sweden: a four-year cohort study. Journal of Ethnicity & Health, 10, 243-256.

Levy, A. (2017). *Barriers to seeking mental health services in Nigeria* (Order No. 10288903). Available from ProQuest Dissertations & Theses Global. (1925001255). Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/1925001255?accountid=14872

Lieber, E., Chin, D., Nihira, K., & Mink, I. T. (2001). Holding on and letting go: Identity and acculturation among Chinese immigrants. *Cultural Diversity and Ethnic Minority*

Psychology, 7(3), 247–261.

Lindert J, Eh renstein OS, Priebe S, Mielck A, Brähler E. (2009) Depression and anxiety in labor migrants and refugees—a systematic review and meta-analysis. Soc Sic Med; 69: 246–57

Marginalization. BusinessDictionary.com. Retrieved July 05, 2018, from BusinessDictionary.com website: http://www.businessdictionary.com/definition/marginalization.html

Marginalization. Syracuse University Counseling Center. Retrieved electronically, July 05, 2018 from: http://counselingcenter.syr.edu/social-justice/impact-of-marginalization.html

Malmusi, D., Borrell, C., & Benach, J. (2010). Migration-related health inequalities:Showing the complex interactions between gender, social class and place of origin. *Social Science & Medicine*, 71(9), 1610-1619. DOI:10.1016/j.socscimed.2010.07.0430

Mathee A, & Naicker N. S. (2015) Afr. Med J. Nov 22; 106; 106(1):705.DOI:10.7196/SAMJ.2016.v106i1.10215.PMID: 26792311

Mberu, B.U & Roland Pongou, R. (2010). Nigeria: Multiple Forms of Mobility in Africa's Demographic Giant. Retrieved from http://www.migrationpolicy.org/article/nigeria-multiple-forms-mobility-africas-demographic-giant

McGillis Hall L., Pink G., Jones C., Leatt P., Gates M. & Peterson J.(2009). Is the grass any greener? Canada to United States of America nurse migration. International Nursing Review 56, 198–205.

McEwen, M.M., Baird, M., Pasvogel, A. & Gallegos, G. (2007) Health-illness transition experiences among Mexican immigrant women with diabetes. Family & Community Health, 30 (3), 201–212.

Meniru, M. O. (2013). *The influence of degree of afrocentric spirituality on psychological*

help seeking attitudes, intentions and stigma among Nigerian Americans (Order No. 3671186). Available from ProQuest Central; ProQuest Dissertations & Theses Global. (1645942077). Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/1645942077?accountid=14872

Migration Policy Institute [Internet] Largest U.S. immigrant Groups over Time, 1960 Present; Washington (DC): 2013. [2015 May 1]. Retrieved from http://www.migrationpolicy.org/programs/data-hub/charts/largest-immigrant-groups-overtime.

Migration Policy Institute, (2015). The Nigerian Diaspora in the United States: *Rockefeller Foundation-Aspen Institute Diaspora Program (RAD)*. Retrieved electronically from www.migrationpolicy.org/sites/default/.../RAD-Nigeria.pd

Migration stressors. The British Journal of Psychiatry Apr 1997, 170 (4) 351-357; DOI: 10.1192/bjp.170.4.351

Mikal, J. P., & Woodfield, B. (2015). Refugees, Post migration Stress, and Internet Use: A Qualitative Analysis of Intercultural Adjustment and Internet Use Among Iraqi and Sudanese Refugees to the United States. *Qualitative Health Research*, 25(10), 1319-1333. DOI:10.1177/1049732315601089

Milenkovic, T., Simonovic, M., Samardzic, L., Nikolic, G., Grbesa, G. & Stankovic, M. (2010). Impact of social support on severity of post-traumatic stress disorder. Acta Medica Medinae, 49, 31–35.

Minkler, M. (2004). Ethical challenges for the "outside" researcher in community-based participatory research. *Health Education & Behavior*, 31(6), 684–697.

Minkler, M & Pies, C. (2011). Ethical Issues and Practical Dilemmas in Community Organization and Community Participation. In M. Minkler (Ed.) *Community Organizing and Community Building for Health* (pp 116-133). Rutgers University Press.

Muñiz-Solari, O., Li, W., and Schleicher, Y. (2010). Migration conceptual framework: Why do people move to work in another place or country? Electronically retrieved from: http://cgge.aag.org/Migration1e/ConceptualFramework_Jan10/ConceptualFramework_Jan10_print.html

Mui, A.C., & Kang, S-Y. (2006). Acculturation Stress and Depression among Asian Immigrant Elders. Journal of the National Association of Social Workers. *Social Work (2006) 51 (3): 243-255. DOI: 10.1093/sw/51.3.243*

Murray, D. M. (1998). *Design and analysis of group-randomized trials*. Oxford University Press, Inc.

Nelson, B. D., Fernandez, W. G., Galea, S., Sisco, S., Dierberg, K., Subaric Gorieva, G., et al. (2004). War-related psychological sequelae among emergency department patients in the former Republic of Yugoslavia. BMC Medicine, 2, 22.

Newbold, B. (2009) The short-term health of Canada's new immigrant arrivals: evidence from LSIC. Ethnicity & Health, 14(3), 315–336

Nieswiadomy, R.M. (2002). *Foundation of Nursing Research*. Prentice Hall

Nuckolls, K., Cassels, B., & Kaplan, B. (1972). Psychological assets, life crises and the prognosis of pregnancy. *American Journal of Epidemiology*, 95, 431-441.

Ogbaa, K. (2003). *The New Americans: The Nigerian Americans*. Greenwood Press.

Okeke, T. A., Okafor, H. U., & Uzochukwu, B. S. C. (2006). Traditional Healers in Nigeria: Perfection of Cause, Treatment and Referral Practices for Severe Malaria. *Journal of Biosocial Science, 38*(4), 491-500. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/203897574?accountid=14872

Onyeonoro, U. U., Ogah, O. S., Ukegbu, A. U., Chukwuonye, I. I., Madukwe, O. O., & Moses, A. O. (2016). Urban-rural differences in health-care-seeking pattern of residents of abia state, Nigeria, and the implication in the control of NCDs. *Health*

Services Insights, 9, 29-36. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/1866540903?accountid=14872

Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods* (3rd edition), (pp. 12-14). Thousand Oaks, CA: Sage Publications, Inc.

Pearlin, L. I. (1989). The sociological study of stress. Journal of Health and Social Behavior, 30, 241–256.

Rajendran, N.S. (2001). Dealing With Biases in Qualitative Research: A Balancing Act for Researchers. Retrieved electronically from: http://nsrajendran.tripod.com/Papers/Qualconfe2001.pdf

Rains, S. A., & Young, V. (2009). A meta-analysis of research on formal computer mediated support groups: Examining group characteristics and health outcomes Human Communication Research, 35, 309–336.

Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J. P., & McKee, M. (2013). Migration and health in an increasingly diverse Europe. The Lancet, 381(9873), 1235-45. DOI: dx.doi.org/10.1016/S0140-6736(12)62086-8

Reel, S., & Lauder, W. (2006). Multicultural aging. A comparison of rural older adult retiree in-migration in Scotland and the United States: implications for health care. *Journal Of Deontological Nursing*, 32(10), 12-18 7p.

Ritsner, M. and Ponizovsky, A., 1999. Psychological distress through immigration: the two-phase temporal pattern? International Journal of Social Psychiatry, 45, 125139.

Roodenrijs, T. C., Scherpenzeel, R. P., & de Jong, J. T. V. M. (1998). Traumatic experiences and psychopathology among Somalian refugees in the Netherlands. Tijdschrift voor Psychiatrie, 40, 132–142

Rubia M, Marcos I, Muennig P (2002). Increased risk of heart disease and stroke among foreign-born females residing in the United States. American Journal of Preventive

Medicine 2002 Jan;22(1):30-5. DOI:10.1016/s0749-3797(01)00400-7

Rubin, A., & Babbie, E. (2001). *Research Methods for Social Work*. Wadsworth/Thompson Learning

Ryder, A.G., Alden, L.E., and Paulhus, D.L. (2000). Is acculturation unidimensional or Bidimensional? A head-to-head comparison in the prediction of personality, self-identity, and adjustment. Journal of Personality and Social Psychology, 79, 4965.

Santelli, J.F. (2006). Ethical Issues in Health Promotion Research. In R. A Crosby, R. J. DiClemente, & L.F. Salazar (Eds.), *Research Methods In Health Promotion* (pp 41- 69). Jossey-Bass- A Wiley Imprint.

Salazar, L.F., Crosby, R.A., & DiClemente, R.J.(2006). Choosing a Research Design. In R.A. Crosby, R.J.DiClemente, & L.F.Salazar (Eds.), Research *Methods in Health Promotion* (pp 75-106). John Wiley & Sons Inc.

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-

Stangor, C. (2011). Research Methods for the Behavioral Sciences. Wadsworth, Cengage Learning.

Stangor, C. (2007). Research Methods for the Behavioral Sciences. WADSWORTH CENGAGE Learning.

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V. & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and postmigration stressors. British Journal of Psychiatry, 170, 351–357.

Sungurova, Y., Johansson, S.E., and Sundquist, J., 2006. East-west health divide and east-west migration: self-reported health of immigrants from Eastern Europe and the former Soviet Union in Sweden. Scandinavian Journal of Public Health, 34, 217-221.

Taylor, V.M. et al. (2008) Development of an ESL curriculum to educate Chinese immigrants about hepatitis B. Journal of Community Health, 33 (4), 217–224.

Teodorescu, D., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and postmigration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal Of Psychology*, 53(4), 316-332. DOI: 10.1111/j.1467-9450.2012.00954.x

The Rockefeller Foundation-Aspen Institute Diaspora Program. (2015). Migration policy institute. RAD DIAOSPORA PROFILE: The Nigerian Diaspora in the United States

United Nations Department of Economic and Social Affairs. (1998). Recommendations on statistics of international migration, revision 1. New York: UNDESA, Statistics Division, 1998.

United Nations (1948, December 10). Universal Declaration of Human Rights. Retrieved from http://www.un.org/en/documents/Udhr/ on 18 July 2009.

United States Health and Human Resources, Office of Human Research Protection (2009). Basic HHS Policy for Protection of Human Research Subjects. Retrieved electronically from http://www.hhs.gov/ohrp/regulations-and policy/regulations/45-cfr-46/index.html

United Nations High Commission for Refugees (2010). 2010 Regional Operations Profile-West Africa. Available online.

United Nations High Commission for Refugees (2009). 2008 UNHCR Statistical Yearbook. Available online.

United Nations High Commission for Refugees (2008). *2008 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons*, Available online.

United Nations High Commission for Refugees (2007). *UNHCR Global Appeal 2007*.

Geneva.

United Nations Population Fund [Internet] Migration: Overview; 2014. [2015 May 1]. Available from http://www.unfpa.org/migration

Veiel, H.O.F., & Baumann, U. ((1992). The Many Meanings of Social Support. In H O. F. Veiel & U Baumann (Eds.), *The Meaning and Measurement of Social Support* (pp.-9). Hemisphere Publishing Corporation.

Weltermann, B. M., Driouach-Bleckmann, Y., Reinders, S., Berndt, P., & Gesenhues, S. (2013). Stroke knowledge among diabetics: a cross-sectional study on the influence of age, gender, education, and migration status. BMC Neurology, 13202. DOI: 10.1016/1471-2377-13-202

Wheat, M.E., Brownstein, H. & Kvitash, V. (1993) Aspects of medical care of Soviet Jewish émigrés. The Western Journal of Medicine, 139 (6), 96–100.

Wienclaw, R. A. (2013). Gender Roles. *Research Starters: Sociology (Online Edition)*,

Wiking, E., Johansson, S.E., and Sundquist, J., (2004). Ethnicity, acculturation, and self-reported health. A population based study among immigrants from Poland, Turkey, and Iran in Sweden. Journal of Epidemiology and Community Health, 58, 574-582.

World Health Organization (1946). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, June 19-22, 1946

World Health Organization (WHO) International Consortium of Psychiatric Epidemiology (ICPE). Cross-national comparisons of the prevalences and correlates of mental disorders: an ICPE study. Bulletin of the World Health Organization. 2000; 78:413-26.

Wu, Yu-Tzu., Matthew Prina, A., Barnes, L E., Matthews, Fiona E. & Brayne, C. Relocation at older age: results from the Cognitive Function and Ageing Study J *Public Health*

(2015) 37 (3): 480-487. DOI:10.1093/pubmed/fdv050

Young, T.K. (1998). Population health: Concepts and methods. New York: Oxford University Press.

Zarate-Abbott, P. et al. (2008) Workplace health promotion – strategies for low-income Hispanic immigrant women. Journal of American Association of Occupational Health Nurses, 56 (5), 217–222.

Zou, P., & Parry, M. (2012). Strategies for health education in North American immigrant populations. *International Nursing Review*, 59(4), 482-488. DOI: 10.1111/j.1466-7657.2012.01021.x

Appendix A: Letter to Nigerian Communities in Diaspora

Date:

Name of the community/Organization

Address

Dear (Name),

My name is XXXX and I am a doctoral student in Public Health at Walden University. I am currently at the final phase of my studies, and conducting a research on the health implications of elderly Nigerians (65 to 80 years) migrating to the United States. Exploring the social factors that affect the health of elderly Nigerian migrants would illuminate the difficulties and problems, associated with migration. This type of research demands that researchers get close to the people who have lived experiences of the problem under study as their personal insights and experiences can be used in making recommendations. The result of the research would inform policy.

I will very much need your assistance and cooperation in conducting this research by helping to identify Nigerians, irrespective of gender, which falls within the category described in the study. Participants would have lived in Nigeria as adults, and would have lived in the United States for at least 2 years. Participation is voluntary, and they have the right to leave at any time during the course of the study.

I will appreciate your willingness to grant me the opportunity of visiting your community/organization so I can have the opportunity to discuss what the research is all

about. Please feel free to contact me at xxx-xxx-xxxx for any questions or concerns you may have concerning this study. You can also email me at jayne.nwankwo@waldenu.edu

Sincerely,

XXX XXXXXX

Doctoral Student

Walden University

Appendix B: Letter to Candidate

Date:

Name of Participant

Address

Dear (Name),

My name is XXXX XXXXXX, and I am a doctoral student in Public Health at Walden University. I am currently at the final phase of my studies, and conducting a research on the health implications of elderly Nigerians (65 to 80 years) migrating to the United States.

Exploring the social factors that affect the health of elderly Nigerian migrants would illuminate the difficulties and problems, associated with migration. This type of research demands that researchers get close to the people who have lived experiences of the problem under study as their personal insights and experiences can be utilized in making recommendations. The result of the research would inform policy.

Your decision to participate in this study is highly appreciated. I will also need to meet with you and explain to you what the study is all about to enable you make an informed decision on whether or not to participate. Meeting with you will also help me fully understand your experience on this subject. The venue of the meeting will be any location you choose, and the

meeting will last for 45 minutes. You have the right to participate or not to participate, and every information you give is confidential.

Please contact me at your earliest convenience to schedule a date and time that we can meet. My telephone number is (XXX) XXX-XXXX. You can also email me at name@waldenu.edu. I look forward to hearing from you.

XXXX XXXXXX

Doctoral Student

Walden University

Appendix C: Demographic Questionnaire

Please provide your answers to the questions below by selecting the most appropriate response or write in your response.

(1) Country of Origin_____

(2) What is your gender?

□ Male

□ Female

(3) What is your marital status?

□ Married

□ Single

□ Other (please explain) _____

(4) What is your date of birth (mm/dd/yyyy)_____/____/_____?

(5) What Nigerian tribe do you belong to? _____

(6) What month and year did you immigrate to the United States? (mm/yyyy)_____

(7) What is your current address?

Number Apt #

Street

City

State

Zip

(8) What county do you live in New York City? _____

(9) Are you currently employed?

- Employed (if employed please specify full or part-time employment
  - Full-time
  - Part-time
- Unemployed
- Retired

(10) What is your highest level of education completed?

(a) Less then high school

(b) High school or GED

(c) Associates Degree

(d) Bachelors Degree

(e) Masters Degree

(f) Doctoral or MD Degree

Appendix D: Interview Protocol

Time of interview:

Date: _____

Location: _____

Name of Interviewer: _____

Name of

Interviewee: _____

Position of interviewee:

This project is aimed at exploring and having a greater understanding of the migration experiences of this study population; and the interpretations that they give their migration experiences in relation to their health. Your participation is needed in this project as you fall within the criteria described by the study; and I believe that your experiences will illuminate the study and assist in answering the research question. Your participation is voluntary, and you have the right to terminate your participation at any time you desire to do so. Your participation does not incur any risk to your health; and it is hoped that the study will have a positive impact on public health practice in general by the inclusion of migration as a health determinant.

Interview Number:

1. Tell me about where you grew up.

2. What made you decide to migrate to the United States?

3. What challenges have you/do you face as you adjust to your new country?

4. How do you deal with the challenges you encounter as a migrant to the United States?

5. Describe the activities you performed on a daily basis while in Nigeria

6. What are your daily activities while in the United States?

7. How would you rate your overall health prior to migrating into the United States?

   a. Excellent

   b. Very good

   c. Good

   d. Fair

   e. Poor

8. How would you rate your overall health at this present time?

   a. Excellent

   b. Very good

   c. Good

   d. Fair

   e. Poor

9. What in your opinion do you attribute the differences in your health status?

10. Describe your functional status while in Nigeria

11. Describe your functional status at this present time

12. What in your opinion do you attribute the differences in your functional status?

13. How and to what extent has living as a migrant affected your health?

14. How does your original cultural deviate from, or align with the culture of your host country?

15. How have you been dealing the differences in culture if any?

16. What does it feel like to be very far away from your home?

17. How in your opinion has your culture influenced your health and health-seeking behavior?

18. What services have you utilized to help with adjustment to the United States of America?