Exploring Suicide Awareness and Prevention Approaches in an Urban Slum in Nigeria: A Qualitative Study

by

Karamat Ayotola Kelani

A Thesis submitted to the
Faculty of Graduate Studies and Postdoctoral Studies
of the University of Manitoba
in partial fulfillment of the requirements of the degree of

Doctor of Philosophy

Faculty of Social Work
University of Manitoba
Winnipeg

Acknowledgement

I acknowledge and give thanks to Almighty God, whose grace, strength, and guidance sustained me through every step of this journey. Alhamdulillah Robil Alameen.

I am deeply grateful to my dissertation committee for their wisdom, encouragement, and support, which became the foundation for this study. To my advisor, Dr. Tracey Bone, I would like to express my sincere gratitude. You have been more than an advisor. You are a mentor, a guide, and a steady presence in my life. You provided intellectual guidance and a thoughtful critique. Through the highs and lows, your patience, kindness, and belief in me kept me focused and shaped both this dissertation and my perspective on life. To Dr. Michael Baffoe, thank you for being my anchor. You welcomed me as an international student and helped me find my footing. Beyond your kindness and guidance, you redirected this dissertation so that it could truly focus on the population it most impacts. To Dr. Shay-Lee Bolton, your sharp insights and thoughtful feedback have constantly challenged me to think more deeply and do better. I appreciate this a lot. I am especially grateful to Dr. Michelle Jonathan for her invaluable contributions towards the success of this dissertation. To Dr. Natalia, thank you for walking with me at the beginning of this journey as a committee member.

I thank Dr. David Delay for his unwavering support and mentorship throughout this journey. To my colleagues, Dr. Abena Boateng and Dr. Richard Koddom, thank you for your friendship, encouragement, and support. I also thank the Faculty of Social Work at the University of Manitoba for providing the space and resources that enabled me to achieve my academic goals.

My heartfelt appreciation goes to the participants from Makoko, who welcomed me into their community and entrusted me with their stories. This work belongs to you as much as to me.

I also sincerely thank Mrs. Giwa Silifat, the community connector, who graciously facilitated my access to the community to conduct this research.

To my beloved family, I owe my deepest gratitude. To my husband, Rasheed Kelani, you are the bedrock of our family; your financial and emotional support carried me through this demanding process. Jazakumllahi Khairan. To my children, Sofiyyah, Maryam, and Habeebah, you have been my constant source of joy and strength. Your love and patience gave me the courage to keep going. I am also profoundly grateful to my mother, Alhaja Saidat Seriki; my siblings, Mrs. Ayomikun Oloye-Benson, Alhaja Basirat Seriki, and Mrs. Omolara Hassan; and my in-laws.

I received exceptional support from Dr. Oladele Raji, Dr. Umar Faruq, and Mohamed Hauna. I also appreciate the support of friends, including Doreen, the Oladeji family, Mrs. Funke Adegoroye, Dr. Felicia Owodara, and the Liasu family, who stood by me throughout this journey. Your constant love, prayers, and encouragement strengthened me beyond measure.

Once again, I would like to thank you all.

Dedication

I dedicate this dissertation to my creator, the Most Gracious and Most Merciful, who made its completion possible against all odds.

Abstract

Suicide is a significant social and public health issue, and preventing it remains a priority. An increasing number of people live in informal settlements in the Global South, often in slum-like conditions, leaving them vulnerable to suicide. Despite this, research on suicide is limited, particularly in Nigerian slums such as Makoko, an informal settlement along the coast of mainland Lagos, Nigeria. This study aimed to explore how community members understand suicide and the support available to address psychological distress in Makoko, to inform the development of culturally relevant, community-driven suicide prevention strategies. The study employed a qualitative phenomenological design. Semi-structured, in-depth interviews were conducted with 20 participants, including 10 residents and 10 key informants (community leaders, healthcare workers, traditional healers, and religious figures), selected through purposive and snowball sampling. The findings revealed five themes: first, community awareness and understanding of suicide; second, awareness of risk and vulnerability factors; third, community-based suicide prevention practices; fourth, gaps in suicide awareness; and fifth, suggestions for future prevention strategies. Based on these findings, a community-centric suicide prevention framework (CCSPF) was developed for Makoko and similar settings in the Global South. Additionally, recommendations were provided to address the issues identified during the study.

Table of Contents

List of Tables

List of Figures

Acronyms

CDC: Centers for Disease Control

DHHS: Department of Health and Human Services

FOMWAN: Federation of Muslim Women's Associations

FMYSD: Federal Ministry of Youth and Sports Development

HICs: High-Income Countries

ILO: International Labour Organization

LBS: Lagos Bureau of Statistics

LMICs: Low- and Middle-Income Countries

OHCHR: Office of the United Nations High Commissioner for Human Rights

SDGs: United Nations' Sustainable Development Goals

WHO: World Health Organization

Chapter 1: Introduction

1.1 Background of the Study

Suicide is a globally significant issue that people require an understanding of, explanation of, and prevention of to reduce mortality and morbidity (Beattie & Devitt, 2015; Bering, 2018). Suicide (sometimes called "completed suicide") is defined as "an act resulting in death which is initiated and carried out by an individual to the end of the action, with the knowledge of a potentially fatal result, and in which intent may be ambiguous or unclear, may involve the risk of dying, or may not involve explicit intent to die" (De Leo et al., 2021, p. 8). According to estimates from the World Health Organization (WHO), over 700,000 deaths by suicide occur annually worldwide, with rates increasing by 60% over the past 45 years (WHO, 2023; WHO, 2019). Suicide attempts, which are more frequent than completed suicides and have rates up to 30 times higher, serve as indicators of subsequent completed suicide (Bachmann, 2018; WHO, 2019).

Of all suicide occurrences globally, nearly three-quarters (73%) occurred in low- and middle-income countries (LMICs) in 2021. This rate tends to be higher than in high-income countries (HICs) (WHO, 2023). Nigeria, with a population of over 200 million, stands out for a growing suicide epidemic that exceeds regional and global averages. The figures indicate that the country has a suicide mortality rate of 17.3 per 100,000, compared with 10.5 globally and 12.0 in Africa (WHO, 2019). This places Nigeria as the 15th most suicide-prone country worldwide and 7th in the African region, underscoring the gravity of this public health threat (Ogundipe, 2019; WHO, 2021).

The devastating impacts of suicide affect not only the individual but also families and communities of belonging, causing them much grief, suffering, and despair (Jacob, 2017). Therefore, the WHO has made suicide prevention a global priority for reducing mortality. It has

been included as an indicator under SDG target 3.4, as well as in WHO's 13th General Programme of Work (2019-2023) and Comprehensive Mental Health Action Plan (2013-2030) (WHO, 2021). Furthermore, SDG target 11.1 indirectly addresses the need to promote residents' health and well-being in slums.

Contextual Understanding of Suicide

While suicide is a global issue, its understanding and perception vary widely across cultures and communities (Oquendo & Porras-Segovia, 2020; Yasgur, 2017). In Western contexts, suicide is often viewed as a potential consequence linked to mental illness or disorder, associated with neurochemical imbalances, particularly involving changes in specific brain regions such as the prefrontal cortex (Bachmann, 2018). In other contexts, such as Africa, including Nigeria, the interpretation of suicide is shaped by cultural and religious beliefs, often framed as a moral transgression, a grave sin, a rejection of God's will, a taboo, or possession by evil forces (Emedo, 2021; Knizek et al., 2011; Ohayi, 2019; Ongeri et al., 2022; Osito; Pridmore et al., 2016; Raschke et al., 2022; Sidana et al., 2020).

Fayemi (2009) has provided evidence that the prevailing Yoruba perception of suicide is primarily based on traditional ideas about destiny, shame, and taboo. The Yoruba saying "*Ikúyáj'ẹ̀sín*," which translates to "death is better than shame," suggests that some believe preserving dignity and avoiding public humiliation can make suicide justifiable (Atilola & Ayinde, 2015). These cultural and religious interpretations prioritize moral, spiritual, and social explanations, with mental distress often interpreted through moral and spiritual framing rather than biomedical/psychiatric models. This often leads to a misunderstanding of the concept and misclassification of suicide risk (Hoven et al., 2009; Oquendo & Porras-Segovia, 2020).

Risk and Protective Factors of Suicide

Research has documented various risk and protective factors for suicide across multiple levels of an individual's environment (CDC, 2022; Cramer & Kapusta, 2017; Hagen, 2022; Stone et al., 2017). Individual risk factors directly influence an individual, including genetics, mental disorders, psychological factors, personality traits, demographics, psychosocial factors, a history of suicide attempts, childhood sexual abuse, family history, and the loss of a parent to suicide in early childhood (Fazel & Runeson, 2020; Hagen, 2022; Hawton & Pirkis, 2017; Renaud et al., 2022; Turecki & Brent, 2016). Contextual risk factors at the family, community, and societal levels include family problems, poverty, unemployment, economic downturns, societal attitudes towards suicide, cultural beliefs, laws, policies, values, stigma, discrimination, exposure to others' suicidal behaviours, lack of access to mental health services, and the availability of lethal means (Cramer & Kapusta, 2017; Hagen, 2022; Hawton & Pirkis, 2017; Renaud et al., 2022; Stone et al., 2017; Turecki & Brent, 2016). Identifying both individual and contextual risk factors is crucial for determining the most effective prevention and intervention measures for suicidal behaviour (Hawton et al., 2016; WHO, 2014, 2018; Zalsman et al., 2016).

Urban Slum Communities in Nigeria

Almost 2 billion people live in urban regions in the Global South, indicating a growing trend toward urbanization (UN-Habitat, 2003). This trend reflects the rapid pace of urbanization in Nigeria, which has led to the expansion of urban slum communities. All major Nigerian cities feature slums, which are formed in two main ways: traditional slums in the city centre and peri-urban slums on the outskirts. Approximately 53% of the Nigerian population lives in urban slums, and this share is likely to increase in the coming years (Akimoju & Sadri, 2017; Sekoni et al., 2022). Slums are consistently overcrowded and lack adequate health security, with residents often

facing poverty, high unemployment, inadequate infrastructure, and substandard living conditions (Ajayi et al., 2019; Fayehun et al., 2022; Swahn et al., 2012; Uriri et al., 2019).

These conditions are not only indicators of deprivation. They also closely align with established risk factors for suicidal ideation and behaviour. Previous research has consistently linked chronic poverty and unemployment to hopelessness, entrapment, and elevated suicide risk (Mäkinen et al., 2021; Martin-Carrasco et al., 2016; Mathieu et al., 2022; Renaud et al., 2022; Rojas, 2021; Santamaría-García et al., 2020). Financial hardship also intensifies strain on family and social relationships that might otherwise buffer distress. Overcrowding erodes privacy and heightens interpersonal conflict, while insecure housing tenure and the recurrent threat of eviction or demolition produce sustained anticipatory stress. In addition, the structural features of slum life compound suicide risk by restricting access to protective resources. Formal mental health services are largely absent from these settlements, health-seeking is constrained by cost and distance, and residents contend with stigma both as slum dwellers and as people experiencing psychological distress (Fayehun et al., 2022; Sekoni et al., 2022). Slum communities therefore concentrate suicide risk factors while lacking the clinical infrastructure through which conventional, facility-based prevention models operate. This underscores the need for prevention approaches rooted in the community itself, motivating the present study.

Lagos State is one of Africa's largest and fastest-growing megacities, with an estimated population of over 25 million. The state serves as the country's commercial hub, boasting a thriving economy that attracts people from across Nigeria and neighbouring countries seeking opportunities (LBS, 2022). Estimates indicate that 50-75% of Lagos State residents live in slum communities, with 140 slums identified (World Bank, 2023).

Figure 1

Map of Nigeria and Lagos State showing the Makoko floating slum in the Lagos Lagoon Complex

Note. From "Bioaccumulation Dynamics, Noncarcinogenic and Carcinogenic Risks of Heavy Metals in Commercially Valuable Shellfish and Finfish Species From the World's Largest Floating Slum, Makoko, Nigeria," by T. L. Jolaosho, I. O. Elegbede, S. L. Akintola, A. A. Jimoh, P. E. Ndimele, A. A. Mustapha, and J. D. Adukonu, 2024, *Marine Pollution Bulletin, 207*, Article 116807 (https://doi.org/10.1016/j.marpolbul.2024.116807). Copyright 2024 by Elsevier B.V.

Makoko, often called the “Venice of Africa”, is a prominent slum community in Lagos State and one of the largest urban slums in West Africa (Methu, 2014). It faces many challenges, including inadequate housing, poor infrastructure, and environmental vulnerabilities (Benard, 2025; Riise & Adeyemi, 2015). Economic constraints, such as limited resources for fish farming and boatbuilding, hinder sustainable growth, while women face significant barriers to education and economic opportunities. Many residents rely on informal work, including fishing, small-scale trading, and boatbuilding. These unstable jobs leave families vulnerable to economic downturns, with nearly 40% living on less than $1.25 per day (Participedia, 2019; Uriri et al., 2019).

Housing in Makoko is largely informal, with many homes constructed from low-cost materials such as bamboo and wood, making them vulnerable to flooding and structural collapse during severe weather (Olafimihan, 2009; Riise & Adeyemi, 2015). Weak education and transportation systems perpetuate poverty, leaving many children without adequate schooling and residents dependent on unsafe boats for transportation (Olajide & Lawanson, 2014). These issues represent everyday stressors and vulnerabilities. Cumulatively, they create an environment of chronic adversity, blocked opportunity, and constrained help-seeking, within which suicidal distress emerges. Any credible prevention framework for this population must be situated within this environment.

Suicide Prevention and Urban Slum Communities in Nigeria

While specific risk factors for suicidal behaviour exist, they can be mitigated through effective strategies at multiple societal levels (Hagen, 2022; Stone et al., 2017). Suicide prevention efforts are more likely to succeed when multiple strategies are combined to work together to prevent suicide (Pirkis et al., 2019; Wasserman et al., 2020; Zalsman et al., 2016). Communities

play a vital role in preventing suicide. Geographical boundaries, shared interests, or other characteristics, such as race, ethnicity, disability, sexual orientation, gender identity, or military background, can define a community. Every community can benefit from a coordinated, comprehensive approach to suicide prevention that incorporates prevention, intervention, and postvention (U.S. DHHS National Strategy, 2024). Community-based suicide prevention is a community-led initiative often carried out in non-clinical settings, involving non-professional community members, including those with lived experience of suicide, in implementing programs (Grattidge et al., 2023). This approach is grounded in the cultural, social, and economic contexts and traditions of the populations being served.

In Nigeria, those experiencing poor mental health rely heavily on culturally rooted informal supports. Informal social support refers to the assistance a person receives and provides within their social network (Spilsbury & Korbin, 2013). Individuals often turn to parents, family, and other figures of authority, such as teachers, religious leaders, mediators, and traditional healers, for informal counselling to address mental health concerns (Nwafor, 2024; Salami & Onuegbu, 2019; Urigwe, 2010). Additionally, each major religion in Nigeria offers a range of effective coping strategies, such as prayer, rituals, and religious services, to help individuals manage difficulties, including suicide (Nwafor, 2024; Ogbolu et al., 2018). Alongside these informal supports, the country has introduced gatekeeper training programs (which prepare healthcare professionals and community members to identify and support at-risk individuals) and established Crisis Support Lines (CSLs) for at-risk individuals (Ogbolu et al., 2020a). Comprehensive strategies in HICs have demonstrated the additive and synergistic effects of integrating multiple interventions (WHO, 2014). This approach could be replicated in LMICs while accounting for variation in cultural context.

Urban slum communities tend to have a temporary or ‘makeshift status’, which can lead city or governance actors to overlook these areas when prioritizing infrastructure development (Benard et al., 2025). As a result, public health programs, including those focused on mental health and suicide prevention that serve low-resource settings, often neglect urban slums, as governance actors frequently view slums as areas that should be eradicated (Adesina-Uthman et al., 2022; Fayehun et al., 2022; Sekoni et al., 2022). Additionally, access to affordable and quality healthcare in urban slums is severely limited, allowing informal health providers to thrive in these areas (Benard et al., 2025), which further restricts residents’ access to timely and effective mental health and suicide prevention supports.

Successful, culturally relevant, community-based suicide prevention in urban slum communities requires a multi-sectoral approach that includes community participation (WHO, 2014). For community members, especially in LMICs, to participate effectively and intervene, they must have a better understanding of suicide (McPhillips et al., 2025; Obarisiagbon et al., 2021). Community members need to understand the concept and accurately identify its risk factors.

Additionally, they should be aware of community resources they can use or refer others to when needed. Researchers assert that people need to correctly understand the concept and recognize the symptoms of mental health issues (Hoven et al., 2009; Oquendo & Porras-Segovia, 2020). Hoven and colleagues have expressed concerns regarding specific dilemmas: some individuals might have the opportunity to prevent suicide by knowing when to ask questions, what to listen for, and when to seek additional help; the suicidal person who wants to share their distress but believes that such a conversation will not be helpful or well-received; and when someone living in an area with limited mental health services or financial barriers turns for support (Hoven et al.,

2009). With good awareness of suicide and how to address it in the communities, members participate effectively in suicide prevention in their communities.

1.2 Problem Statement

Suicide remains a significant public health issue in Nigeria, yet research on suicide awareness and prevention has overlooked marginalized urban slum communities. Existing research in Nigeria relies on secondary sources, such as media reports, or focuses narrowly on clinical settings, offering limited insight into how suicide is understood, experienced, and prevented in informal settings such as Makoko in Lagos State. As a result, suicide prevention lacks culturally grounded, community-specific evidence relevant to slum communities.

1.3 Rationale for the Study

Despite the significant burden of suicide in Nigeria, especially in low-resource urban settings, there is a notable lack of empirical research on suicide awareness and prevention in slum communities. Existing research has relied predominantly on quantitative methods and secondary sources. Because effective suicide prevention requires community participation, awareness of risk factors, and knowledge of available support options (Hoven et al., 2009), there is a critical need for in-depth, contextually grounded research. This study addresses this gap by focusing on Makoko, a marginalized urban slum community in Lagos State, to generate evidence that can inform culturally relevant, community-based suicide prevention strategies.

1.4 Purpose of the Study

The purpose of this study was to explore the nature and extent of suicide awareness of suicide and community-based suicide prevention approaches among residents of the Makoko community in Lagos State to inform the development of culturally relevant, community-based suicide prevention strategies. Specifically, it sought to:

(1) Assess the nature and extent of suicide awareness among the community members in the Makoko community.

(2) Explore awareness of suicide prevention approaches in the community.

(3) Identify key gaps in their awareness that could be addressed in future community-based strategies.

1.5 Scope of the Study and Delimitations

This study employed a qualitative, phenomenological approach to explore the extent of awareness about suicide and community-based prevention strategies among adult residents in the Makoko community. The focus is intentionally limited to understanding community perspectives, risk factors, and community-based prevention methods within this unique socio-cultural and economic context. The study considered both residents' and key informants' views, capturing a wide range of lived experiences, perceptions, and suggestions. While it does not provide a nationwide overview of suicide awareness in Nigeria, it offers detailed qualitative insights specific to an urban slum environment characterized by systemic deprivation, limited mental health services, and socio-cultural complexities.

1.6 Definitions of Key Terms

Informal Settlements: Defined primarily by their legal and planning status: residential areas built outside formal regulations, usually without legal land tenure or official recognition by the state (UN-Habitat, 2015). Many informal settlements are slums.

Slum: Refers to an area that lacks one or more basic conditions: durable housing, sufficient living space, access to improved water and sanitation, or security of tenure (UN-Habitat, 2003). Although not all slums are informal settlements, Makoko is. However, this study uses the term because of its prevalence in policy and academic literature, and it is employed to critically and

descriptively foreground residents' lived experiences, community knowledge, and collective capacity for change rather than to downgrade it. Makoko is treated as a community with significant structural challenges and substantial strengths.

Risk Factors: Characteristics, conditions, or behaviours that raise the risk of a person dying by suicide (CDC, 2022).

Protective Factors: Factors that can either counteract specific risks or buffer against multiple risks associated with suicide (CDC, 2022).

Suicide Prevention Strategies: Involve actions or interventions that aim to reduce risk factors and strengthen protective factors, such as screening and evaluation, crisis intervention, Psychotherapy, medication, and public awareness campaigns (Stone et al., 2017; WHO, 2021).

Suicide Awareness: Suicide awareness is a central concept in this study and therefore warrants conceptual clarification. It is conceptualized as a multidimensional, community-level, socially constructed, and culturally embedded phenomenon rather than a fixed individual attribute that can be measured on a scale. In this study, suicide awareness encompasses (a) knowledge and understanding of suicide and its contributing factors; (b) recognition of warning signs, risk factors, and vulnerability conditions; (c) awareness of community-based and formal prevention and support strategies; and (d) knowledge of formal and informal help-seeking pathways and support resources. This conceptualization reflects the study's constructivist epistemological position and is informed by existing literature (Hoven et al., 2009; McPhillips et al., 2025; Obarisiagbon & Abu, 2021). Operationally, suicide awareness was made observable through participants' articulated knowledge, interpretations, and reported practices across these four dimensions, as elicited by the semi-structured interview guides (Appendices H and I). Olajide & Lawanson, 2014). The questions in these guides were organized to correspond to each dimension. Awareness

was therefore assessed not as a numerical score but as the depth, content, and cultural framing of what participants could describe about the definition of suicide, its warning signs and risk factors, existing prevention and support responses, and available help-seeking pathways. The conceptualization of suicide awareness informed the design and the conduct of the research process.

Youth: The United Nations defines youth as ages 15 to 24, but this age bracket is often considered too narrow for countries in Africa, given their political, economic, and socio-cultural contexts. In Nigeria, as in many other African countries, the transition to independent adulthood life, in terms of achieving the economic and social stability that comes with steady employment, may extend into the late twenties and sometimes beyond. Thus, the African Youth Charter of 2006 defines youth as persons aged 15 to 35. Similarly, Nigeria's 2009 National Youth Policy defined youth as persons aged 18 to 35 years (FMYSD, 2019). This study defined the age group 18-35 years as youth, and no participants were younger than 18 years old.

1.7 Organization of the Dissertation

The dissertation is organized into seven chapters. The first chapter presents the introduction, including the study's background, rationale, purpose, problem statement, and definitions of terms. The second chapter provides a comprehensive literature review of the global context of suicidal behaviour, covering its risk and protective factors, stigma and help-seeking behaviour, the global context of suicide prevention, community-based prevention approaches, suicide awareness, suicidal behaviour in Nigeria, factors contributing to suicide risk and vulnerability in Nigeria, and community-based prevention approaches in Nigeria. Chapter 3 discusses the theoretical frameworks underpinning the study. Chapter 4 describes the research paradigm, research design, methodology, and methods used to achieve the study's objectives. This

chapter also addresses ethical considerations and validation strategies. Chapter 5 presents the research findings, including both demographic data and qualitative findings. Chapter 6 discusses these findings, while Chapter 7 summarizes the key findings, discusses the study's contributions and recommendations, outlines implications for social work (practice, policy, and education), offers recommendations for future research, and outlines the study's limitations and plans for disseminating the findings.

Conclusion

This chapter introduces the study by discussing the background on suicide, including its definition, risk and protective factors, suicide prevention, and urban slums. It also explains the rationale for the study. The chapter further presents the problem statement, the research purpose, and the scope and delimitations.

Chapter 2: Literature Review

Introduction

Suicide is a complex global issue studied across many contexts due to its significant challenges. This chapter presents a literature review. It begins with an overview of the literature search strategy used to identify relevant studies for the review. It then discusses the international perspective on suicidal behaviour, focusing on research from various regions. The areas covered include trends, methods, risk and protective factors, stigma, and help-seeking behaviours. Next, it examines global suicide prevention efforts and highlights effective implementation strategies. This is followed by an exploration of community-based approaches and recent initiatives worldwide. The chapter also reviews evidence from the literature on awareness of suicide. It then shifts focus to Nigeria, analyzing trends, issues with official statistics, and factors influencing suicidal risk, including protective elements. It reviews community-based suicide prevention programmes in Nigeria. Additionally, it demonstrates how global and Nigerian findings apply to informal urban settlements, thereby emphasizing the research gap. Finally, it offers a summary of the chapter.

2.1 Literature Search and Selection Process

The literature reviewed for this study was identified through searches in academic databases such as PubMed, Scopus, Web of Science, PsycINFO, and Google Scholar (where most Nigerian studies are available), as well as the reference lists of relevant studies. Keywords included combinations of “suicide,” “suicide prevention,” “suicide awareness,” “informal settlements,” “urban slums,” “Nigeria,” “LMICs,” and “community-based prevention. Studies published in English between 2000 and 2025 were prioritized. Both global and Nigerian literature were included to situate the study within the broader scholarship on suicide prevention and to highlight the specific contextual challenges of informal settlements.

2.2 Global Context of Suicidal Behaviour

Globally, suicide remains a public health issue, ranking as the third leading cause of death among 15–29-year-olds in 2021(WHO, 2023). However, in most HICs, suicide rates generally increase with age, particularly among middle-aged and older adults (Bachmann, 2018; Centers for Disease Control and Prevention [CDC], 2021; Turecki, 2016), whereas in LMICs, younger adults are disproportionately affected (Turecki, 2016). A consistent gender pattern also emerged; men are more likely to die by suicide, while women report a higher rate of suicide attempts (Barak et al., 2020; O'Donnell & Richardson, 2020). These differences are often attributed to the method of choice, with men in HICs more frequently using more lethal methods such as firearms, while women rely more frequently on less lethal means (Curtin et al., 2016; National Institute on Drug Abuse, 2020).

Research evidence has documented various methods of suicide. Worldwide, almost 20% of suicides were due to pesticide poisoning (WHO, 2023). Other common methods include the use of firearms, jumping from heights, and medication overdoses (Bachmann, 2018; Fazel & Runeson, 2020; Zalsman et al., 2016). These methods vary by context. For example, pesticide ingestion accounts for suicide worldwide, particularly in rural Asia and Africa, where access is widespread (Reccord et al., 2021; WHO, 2023). This method accounts for about 14% to 20% of suicide deaths globally (Ritchie, 2025). In contrast, firearms predominate in North America, while overdoses and jumping from heights are more common in urban settings. These patterns emphasize the need to consider both structural access and cultural context when understanding suicidal behaviour.

2.2.1 Determinants of Suicide: An Ecological Perspective

Using an ecological perspective, it is important to note that suicide is a complex and multifaceted phenomenon with multiple risk and protective factors which interplay at different

levels of an individual's environment (Cramer & Kapusta, 2017; Hagen, 2022). At the individual level, risk factors such as depression, anxiety, bipolar disorder, borderline personality disorder (BPD), substance abuse, trauma and previous suicide attempts are well-established in the literature as making individuals susceptible to suicidal risk (Bachmann, 2018; Fazel & Runeson, 2020; Renaud et al., 2022; WHO, 2020). At the relational or family level, issues such as youth bullying, a history of suicide within the family, conflict between intimate partners, marital disruption, and family dysfunction are linked to increased risk (CDC, 2021). At the community level, policies affecting access to lethal means, social isolation, stigma around seeking help, and limited access to mental and physical healthcare are associated with risk (Gunnell & Chang, 2016; Mäkinen et al., 2021; Fazel & Runeson, 2020; Santamaría-García et al., 2020).

On a societal level, factors such as public health crises like the COVID-19 pandemic, economic instability, historical trauma, and inadequate access to culturally appropriate care, along with siloed approaches to public health, mental health, substance misuse, and suicide prevention, as well as systemic oppression, can increase risk (Reed et al., 2021; Sher, 2020). Suicide contagion, whether through imitation, affiliation, or contextual influence, may also be worsened by media reports that do not follow safe reporting guidelines (Cheng, 2014). At this level, suicide risk is also shaped by broader structural issues that disproportionately affect certain populations. Vulnerable groups such as Indigenous communities, adolescents, rural populations, and residents of informal urban settlements often face increased risk due to intersectionality, including socioeconomic deprivation, stigma, and limited access to health and social services (Culbreth et al., 2018; Iemmi et al., 2016; Swahn et al., 2018).

Researchers have established that protective factors are present at every level of the system, thereby protecting at-risk individuals. At the individual level, religion/spirituality is a significant

protective factor against suicide, reducing the risk (Austin, 2017; Ishor & Iorkosu, 2022; Wu, 2015). For some, religion serves as a profound source of support in people's lives, contributing to an enhanced sense of meaning, increased life satisfaction, improved coping mechanisms for life challenges, and greater social support (Nwafor, 2024).

At the relational level, connection with informal social networks, including family, friends, or community groups, has been linked to a lower risk of suicide. These networks offer emotional support, assistance, and a sense of belonging, especially among those who are vulnerable (CDC, 2022; Junus & Yip, 2022; Standley, 2019).

Informal social networks can vary significantly in terms of size, stability, and relationship strength, depending on an individual's traits and social position within their community (Threlfall et al., 2025). They usually consist of both 'strong' and 'weak' ties, where strong ties are characterized by intimacy and obligation, and weak ties provide a sense of belonging and access to resources and information (Granovetter, 1973; Moreton et al., 2023). Support can be multifaceted, including emotional, tangible (also referred to as instrumental), esteem-based, or informational (Scott, 2023; Threlfall et al., 2025).

Research indicates that many individuals prefer informal support/help when facing emotional difficulties, including suicidal thoughts, often turning to family and friends rather than formal services (Mojaverian et al., 2013; Wong et al., 2024). However, it is essential to acknowledge that having an informal support network does not necessarily imply that social support will be exchanged (Threlfall et al., 2025). In collectivist societies, seeking external help may be regarded negatively (Kim et al., 2008), further underscoring the importance of close-knit networks as protective buffers. Additional evidence indicates that support from care providers is a protective factor (CDC, 2021).

At the community level, strong community ties and policies that restrict access to lethal means for at-risk individuals can serve as protective factors (CDC, 2021). Surveillance and vigilance also serve as protective mechanisms. Community members, peers, neighbours, and local leaders often act as organic safety nets, monitoring vulnerable individuals and intervening early when signs of distress are detected (Cwik et al., 2021). This form of community-based surveillance is particularly relevant in informal settlements, where stigma and limited resources hinder access to professional care. In such settings, informal surveillance can serve as an early warning system and a culturally congruent prevention approach (Cwik et al., 2021).

Additionally, gatekeeper training initiatives, such as Mental Health First Aid and Question, Persuade, Refer (QPR), have demonstrated effectiveness globally in equipping laypersons with the skills to recognize warning signs, provide initial support, and facilitate referrals to appropriate services (Burnette et al., 2015). These approaches extend the reach of protective factors by empowering communities to act as first responders in suicide prevention.

Researchers have argued that much research has focused on individual risk factors, thereby pathologizing and individualizing the problem (Baril, 2020; Fazel & Runeson, 2020). This perspective places the responsibility of engaging in suicidal behaviour on the individual. Besides overlooking the existence and influence of socio-environmental and structural stressors that may compound the "risk" of suicide, it also ignores the factors that may "protect" against it (Eriksson et al., 2018; Standley, 2019). Moreover, this individualizing approach increases the stigma associated with suicide, thereby causing a barrier to help-seeking (WHO, 2014).

2.2.2 Stigma and Help-Seeking

The scientific literature on stigma varies significantly: some refer to it as a mark of shame or disgrace (Stuart, 2016), while others, such as Goffman's conceptualization, view it as an

attribute that deeply discredits and reduces its social value. On the contrary, Thornicroft (2006) focuses on three social psychological aspects: knowledge, attitudes, and behaviour. Additionally, Link and Phelan (2001) take a broader socio-structural view. This perspective views stigma as existing when people distinguish and label a particular human difference, such as mental illness, as socially salient, leading to culturally derived categories that differentiate people into groups. These labelled differences are associated with undesirable characteristics, creating a negative cultural stereotype for each group member. Stigmatized groups are socially devalued and systematically disadvantaged, leading to poorer health and social outcomes. Stigmatization is contingent on access to social and economic power, as only powerful groups can entirely disapprove and marginalize others (Stuart, 2016).

Lannin et al. (2016) highlight that seeking help for mental health issues is a complex and evolving process, not a quick decision. It involves dealing with stigma and feelings of isolation. Throughout this process, individuals constantly weigh whether help is necessary and determine the best time and manner to seek it (Biddle et al., 2007). They described this inner conflict using the Cycle of Avoidance (COA) model, which illustrates the tensions involved in understanding, accepting, and avoiding mental distress. Key actions that delay help-seeking include normalizing symptoms, offering alternative explanations, accommodating worsening distress, shifting the boundary between "normal" and "serious" distress, and postponing help (Liu & Zhang, 2024). Additional research has identified similar cognitive strategies, such as relying on self-resilience, denying the need for professional help, or challenging the idea of seeking help (Ishikawa et al., 2022; Martínez-Hernáez et al., 2014).

One of the most widely used classifications of mental health resources is based on Rickwood and Thomas' (2012) model, which outlines four help types: formal, semi-formal,

informal, and self-help. Formal help-seeking involves structured professional support within established healthcare systems, including healthcare professionals, medical treatments, and public institutions. Semi-formal options involve sources that provide some structure but may lack formal professional training, such as teachers or school counsellors. Informal help-seeking often depends on personal relationships, primarily with friends and family. These informal sources are vital for mental health help-seeking, providing important channels for individuals to access support and assistance (Amato & Bradshaw, 1985). Family and friends often serve as the first point of contact for those experiencing mental health issues (Rickwood et al., 2005). Finally, self-help encompasses individual efforts, such as reading self-help books or exploring online resources.

2.3 Suicide Prevention Efforts: The Global Evidence

Global suicide prevention efforts have utilized two basic approaches. The traditional approach comprises primary, secondary, and tertiary prevention (Bachmann, 2018; Cramer & Kapusta, 2017). Primary prevention aims to prevent the onset of mental illness, secondary prevention to detect and treat illness, and tertiary prevention to reduce relapses and deterioration (WHO, 2014). The 'second' approach focuses on the effectiveness of interventions (Zalsman et al., 2016).

WHO has created a comprehensive framework to identify effective interventions, align them with suicidal risk factors, and classify them into three types of prevention strategies: universal −target everyone in a defined population (e.g. in a community, a state, or a country), selective− are meant for specific groups who are at increased vulnerability for suicidal behaviour (e.g., people who have experienced trauma, abuse, affected by conflict/disaster or living in poor conditions) and indicated−target high-risk individuals (e.g., people living with a mental illness, people who abuse substances, and those who have previously attempted suicide) (WHO, 2018; WHO, 2014).

Evidence consistently supports universal strategies. A systematic review of 33 high-income OECD countries found that universal suicide-prevention strategies, including physical barriers and legal and regulatory reforms, were largely effective in reducing suicide mortality, although effectiveness varied widely across intervention types, follow-up periods, and sex (Ishimo et al., 2021). Another body of evidence from 18 studies showed a consistent reduction in suicide following restricted access to and increased safety at sites where people often take their lives (Pirkis et al., 2015). These findings are consistent and support the implementation of this intervention in LMICs (Fleischmann et al., 2016).

Responsible media reporting of suicide has been shown to significantly impact suicide rates by reducing stigma and encouraging help-seeking behaviour (Niederkrotenthaler et al., 2014). One review found that following reporting guidelines lowers the risk of imitative or copycat suicides (Sisask & Värnik, 2012). In addition to traditional media, emerging evidence points to the increasing influence of social media platforms in suicide prevention. A systematic review of 30 studies on social media for suicide prevention indicated that social media platforms can reach large audiences, which may enable others to intervene when they see suicidal behaviour (Robinson et al., 2016). Nonetheless, challenges include limited control over user behaviour, the risk of suicide contagion, difficulties in accurately assessing suicide risk, and concerns about privacy and confidentiality (Arensman, 2017). In LMICs, the importance of responsible media reporting of suicide is particularly highlighted (Fleischmann et al., 2016).

Awareness campaign programs have been shown to reduce suicide rates. One pre- and post-citywide awareness campaign involved distributing materials to commuters at train stations and on city streets in Japan. The results indicated a decrease in suicides in the months following

the campaign. It was particularly effective among the city's male residents (Matsubayashi et al., 2014).

Selective prevention strategies, including gatekeeper training for physicians, comprehensive screening and counselling for at-risk individuals, availability of crisis helplines, and interventions for vulnerable populations, have been shown to reduce suicide rates in the HICs (Hetrick et al., 2016; Isaac, 2009; Kreuze et al., 2018; Sakashita & Oyama, 2019; Zalsman et al., 2016). Routine screening has been found to lower suicide rates. Simon and colleagues investigated the link between heightened responses to question nine on the widely used Patient Health Questionnaire for depression ("thoughts that you would be better off dead or hurting yourself in some way" in the past two weeks) and suicide deaths (Simon et al., 2013, p. 1195). They observed a tenfold increase in suicide within the following year among patients reporting frequent thoughts of self-harm, suggesting that treatment and suicide prevention may benefit from follow-up after routine screening (Hogan & Grumet, 2016).

There are some signs of a connection between improvements in intermediate outcomes, such as enhanced knowledge, attitudes, and confidence among healthcare and community professionals, and primary outcomes, like lower suicide and self-harm rates (Hegerl et al., 2013; Zalsman et al., 2016). Furthermore, the availability of healthcare services has been identified as an important factor in suicide prevention. Evidence from two Eastern European countries, for instance, revealed an inverse correlation between suicide rates and the number of physicians (Berrouiguet et al., 2018). This finding highlights the potential role of accessible and responsive health systems in supporting early identification, treatment, and intervention for individuals experiencing distress. The critical role of training and education for non-specialist healthcare providers, as highlighted through the WHO mhGAP in LMICs, is also emphasized (Fleischmann

et al., 2016). Crisis Support Lines (CSL), also known as helplines, telephone counselling services, hotlines, and distress lines, are evidence-based suicide prevention tools that offer immediate, anonymous assistance to individuals in crisis (Ogbolu et al., 2020a; Sakashita & Oyama, 2019; WHO, 2018). Ramchand et al. (2017) noted that crisis lines play a crucial role in suicide prevention by providing empathetic listening, risk assessment, and referrals to mental health services. A meta-analysis by Hoffberg et al. (2020) found that crisis line services were linked to significant reductions in suicidal ideation among callers. Another study conducted in the United Kingdom examined the effectiveness of a telephone crisis line among adult callers experiencing acute distress over a one-year service evaluation period (Tyson et al., 2016). The study assessed callers' mental states at the beginning and end of individual crisis calls using a brief questionnaire, allowing for examination of immediate changes in suicidal and self-harm ideation. Findings indicated a reduction in suicidal and self-harm thoughts among adult callers by the end of the call, suggesting that timely, brief crisis intervention can play an important role in alleviating acute distress. The study underscores the potential effectiveness of low-threshold, non-clinical support mechanisms for adults experiencing suicidal distress (Tyson et al., 2016).

A range of clinical and indicated interventions has been shown to be effective in reducing suicidal behaviour. These include the assessment and management of mental disorders, psychosocial interventions, and follow-up care for individuals at elevated risk (Sakashita & Oyama, 2019). Pharmacological treatments have also demonstrated anti-suicidal effects in specific populations. For example, lithium, clozapine, and ketamine have consistently emerged as promising treatments with significant anti-suicidal properties (Ahmed et al., 2023; Waszak et al., 2025; Wilkinson et al., 2023). A systematic review of 8,480 participants included in 29 RCTs revealed the effectiveness of psychosocial interventions for self-harm (Hawton et al., 2016). The

most frequently evaluated intervention was CBT-based psychological therapy, with an average of 10 sessions (Arensman, 2017). At follow-up, people who had received CBT were significantly less likely to have engaged in repeated self-harm compared with those receiving treatment as usual.

For people with a history of multiple self-harm episodes, dialectical behaviour therapy was identified as reducing the frequency of repeated self-harm but did not reduce the proportion of individuals repeating self-harm. Hospital-based studies, including follow-up care after suicide attempts, are associated with reduced risk of re-attempting in all ages (Luxton et al., 2013; Yip et al., 2012). Although there are indications that these treatments are eligible for use in LMICs, national implementation may be infeasible due to costs and a shortage of trained mental health professionals (Fleischmann et al., 2016).

It has been argued that a multi-level approach is needed to reduce the suicide rate effectively. This approach encompasses multiple synergistic strategies that address various aspects of suicide at both individual and contextual levels (Hegerl et al., 2013; Krysinska, 2016; Wasserman et al., 2020; Zalsman et al., 2016). Emerging evidence has demonstrated the effectiveness of this approach (Bolton et al., 2015; O'Connor et al., 2017; Pirkis et al., 2019; Zalsman et al., 2016).

Despite the evidence on the effectiveness of comprehensive suicide prevention strategies recommended for countries globally by the WHO, Nigeria remains one of the countries yet to adopt and implement them. This is due to various challenges, including stigma and resource limitations, that impede their implementation (Osafo et al., 2020).

2.4 Community-Based Approaches: Global Evidence

The WHO recommends that countries tailor their suicide prevention efforts to the local contexts, drawing on existing resources and social capital to implement suicide prevention

programs supporting their populations (Grattidge et al., 2023). This underscores the value of community-based approaches to suicide prevention (Omokhabi & Omokhabi, 2023; Pridmore et al., 2016; Raschke et al., 2022; Sidana et al., 2020; WHO, 2021). The approaches acknowledge that suicide is not solely an individual problem but is influenced by complex psychological, social, cultural, and environmental factors (Hegerl et al., 2019; Klonsky et al., 2016; O'Connor & Kirtley, 2018; WHO, 2018). Community-based prevention is rooted in the cultural, social, and economic conditions and traditions of the populations being served (National Suicide Prevention Strategies, 2024).

Evidence suggests that shifting toward community-based strategies offers a more comprehensive, participative, and context-aware way to lower suicide rates (Barlow et al., 2023; Caine et al., 2018; Hegerl et al., 2019; Klonsky et al., 2016; Lestari & Fitriyah, 2024; O'Connor & Kirtley, 2018; WHO, 2018). Moreover, the top-down approach to suicide prevention, in which government-led strategies serve as yardsticks, requires a lengthy development process; therefore, a concurrent bottom-up approach could also prove beneficial. These strategies are viewed as cost-effective for preventing suicide, which helps align partners in communities to take the necessary steps for community ownership and sustainability (Suicide Prevention Australia, 2014). They also enable previously overlooked community groups to participate in suicide prevention efforts, and community leaders can act as potential gatekeepers in resource-poor settings (Bazley, 2019; Osafo et al., 2019).

Some community-level strategies that may have the potential to prevent suicide include community awareness and education (Bachmann, 2018). These typically include public education initiatives in workplaces and schools aimed at increasing awareness and reducing stigma. Programs draw on lay gatekeepers such as clergy, teachers, and first-line responders who receive

special training on how to identify suicidal individuals and refer them to appropriate services (Isaac et al., 2009; WHO, 2014). One study evaluated the impact of a suicide awareness campaign that included billboards displaying images reminding people of reasons to live and a telephone emergency service connecting individuals to volunteers trained in suicide prevention. Compared with regions that had access only to telephone crisis services, the campaign was associated with an increase in overall hotline utilization, although no significant reduction in suicide rates was observed (Till et al., 2013).

Extensive evidence supports the efficacy of raising awareness regarding mental health, as well as risk and protective factors associated with suicide in schools. This intervention was found to reduce the occurrence of suicide attempts and severe suicidal ideation (Robinson et al., 2013; Robinson et al., 2018). School-based prevention programs typically prioritize identifying at-risk youth and their connection with appropriate resources, including peer support, school-wide screening, gatekeeper training, and the acquisition of healthy coping skills (Meyer et al., 2015). Similarly, physician education on recognizing and treating signs of depression has been proven to reduce suicide rates (Mann et al., 2005).

Alongside these educational approaches, community-based support services such as helplines have been widely accepted as an adequate support mechanism, playing an important role in suicide prevention by providing immediate, accessible support to individuals experiencing distress. These may take the form of online and telephone counselling by trained volunteers (Coveney et al., 2012; Ogbolu et al., 2020a).

LMICs have also implemented community-based approaches. Jordans et al. (2019) highlighted the effectiveness of task-sharing models in Nepal, where non-specialist community health workers were trained to deliver primary mental health interventions, including suicide

prevention measures. This approach has shown promise in expanding access to mental health support in resource-limited settings.

Among the few strategies that address multiple levels of prevention is the European Alliance Against Depression (EAAD) program, which has demonstrated significant reductions in suicidal behaviour through a community-based, multi-level intervention approach involving community stakeholders (Hegerl et al., 2021). This four-level intervention includes training and supporting primary care providers (level 1), a professional public relations campaign (level 2), training community facilitators such as teachers, priests, geriatric caregivers, pharmacists, and journalists (level 3), and providing support for self-help among patients with depression and their families (level 4) (Hegerl, 2021). In the United States, the Zero Suicide framework has gained recognition as a comprehensive, community-focused method for suicide prevention within health and behavioural healthcare systems (Labouliere et al., 2018). This model highlights the importance of leadership, training, identifying and assessing suicide risk, and ensuring smooth care transitions within a community context.

Canada does not yet have a unified national suicide prevention strategy. However, the government has implemented a Federal Framework for Suicide Prevention and a corresponding Action Plan (Public Health Canada, 2024). In this context, the *Roots of Hope* initiative, developed by the Mental Health Commission of Canada, represents a community-led approach to suicide prevention as part of efforts to build evidence to inform a coordinated national strategy and future policy development. The model is built around five pillars: safety, public awareness, research, specialized supports, and training and networking for community leaders. Additionally, the model has 13 guiding principles that emphasize collaboration, measurement and evaluation, and the recognition of lived experience (Bauer, 2023). Moreover, they suggest integrating prevention,

intervention, and postvention services to make them community-centred and innovative. The model has shown promising results in reducing suicide rates and promoting well-being. It has already expanded to 18 unique communities, three provinces, and one territory, with ongoing discussions with additional communities, provinces, and territories interested in adopting the model and potentially expanding further (Bauer, 2023).

Hofstra et al. (2020) suggest how to accomplish multi-level suicide prevention at the community level. They suggest combining (1) training gatekeepers such as teachers and priests to aid recognition of individuals potentially at risk; (2) a publicity campaign (Collings et al., 2020); and (3) providing instructions to the press on how to publish information on suicides. Additionally, at the primary care level, general practitioners could be trained on how to address suicidal thoughts and behaviour in patients (Hofstra et al., 2020). However, implementing multilevel suicide prevention interventions can be challenging, and several barriers may impede their effectiveness.

2.5 Suicidal Behaviour in Nigeria

Official statistics about suicide in Nigeria are limited and mainly depend on media reports, underscoring ongoing gaps in surveillance (Oyetunji et al., 2021). Evidence indicates that young adults face the highest risk, with media analyses from 2010 to 2019 showing elevated suicide rates among those aged 18–34, especially male students and young urban residents (Olibamoyo et al., 2021; Oyetunji et al., 2021). This trend differs from HICs, where middle-aged and older adults have the highest rates (Bachmann, 2018). Interestingly, among adolescents under 18, Nigerian studies reveal higher rates among females, pointing to specific gendered vulnerabilities (Adewuya et al., 2018; Olibamoyo et al., 2021).

However, caution is needed when interpreting Nigerian suicide statistics, as many cases are poorly reported and documented due to inadequate death registration and cause-of-death

records (Ogbolu et al., 2018; Olibamoyo et al., 2021). Most reports come from police and hospitals, but many cases go unreported because individuals often avoid reporting to prevent legal repercussions. Nigeria remains among the few countries where suicide is still criminalized. According to the country's Criminal Code Act (2004), Section 327, attempting suicide can lead to a year's imprisonment (Constitution of Nigeria, 2019). Olibamoyo et al. (2021) also reveal that only 4.5% of suicide cases reported in the media are charged and prosecuted in court by law enforcement agents. Notably, Lagos State has amended its laws and has reviewed the punishment for attempted suicide from imprisonment to hospitalization, stating that "Any person who attempts to kill himself is guilty of a simple offence and the court shall make a hospitalization order" (Section 235 of the Criminal Law of Lagos State, 2019). This legal stance distorts statistical data and may exacerbate the problem by promoting stigma and discouraging help-seeking behaviour.

Suicide methods in Nigeria mirror the country's structural context. Over half of the cases involve pesticide ingestion, with synthetic organophosphates, such as "Sniper," readily available in urban markets (Buhari et al., 2022). This pattern is consistent with evidence that the availability and accessibility of specific means strongly influence the methods used in suicide. For example, in the United States, where firearms are more accessible, they account for a large proportion of suicide deaths, while in some Asian contexts, hanging is more commonly reported (Mann et al., 2005; WHO, 2014). Research among vulnerable groups highlights this trend, with university students in Nigeria citing suicide as a leading cause of death among their peers (Ajibola & Agunbiade, 2022). For individuals living with HIV, 7.3% report experiencing suicidal thoughts (Bamidele et al., 2024). Lagos State has a notably high suicide rate, where incidents have increased significantly in the past decade. The Federal Neuro-Psychiatric Hospital in Yaba, Lagos, reported 25,000 cases in 2015, which rose to around 53,000 in 2016. This rate surpasses Nigeria's reported

lifetime prevalence of 3.2% (Adewuya et al., 2016). In its schools, 6.1% of adolescents report having suicidal thoughts, with 2.8% attempting suicide in the past month (Adewuya & Oladipo, 2020). Furthermore, young adults, males, unmarried individuals, and those with mental health issues or substance use disorders are more likely to experience suicidal thoughts (Adewuya, 2018). These findings suggest that suicidal behaviour affects both the general population and vulnerable groups, influenced by stressors such as academic pressures and ongoing challenges with illness.

2.5.1 Factors Contributing to Suicide Risk and Vulnerability in Nigeria

Similar to many settings, mental health disorders play a significant role in increasing the risk of suicide. In Nigeria, approximately 20–30% of the population experiences mental health issues, with depression being prevalent, affecting nearly 4% of the population at a given time, reflecting point prevalence rather than lifetime risk (Adewuya et al., 2018; WHO, 2019). Additionally, anxiety, substance abuse, and co-occurring conditions can further heighten this risk (Ajibola & Agunbiade, 2022; Tolulope et al., 2021). Various psychological factors have been identified that make individuals more susceptible to the risk of suicide (Lawrence, 2022; Ogunleye et al., 2019; Okoro & Okhakhume, 2017; Onu et al., 2020). Furthermore, poor academic performance and supervisor mistreatment can intensify academic pressures, especially when students are also dealing with other stressors such as poverty and family issues (Ajibola & Agunbiade, 2022; Omeje et al., 2022). Urban stressors also influence mental health: in Lagos, factors like long commutes and insecure living conditions lead to insomnia and psychological distress (Akorede, 2019). Despite this substantial burden, mental health services are often underfunded, underused, and challenging to access for many (Coker et al., 2019).

Nigeria's structural inequalities significantly influence suicide risk. Unemployment was 33% in 2020, and over 40% of the population lives below the poverty line, with recurrent economic

recessions spreading feelings of hopelessness and despair (NBS, 2021; Abdu-Raheem, 2021; Oderinde & Oderinde, 2023; Oyafunke-Omoniyi et al., 2022). Research shows that economic recessions, leading to job losses, financial struggles, and reduced welfare spending, increase vulnerability to suicide (Asogwa & Okafor, 2020). These issues primarily affect youth and urban poor communities, such as Makoko, where survival relies on unstable informal labour markets.

Religious and cultural beliefs have a complex impact. While religious prohibitions against suicide can provide moral protection (Labinjo et al., 2020), they also reinforce stigma, making individuals less likely to disclose their struggles or seek help (Jidong et al., 2024; Ongeri et al., 2022). Studies found that stigma may be directed towards the suicidal individual and, in cases of fatal suicidal behaviour, towards the bereaved family members, increasing distress and fostering ongoing isolation (Jidong et al., 2024; Labinjo et al., 2020; Ongeri et al., 2022). Previous research indicates that help-seeking behaviour for mental health issues is significantly impacted by stigma, as individuals often fail to recognize early mental health symptoms out of fear of negative labelling and concerns about potential social disconnection, ridicule, and marginalization (Gureje et al., 2015a; Labinjo et al., 2020). Also, families often conceal suicide attempts to avoid societal judgment, which results in a lack of accurate data and, consequently, insufficient resources for intervention (Alabi et al., 2014; Lawal, 2018; Ogbolu et al., 2018).

Additionally, individuals can delay treatment and seek spiritual solutions, such as prayers and traditional rituals, rather than Western psychiatric care (Burns & Tomita, 2015; Labinjo et al., 2020; Ongeri et al., 2022). Research indicates that a significant number of people in LMICs who need assistance seek help from traditional and religious healers for various health issues, including mental disorders (Adewuya et al., 2017; Gureje et al., 2015a; Jordans et al., 2018; Ongeri et al.,

2022). This pattern has been attributed to a combination of factors, including stigma surrounding mental illness (Burns & Tomita, 2015; Labinjo et al., 2020; Ongeri et al., 2022).

While this help-seeking pattern is well documented at a general population level, little is known about how it operates within urban slum communities like Makoko, where structural barriers such as poverty, overcrowding, geographic marginalization, and limited access to formal care constrain residents. This gap underscores the need for qualitative, community-based research that centres the perspectives of slum residents and examines how suicide is understood and addressed within these informal care pathways.

Another significant factor influencing suicidal behaviours in Nigeria is family dynamics. Nigeria has a collectivist culture that places great importance on family and community ties for emotional support and social identity (Oyafunke-Omoniyi, 2022). Research continuously links higher suicide risk to family dysfunction, such as marital problems, family conflicts, divorce and physical violence from an intimate partner (Abdu-Raheem & Alonge, 2021; Ajibola & Agunbiade, 2022; Lamis et al., 2018; Ojagbemi et al., 2013; Oyafunke-Omoniyi et al., 2022). Relationship difficulties (24.4%) were the most reported narratives for a desire for suicidal behaviours (Adewuya & Oladipo, 2020; Oyetunji et al., 2021).

When individuals experience relationship breakdowns or conflicts within their families and relationships, this may limit their access to social support systems, leading to social isolation (Oderinde & Oderinde, 2023). Consequently, this may lead to significant mental health issues and subsequent suicidal behaviours in people. Social isolation resulting from a lack of social support is a common problem in Nigeria, especially among the elderly (Ojagbemi et al., 2013; Oladeji et al., 2017). It is important to note that individuals in vulnerable communities may be at a higher risk of suicidal behaviours when they face negative family dynamic challenges.

Finally, structural barriers within Nigeria's health system increase risks. Access to mental health services is limited, expensive, and stigmatized, contributing to their underutilization (Adewuya et al., 2016; Coker et al., 2019; Mba-Oduwusi et al., 2024). While large-scale surveys such as the Lagos State Mental Health Survey provide important population-level insights, marginalized groups, including residents of urban slum communities, are often underrepresented or insufficiently captured due to challenges related to sampling, geographic accessibility, and service engagement. For residents of slums, these obstacles are worsened by poverty, overcrowding and isolation, leading many to depend on traditional healers or informal care networks (Fayehun et al., 2022).

These limitations highlight the need for community-based qualitative research that centres the experiences and perspectives of slum residents, thereby strengthening the relevance and context-specificity of suicide prevention efforts.

2.6 Community-Based Suicide Prevention Approaches in Nigeria

Community-based suicide prevention is still emerging in Nigeria, demonstrating both potential and challenges. Formal supports, including telephone helplines that provide essential crisis support, have seen an increase in calls, particularly among young people. Nonetheless, maintaining 24/7 multilingual services is resource-demanding (Ogbolu et al., 2020a). Similarly, incorporating mental health into primary care by training primary care workers through the WHO mental health GAP (mhGAP) has strengthened health workers' ability to detect and treat depression and suicide risk (Adewuya et al., 2016; Ali & Chakraborty, 2022; Gureje et al., 2015b). This approach suggests how community-based suicide prevention can be integrated into broader mental health initiatives.

Gureje et al. (2015b) conducted a study among 198 primary healthcare workers from 68 primary care clinics across eight local government areas (LGAs) in Nigeria, with a combined population of 966,714. These populations have been trained to detect and manage four mental health conditions, including depression, using the mhGAP intervention guide. The results showed a marked improvement in the knowledge and skills of the health workers, and a significant increase in the number of persons identified and treated for mental health conditions, as well as in the number of referrals. This approach is promising in Nigeria; however, the reach and sustained retention of the skills remain limited.

Other emerging strategies involve training and showcasing the innovative use of accessible professionals as gatekeepers (Chike-Obuekwe et al., 2022; Olibamoyo et al., 2023), who conducted a brief 90-minute suicide intervention training program for police constables. The results found a significant improvement in three key areas, including perceived knowledge about suicide, self-confidence in preventing suicide and attitudes toward suicidal behaviours. This suggests that even a short training intervention can have a measurable positive impact on police officers' readiness to act as “gatekeepers” in suicide prevention efforts. While this study is helpful, it does not address long-term retention of skills or the actual impact on suicide rates.

Chike-Obuekwe et al. (2022) explore the potential role that community pharmacists in Nigeria could play in suicide prevention, highlighting that they are easily accessible and trusted healthcare professionals, making them well-positioned as potential gatekeepers to support suicide prevention efforts. However, the study is theoretical and does not provide empirical evidence of effectiveness. Omokhabi and Omokhabi (2023) highlighted the importance of community engagement for effective suicide prevention, involving awareness campaigns, training community members, organizing support groups, and reducing access to common suicide methods. They also

pointed to the crucial role of social workers as potential gatekeepers and counsellors in suicide prevention in Nigeria.

Informal support, including strong family and social connections, such as those with friends or community groups, has been shown to provide a protective effect against suicidal behaviour (Atilola, 2017; Kukoyi et al., 2023; Sekoni et al., 2022). Strengthening these factors potentially provides resilience to individuals and consequently prevents suicide. The provision of job opportunities, social assistance for unemployed individuals, initiatives that increase access to vocational training, microfinance loans, and job placement were suggested as protective factors that could make a difference and prevent suicide in Nigeria (Abdu-Raheem & Alonge, 2021; Atilola & Ayinde, 2015; Oyafunke-Omoniyi et al., 2022).

Faith-based organizations have a vital role, as many Nigerians often seek support and guidance from religious leaders. Research indicates that pastors and imams already provide counselling, follow-up support, and group interventions, but their effectiveness varies with proper training (Ogbolu et al., 2020b; Nwafor, 2024; Salami & Onuegbu, 2019). The role of religious institutions goes far beyond meeting spiritual needs; they are also concerned with the socioeconomic well-being of their communities (Nwafor, 2024). In fact, religious leaders, particularly Pentecostal pastors, facilitate both physical and spiritual healing, which can lead to psychological healing, given the connection between spiritual beliefs and mental well-being (Dyikuk, 2019; Salami & Onuegbu, 2019). This has significant implications for suicide prevention.

Despite these efforts, gaps still exist. There are no programs targeting slums like Makoko, where stigma, poverty, and inadequate infrastructure increase suicide risk. Most initiatives remain as pilot projects or theoretical frameworks rather than evolving into ongoing, scalable solutions.

2.7 Evidence on Awareness of Suicide and Prevention Strategies

Awareness of suicide, its risks and prevention strategies/programs remains inconsistent. Research across various settings, including a study in nine countries, including Armenia, Azerbaijan, Brazil, China, Egypt, Georgia, Israel, Russia, and Uganda, revealed relatively low pre-campaign awareness levels, particularly among teachers, who showed limited interest in mental health knowledge and discussions about emotional problems (Hoven et al., 2009). Similarly, healthcare students in Australia also demonstrate persistently low baseline knowledge of suicide, even after participating in mental health programs (De Silva et al., 2015). Additionally, rural communities in India show limited recognition of suicide as a public health concern (Sidana et al., 2020). Even within healthcare systems, professionals show variable and often insufficient awareness of suicide risk, highlighting a global challenge in frontline detection and intervention (Dillon et al., 2020; Granek et al., 2018).

A nationally representative sample of 1002 U.S. veterans were surveyed online in 2018 to assess their awareness and participation in suicide prevention programs offered by the Department of Veterans Affairs (VA). The results found that most veterans (54–72%), including those who did not identify the VA as their primary healthcare provider, were aware of the Veterans Crisis Line, Vet Centers, and the VA Center for Suicide Prevention (Tsai et al., 2020; U.S. Department of Veterans Affairs, 2018).

In Nigeria, a study conducted among 3,000 students at a tertiary institution to assess their awareness of the causes of suicidal behaviour and prevention strategies revealed that students had high awareness of both (Okudo et al., 2023). In addition, another study conducted in an urban setting in the country found that participants demonstrated a general awareness of suicide (Obarisiagbon & Abu, 2021; Okudo et al., 2023). However, the broader literature on awareness of

suicide and prevention in Nigeria is limited and existing studies have primarily used quantitative methods, which have offered only a partial understanding of the issue. Additionally, to the best of the researcher's knowledge, this is the first study focused on understanding and addressing suicide in the slum communities. Therefore, this research sought to fill the gap in the literature by employing a qualitative methodology to explore the awareness of suicide and prevention among Makoko residents in Lagos State.

2.8 Relevance of the Global and Nigerian Findings to Informal Urban Settlements

Global and Nigerian studies offer valuable insights into suicidal behaviour. Much of the global literature has traditionally focused on individual-level factors that influence suicidal risk and clinical care, often in settings where formal mental health services are more accessible (Bachmann, 2018; Fazel & Runeson, 2020; Ishimo et al., 2021; Mann et al., 2021; WHO, 2023).

Within the Nigerian context, existing literature has identified important factors influencing suicide, including stigma, cultural and religious interpretations, and challenges related to underreporting (Gureje et al., 2015a; Labinjo et al., 2020; Oyetunji et al., 2021). However, much of this evidence is derived from hospital-based data, media reports or institutional records, which may not adequately reflect the realities of residents in informal urban settlements. In such contexts, access to formal healthcare services is often limited, and individuals are more likely to rely on informal support systems, including family networks, religious leaders, and community structures (Osafo, 2011). These differences suggest that while Nigerian findings provide valuable cultural and contextual insights, they may not fully explain how suicide is understood and addressed in marginalized urban settings where structural conditions significantly shape both vulnerabilities to distress and pathways to care.

Empirical studies examining suicide in informal settlements or slum communities remain relatively limited; however, the available literature consistently demonstrates that suicidality in these contexts is shaped by an interplay of structural deprivation, social adversity, and individual psychosocial vulnerabilities. Unlike dominant biomedical perspectives that frame suicide primarily as an individual mental health issue, research in low-resource urban settlements emphasizes the role of poverty, unstable living conditions, and social marginalization in producing heightened vulnerability (Subbaraman et al., 2014).

Evidence from sub-Saharan Africa provides some of the most robust insights into suicide-related vulnerabilities in slum settings. In a study of youth living in the slums of Kampala, Uganda, Swahn et al. (2012) reported alarmingly high prevalence rates, with 31% of participants reporting suicidal ideation and 20% reporting suicide attempts. Suicidal ideation was significantly associated with a range of vulnerability factors, including parental neglect linked to alcohol use, substance use, loneliness, sadness, and engagement in high-risk survival behaviours such as trading sex for money. Similarly, Culbreth et al. (2018), using a larger sample of 1,134 youth in Kampala's informal settlements, found that nearly one-quarter of participants reported past-year suicidal ideation. Key predictors included female gender, orphanhood, history of living on the streets, parental physical abuse, rape, sexually transmitted infections, and problem drinking. These findings highlight how suicide risk clusters around experiences of trauma, family disruption, and social instability in slum environments.

Further evidence from Kampala underscores the magnitude of the problem among adolescents. Bukuluki et al. (2021) found that 30.6% of adolescents reported suicidal ideation within the past four weeks, while 24.2% reported suicide attempts within the previous six months. Financial hardship, family conflict, and exposure to traumatic events were identified as major

contributing factors. Importantly, adolescents who reported awareness of where to access professional psychological support were less likely to experience suicidal ideation, suggesting that access to care may serve as a protective factor even within highly deprived settings.

Research from South Asia adds a critical sociocultural dimension to the understanding of suicide in informal settlements. In a sociocultural autopsy study conducted in the Malavani slum in Mumbai, India, Parkar et al. (2009) found that suicide was often attributed to "tension," a locally meaningful term encompassing psychological distress arising from multiple intersecting stressors. These included marital conflict, gender-based violence, alcohol misuse, chronic illness, and culturally embedded beliefs such as spiritual causation. The study further highlighted gendered vulnerabilities, with women disproportionately affected by the consequences of a partner's alcohol use and domestic instability. This sociocultural framing reinforces the need to interpret suicide within locally grounded meanings rather than imposing purely clinical explanations.

Beyond suicide-specific studies, broader research on mental health in slum settings provides additional context for understanding vulnerability. A mixed-methods study in Mumbai demonstrated that poverty, insecure housing, and limited access to services were strongly associated with common mental disorders, while qualitative findings emphasized the psychological toll of exclusion, deprivation, and strained relationships with institutions (Subbaraman et al., 2014). Similarly, a systematic review by Abdi et al. (2021) identified overcrowding, low educational attainment, and marital strain as key determinants of poor mental health among women in slum communities. These structural and social conditions form the broader context within which suicide vulnerability emerges.

In the Nigerian context, there are no studies focusing on suicide in informal or slum communities. This study addresses this gap by exploring suicide awareness and community-based

prevention strategies within the Makoko community to contribute to a more contextually grounded understanding of suicide in marginalized urban settings. Through a qualitative exploration of community members' experiences, it aims to develop insights to inform culturally relevant, community-based approaches to suicide prevention in similar low-resource settings.

Conclusion

This chapter focuses on the literature review and highlights both global and Nigerian perspectives on suicidal behaviour, outlining the determinants of suicide and various prevention strategies used across different contexts. It demonstrates that suicide results from the interaction between mental health issues and broader socio-economic and cultural factors. These factors are categorized across the ecological levels of an individual. While research worldwide shows that universal, targeted, and indicated interventions are effective, these often need adaptation for LMICs, where structural barriers, stigma, and resource shortages are common. In Nigeria, suicide mainly affects young people and urban populations, predominantly through pesticide ingestion, with stigma and criminalisation leading to underreporting. Risk factors for suicide extend beyond mental health issues to include poverty, unemployment, family conflicts, cultural taboos, and healthcare system failures. Social support, community monitoring, and gatekeeper programmes are some recognized protective factors, but they remain underdeveloped in Nigeria. Community initiatives such as helplines, faith-based efforts, and mhGAP integration show promise but are fragmented and limited, particularly in informal settlements.

Chapter 3: Theoretical Frameworks

Introduction

This chapter introduces the theoretical framework used in this study to understand suicide awareness and prevention through a structured lens. It is organized into three parts. The first part provides an overview of multi-level theories in suicide prevention, positioning them as more comprehensive than traditional theories. Three such theories are discussed: Intersectionality Theory (IT), Transactional Ecological Theory and Ecological Systems Theory (EST). EST is the primary theory that guides this study. The second part describes two complementary frameworks that are later integrated with EST. This framework includes Social Learning Theory and a Strength-Based Perspective, both of which contribute to a holistic understanding of suicide awareness and prevention. The final part integrates EST, Social Learning Theory (SLT), and the Strength-Based Perspective (SBP) into a cohesive framework for understanding suicide awareness and prevention in Makoko.

3.1 Overview of the Multi-Level Theories Framework for Suicide Prevention

Previous research on suicide has indeed placed a strong emphasis on isolated or single risk factors associated with suicidal behaviour. Isolated risk factors are based on single-level theories such as biological perspectives (Oquendo et al., 2014), sociological approaches (Abrutyn & Mueller, 2019), cultural influences (Chu et al., 2010), psychological factors (Van Orden et al., 2010), a range of diathesis-stress models (O'Connor, 2011), ideation-to-action theories (O'Connor, 2011; O'Connor & Kirtley, 2018; Klonsky et al., 2018; Van Orden et al., 2010), and others. The ideation-to-action theories, which include the interpersonal theory (IPTS), integrated motivational–volitional model (IMV), three-step theory (3ST), and fluid vulnerability theory (FVT), are among the most recent and promising suicide prevention theories because they

differentiate between the factors that lead an individual to experience suicidal ideation from those that lead them to attempt suicide (Klonsky et al., 2016; Klonsky et al., 2018).

While traditional theories attempt to understand suicide risk, they do not offer a nuanced understanding of specific risk factors for suicidal behaviours. However, they lack specificity regarding the complex interactions among factors that lead to suicidal behaviour, including ideation (O'Connor, 2011; O'Connor & Kirtley, 2018; O'Connor & Nock, 2014). They also fail to account for both individual and contextual risk and protective factors for suicidal behaviour. Moreover, their conclusions pathologize individuals experiencing suicide (Baril, 2020). Recent research indicates that contextual factors such as discrimination, poverty, and unemployment can significantly predict suicide risk, sometimes even more so than individual psychopathology (O'Connor & Nock, 2014). Eriksson et al. (2018) recommend moving beyond merely contextualizing isolated factors, as this contributes to the current limited knowledge of suicide and its prevention.

Multi-level theories serve as comprehensive frameworks for explaining the complex interactions among biological, environmental, psychological, and social factors (Klonsky et al., 2016; O'Connor & Kirtley, 2018; O'Connor & Nock, 2014). They recognize how these multi-layered and intersecting factors operate across individual, interpersonal, community, and societal levels in understanding personal development. As a result, they are appropriate frameworks for analyzing suicide.

3.1.1 Intersectionality Theory (IT)

Kimberlé Crenshaw, a law scholar specializing in Black feminism, introduced the concept of intersectionality in the late 1980s. The core idea is that social outcomes are shaped by multiple overlapping factors that interact simultaneously and inseparably. Intersectionality examines how

various social identities, such as gender and race, intersect and how power and oppression overlap (Crenshaw, 1989). It acknowledges that identities such as gender, race, sexuality, class, and disability are shaped by diverse historical, social, cultural, and political contexts. Since its origins in Black feminist thought, the concept of intersectionality has evolved significantly. Early research primarily focused on the convergence of race and gender, but over time, scholars expanded this to include sexuality, class, ability, and other identities (Bilge & Collins, 2016).

Understanding intersectionality is crucial when addressing issues like suicide and mental health. Studies indicate that effective prevention requires insight into how social identities intersect and impact suicidal behaviour (Bowleg, 2012; Mueller et al., 2015; Standley, 2022). During adolescence, a key period for identity development, victimization and discrimination based on these identities increase (Garnett et al., 2014), which can be harmful. Multiple studies support this, showing youth with intersecting marginalized identities are at higher risk of suicidality (Hong et al., 2011; Standley, 2019). According to Standley (2019; 2020), youth with more than one marginalized identity are considered a high-risk group compared to those with only one or none. Therefore, youth suicide must be understood within the context of intersecting forms of marginalization (Hagen, 2022).

Virupaksha et al. (2016) argue that intersectionality provides a valuable framework for analyzing suicide risk by considering systemic oppression and marginalization's effects on mental health disparities and suicide rates among minorities. The theory emphasizes the importance of culturally inclusive prevention and intervention strategies that address interconnected forms of prejudice and adversity (McKenzie-Mohr & Lafrance, 2011; Pompili et al., 2014). Various studies explore how the complex interaction of marginalized identities amplifies minority stress and suicide vulnerability (Pompili et al., 2014; Virupaksha et al., 2016). For example, research

highlights the higher suicide rates among LGBTQ+ adolescents from racial and ethnic minorities, emphasizing the combined impacts of racism, heterosexism, and cisgenderism (Pompili et al., 2014).

Disability is another critical axis of oppression that, alongside racism and sexism, benefits from an intersectionality perspective, which is more commonly studied (King et al., 2018). When considering the intersection of suicide and disability, it is important to recognize that people with disabilities, regardless of their disability type, are at a higher risk of suicide than the general population and that this risk can be influenced by a variety of factors, including social isolation, discrimination, and lack of access to mental health services (Saxe, 2017). When examining the intersection of suicide, disability, and other social identities, it is important to recognize that these identities can interact in complex ways to create unique experiences of oppression and marginalization.

Considering the lack of mental health services and structural inequalities confronting residents in Nigeria, individuals with disabilities may face additional challenges and discrimination in accessing support and services due to their impairment (Olalekan & Jimoh, 2021). They may also experience negative attitudes and stereotypes from society, family, and peers, which can affect their self-esteem and mental well-being (Olalekan & Jimoh, 2021). Moreover, people with disabilities who belong to other marginalized groups, such as women, ethnic minorities, or sexual minorities, may encounter multiple forms of oppression and exclusion, which can exacerbate their vulnerability and isolation, consequently leading to suicide (Meltzer et al., 2012).

Although intersectionality theory offers a framework through which one may comprehend the intricate dynamics of how several marginalized identities intersect and contribute to the

heightened risk of suicide, the theory has some drawbacks. One of these drawbacks is the challenges posed by the theory, including managing complex social identities amid disagreements over priorities and assessment methods (Cooper, 2015). Also, quantifying these identities is challenging, and there is no transparent methodology for the concept (Bauer et al., 2021). Furthermore, there is uncertainty over the extent and generalizability of intersectionality, with some arguing that it upholds rigid societal categories (Cooper, 2015).

3.1.2 Transactional Ecological Theory (TET)

Transactional-ecology theory, developed by psychologist Arnold Sameroff in the 1970s, posits that human development is shaped by multiple factors at various levels, including the genotype, phenotype, and environtype. According to this perspective, development is an ongoing process that involves continuous interaction between individuals and their environment, with influence operating at nested levels, from the micro to the macro. Sameroff emphasized the importance of processes and individual traits in development. TET is a holistic, interdisciplinary approach that integrates insights from genetics, psychology, sociology, and ecology to deepen understanding of human development. At the core of TET is the idea that individuals are not passive recipients of their environment but active agents who shape and are shaped by it. Thus, TET emphasizes the importance of understanding the bidirectional and dynamic nature of the relationship between individuals and their environment.

Since its initial development, TET has undergone several revisions and refinements, expanding and elaborating on its core principles. One critical development has been the incorporation of gene-environment interaction (GxE) into the theory. GxE posits that genetic and environmental factors interact to shape human development and behaviour and that this interaction is not fixed or deterministic but rather dynamic and reciprocal (Cicchetti & Blender, 2004).

Another vital evolution of TET has been the recognition of the importance of context in shaping development. Specifically, TET has emphasized the role of multilevel, nested environments in shaping human development, from the microsystem level (immediate family and friends) to the mesosystem level (schools and neighbourhoods) to the macrosystem level (cultural and societal norms) (Sameroff, 1989). Recent developments in TET have also highlighted the importance of individual agency and active engagement with the environment in shaping human development. This perspective emphasizes the dynamic, transactional nature of development, in which individuals actively shape their environments and, in turn, are shaped by them (Lerner, 2006).

Given the emphasis on the bidirectional and dynamic nature of human development, TET has essential implications for understanding suicide. TET provides a valuable framework for understanding the various levels of influence on suicide and the transactional processes that underlie it. At the level of the genotype, there is evidence to suggest that genetic factors play a role in suicide. Studies have shown that there is a heritable component to suicidal behaviour, with genetic factors accounting for around 30-50% of the variance in suicide risk (Mann et al., 2009). However, it is essential to note that genetic factors do not operate in isolation but rather interact with environmental factors to shape suicide risk. For example, certain genetic variations may increase an individual's susceptibility to stress, which can, in turn, increase their risk for suicide (Mann et al., 2009).

At the phenotype level, numerous psychological and behavioural factors are associated with suicide risk, such as depression, anxiety, impulsivity, hopelessness, and low self-esteem (Joiner, 2005). These factors can be influenced by both genetic and environmental elements, which may interact to elevate risk. For instance, a genetic predisposition to depression might combine with stressful life events to spark suicidal thoughts (Joiner, 2005).

However, not everyone experiencing these risk factors will attempt suicide, underscoring the significance of environmental influences within TET. Various environmental factors, such as social isolation, lack of social support, stressful events, accessibility to lethal means, and exposure to suicide, have been identified as risk contributors (Fazel & Runeson, 2020). Given all the above, it is important to analyze suicide risk from a multidimensional and transactional perspective instead of concentrating on a single factor. The major weakness of TET is that conducting empirical research with it is challenging due to its complexity and numerous reciprocal influences.

3.1.3 Ecological Systems Theory (EST)

Bronfenbrenner developed the theory in the 1970s as a response to earlier theories of child development. The theory uses the ecology of human development to explain how an individual interacts with interrelated systems in their environment (Bronfenbrenner, 1983). It posits that human development is a function of reciprocal interactions between individuals and their environments (Bronfenbrenner, 1979). According to him, the individual's environment is a nested arrangement of structures, with one structure a subset of another, like concentric circles (Bronfenbrenner, 1977). The structures are organized according to their impact on an individual. Bronfenbrenner proposed five structures: microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

3.1.3.1 The Microsystem. The microsystem is the most immediate system to an individual, comprising environments such as family, friends, workplace, and school (Bronfenbrenner, 1977). An individual's development at this level is shaped by bidirectional relationships with family members, in which influence flows both ways (Guy-Evans, 2020). Strong, nurturing family bonds tend to have positive effects, whereas distant or unloving family bonds can harm individuals.

3.1.3.2 The Mesosystem. The mesosystem comprises connections between microsystems, such as between a family and a school or a family and peer groups (Bronfenbrenner, 1977). It explains how a person's microsystems influence one another (Guy-Evans, 2020). The interactions between the microsystems may lead to an increase or decrease in the risk of suicide. For instance, a positive relationship between the family and the school can increase the protective aspect of social support. In contrast, a negative relationship between the two may increase the risk of suicide.

3.1.3.3 The Exosystem. This describes interactions among two or more environments, at least one of which does not directly involve the individual. The exosystem can either reinforce protective networks or increase vulnerabilities. For example, a parent's work environment might indirectly affect their relationship with their children and their parenting style, which in turn influences the children. Also, when parental employment is unstable, it can raise family stress levels and potentially increase the risk of suicide among youth.

3.1.3.4 The Macrosystem. The macrosystem encompasses the overarching patterns, values, and ideologies within a culture or subculture, including economic, political, and social contexts that shape an individual's actions across micro-, meso-, and exosystem levels (Bronfenbrenner, 1977). As Kitchen et al. (2019) note, the macrosystem influences how other systems, such as family, schools, and neighbourhoods, operate.

3.1.3.5 The Chronosystem. In Bronfenbrenner's ecological systems theory, the chronosystem is the last level of analysis. It is the time component of human development, focusing on the long-term effects of developmental changes. It highlights the impact of time, historical events, and changes on an individual's development (Bronfenbrenner, 1979; Guy-Evans, 2020; Hong et al., 2011). The chronosystem encompasses an individual's experiences (e.g.,

maturation, childhood trauma, historical events, and significant life transitions) and transformations as they move through various life stages, from conception to death. For example, early-life stress or hardship may have a lasting impact on development and the likelihood of suicide (Guy-Evans, 2020).

Bronfenbrenner's ecological systems theory has undergone several modifications since its first inception in 1977. In fact, it continued to evolve until 2005, when he died (Eriksson et al., 2018). The development of Bronfenbrenner's theory unfolded in three stages. The initial phase (1973-1979) proposed an ecological approach to research in human development. During the following phase (1980-1993), "a stronger emphasis [was placed] on the role of the individual and developmental processes" (Eriksson et al., 2018, p. 416), along with changes over time in the individual and their environments, which Bronfenbrenner called the *chronosystem*.

In the latter phase (1993-2006), the Process–Person–Context–Time (PPCT) model was developed (Eriksson et al., 2018). This Model (PPCT) has since become the bedrock of the bioecological model. Ecological systems theory has been previously applied to various areas of research and used to understand numerous issues, including suicide (Eriksson et al., 2018). Systems theory has been meaningfully applied to a range of health issues and prevention programs. For example, the Centers for Disease Control and Prevention has developed a social-ecological model (SEM) as a prevention framework (CDC, 2017). Cramer & Kapusta (2017) apply the CDC's ecological framework to organize suicide risk and protective factors, thereby informing corresponding prevention strategies. This study used the earlier version of the theory, which emphasizes the nested environmental systems, and uses the terms "ecological systems theory" and "Bronfenbrenner's theory" interchangeably throughout this dissertation.

Notwithstanding the relevance of the theory in gaining insight into the suicide phenomenon, it has some limitations. A significant limitation of ecological systems theory is that it is challenging to test empirically; studies investigating ecological systems may establish an effect but cannot determine whether the systems directly cause it. Furthermore, this theory may lead to the assumption that individuals who lack stable, positive ecological systems may experience developmental delays. Whilst this may be true in some cases, many people can still develop into well-rounded individuals without positive influences from their ecological systems. For instance, it is not true to say that all people who grow up in poverty-stricken areas will develop negatively. Similarly, if a child's teachers and parents do not get along, some children may not experience adverse effects if they are not involved. Therefore, making broad assumptions about suicidal individuals using this theory should be done with care.

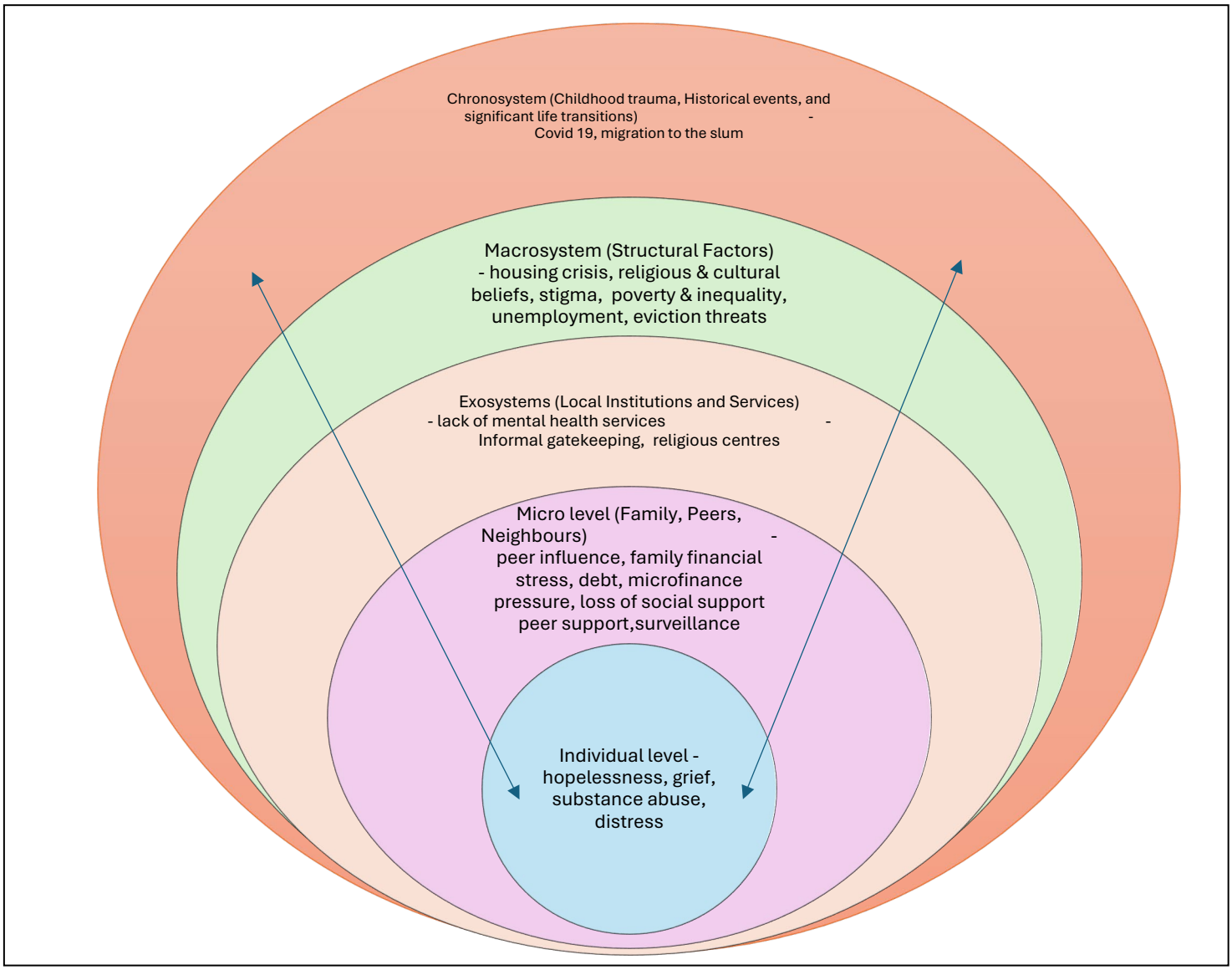
In the context of suicide prevention in Makoko, the ecological framework examines both individual and broader environmental factors. The individual is considered a system, and suicidal behaviour is the product of the interplay between their characteristics, their immediate environment (e.g., family, school and peer group), and the broader social system of which they are a part (e.g., culture and values). Families, peers, and religious groups are crucial support networks in Makoko. Healthy relationships can protect against suicidal thoughts, while dysfunctional or abusive relationships can heighten risk. Additionally, a person experiencing suicidal thoughts might contribute to prevention efforts by engaging in programs where they share their experiences, helping to reduce suicide rates. In addition, cultural norms such as religious prohibitions against suicide can both protect individuals and reinforce stigma, which may hinder help-seeking.

Furthermore, life transitions, including migration into the slum, receiving eviction notices, bereavement, or economic shocks, as well as ongoing stress over time, contribute to long-term

vulnerability. In this study, ecological systems theory is integrated with social learning theory and a strength-based perspective as the framework for understanding how the residents understood the concept of suicide, to identify the interplay of complex factors that can pose unique challenges for individuals at risk of suicide and affect their mental health, as well as ways to address them.

Figure 2

Ecological Model of Suicide Risk and Prevention in Makoko



3.2 Complementary Theories

3.2.1 Social Learning Theory (SLT)

SLT was developed by Albert Bandura in 1977. The theory suggests that learning involves cognitive, observational, and imitative processes through which individuals acquire new behaviours, attitudes, and knowledge by observing and imitating others (Bandura, 1977). Earlier theories focused on responses to environmental stimuli, such as rewards or punishment. In contrast, SLT emphasizes the dynamic relationship between social environment characteristics, how individuals perceive them, and their motivation and ability to imitate observed behaviours. People influence and are influenced by their environments. According to the theory, learning occurs through observation, imitation, reinforcement, modelling, and self-efficacy.

Social learning theory has roots in social behaviourism, a psychological movement dating back to the early 1870s that highlighted the role of the environment in shaping social behaviour (Woodward, 1982). Over time, this approach evolved into stimulus-response theories, notably B.F. Skinner's operant conditioning posits that behaviour is shaped and reinforced through rewards and punishment (Woodward, 1982). The modern form of social learning theory, however, was pioneered by Albert Bandura, who argued that social variables and interpersonal contexts are vital to learning (Bandura, 1977). The theory posits that learning is a cognitive process that occurs in social contexts, primarily through observation and modelling. Humans learn by watching and mimicking the behaviours, attitudes, and emotional reactions of others.

Models facilitating this process include live models, who physically demonstrate behaviours; verbal models, who explain or instruct on expected actions; and symbolic models, representing fictional or real characters from media such as movies, television, radio, books, or online sources. These models can promote learning, much like live demonstrations. Social learning

is an active process; while social environments influence attitudes and behaviours, individuals also shape their environments through reciprocal determinism (Bandura, 1977; 1986). Observation alone is not enough for learning; four processes are essential: attention, retention, reproduction, and motivation. Learners need to focus on what they observe, remember the information, reproduce the behaviours, and be motivated to do so. If a model is admired or if behaviours lead to positive outcomes, learners are more likely to retain and imitate them (Bandura, 1977).

In Makoko, people acquire knowledge about suicide through everyday interactions with family, friends, religious figures, and traditional healers. These individuals play a central role in shaping understanding and responses to suicide. Cultural and religious beliefs, stigma, and informal prevention methods strongly influence this environment. For example, religious teachings and cultural norms often frame suicide as a moral or spiritual problem, which fosters silence and discourages open conversations. The absence of formal mental health services leads community members to depend on informal care networks, where beliefs about suicide are shared through observation and repetition rather than evidence-based information.

These factors demonstrate that awareness is not merely an individual concern but is shaped and sustained by social learning and collective perspectives. Simultaneously, SLT provides a framework for recognizing opportunities to change these patterns. By integrating positive models like trained community gatekeepers, peer educators, and faith leaders who possess culturally appropriate suicide prevention skills, future efforts can break cycles of stigma and silence. Thus, SLT not only clarifies existing challenges but also directs the creation of more effective, culturally tailored community strategies for suicide prevention.

3.2.2 Strengths-Based Perspective (SBP)

The strength-based perspective, also known as the strength-based approach (SPA), is a practice model with theoretical origins in several diverse yet related fields, exhibiting an eclectic nature (Gray, 2011). It is often associated with Bertha Reynolds, a mid-20th-century social worker, and Dennis Saleeby, a late-20th-century scholar. However, its roots lie in the work of Black scholars and social workers. Du Bois highlighted the resilience of Black people in adapting to and surviving challenging conditions. Early 20th-century Black social workers, such as Birdye Henrietta Haynes and Elizabeth Ross Haynes, shifted their focus from pathology to an emphasis on the strengths and resilience within families and communities (Wright et al., 2021).

SBP asserts that all individuals, groups, families, and communities possess strengths. Instead of focusing on weaknesses, the goal is to empower, utilize existing community resources, and promote both individual and collective strengths (Saleebey et al., 1996). The seven core principles of SBP include recognizing that people possess numerous strengths and have the capacity for ongoing learning and growth. Saleebey (1992a) emphasizes that individuals and groups possess extensive, often underappreciated reservoirs of physical, emotional, cognitive, interpersonal, social, and spiritual energies and resources (p. 6).

The second principle highlights that interventions should focus on clients' strengths and aspirations. Traditionally, service providers tend to concentrate on problems, deficits, and pathologies, which Graber and Nice (1991, as cited in Miley, O'Melia & DuBois, 2001) note "empowers the problem and disempowers the person" (p. 79). Third, communities and social environments are viewed as rich resources. When viewed as "pathological, hostile, or toxic" (Kisthardt, 1992, p. 66), their potential resources are often neglected, and interventions might be avoided. Conversely, SBP considers social contexts as "a lush topography of resources and

possibilities," with individuals and institutions offering knowledge, support, resources, or simply time and space (Saleebey, 1992, p. 7). Such environments provide vital resources for everyone, not only clients, including family, friends, workplaces, religious groups, sports clubs, and local businesses.

The approach encourages service providers to explore the whole support network within their communities, rather than relying solely on welfare or specialist organizations. Fourth, collaboration between service providers and clients is essential. Since clients are generally the experts on their own situations, Saleebey (1992) suggests that the professional role may not be the best vantage point for recognizing client strengths (p. 7). Therefore, strengths-based methods emphasize partnership and cooperation. Fifth, interventions are grounded in self-determination. A collaborative, non-expert relationship reduces the likelihood that providers will make decisions on clients' behalf, preserving their autonomy. Sixth, there is a focus on empowerment. Despite its occasional overuse, empowerment remains a vital concept (Sullivan & Rapp, 1994). It aligns with collaboration and self-determination, defined by Staples (1990, as cited in Sullivan & Rapp, 1994) as "the ongoing capacity of individuals or groups to act on their own behalf for greater control over their lives and futures" (p. 92-93).

Finally, problems are seen as arising from interactions among individuals, organizations, or structures rather than being inherent deficits within them. From a strengths perspective, problems are frequently the result of interactions between people, organizations or structures. By focusing on how the interactions contribute to the situation and on people's strengths, it is possible to avoid blaming the victim (Saleebey, 1992a).

SBP has been applied across a wide range of settings and populations, including family work, youth work, chronic illness, substance misuse, poverty and community development, to name but

a few (Saleebey, 2006). It has been viewed as an alternative approach that hinges on the belief that communities are experts in their own experiences and have the capabilities and motivation to make necessary changes (Bryant et al., 2021; Russell-Bennett et al., 2023). SBP represents a fundamental shift toward 'working with,' rather than 'working on,' communities. This approach encourages a focus that extends beyond merely identifying problems within communities, aiming instead to uncover the potential of what can be (Hammond, 2010).

Research frequently characterizes local areas, including informal urban settlements often described as slums, primarily in terms of poverty and deprivation, an approach which can be problematic (Bourke et al., 2010). This emphasis on shortcomings is known as 'deficit discourse' or the 'deficit paradigm,' terms that highlight perceived deficiencies in individuals or groups (Fogarty et al., 2018a). Such discourse tends to assign blame to individuals for problems while ignoring the broader socio-economic, environmental, and cultural factors that influence their situations (Fogarty et al., 2018b). Although it can increase awareness of service gaps in vulnerable communities, it often neglects their strengths, adaptive support strategies, and potential for change (Bourke et al., 2010).

SBP aligns well with integrative frameworks like the ecological model, encouraging practitioners to adopt an ecological perspective and view individuals as part of families, groups, and communities, which are considered "a function, at least in part, of the resources available to people" (Sullivan & Rapp, 2002, p. 248) in their environment. These models typically follow a rational problem-solving approach involving assessment and intervention. In contrast, SBP prefers an inductive method in which insights develop through relationships with clients and their stories. It complements various postmodern perspectives in social work, such as narrative, spiritual, and multicultural views, which favour an interpretive understanding of reality. One criticism of SPB

is that it is heavily focused on Western notions of optimal functioning and may not adequately consider alternative cultural perspectives on strengths (Peterson, 2023). Recognizing this limitation, the SBP was not applied as a universal or prescriptive model in this study but was used as a complementary heuristic lens to explore existing sources of resilience, social support, and community capacity. Its application was guided by participants' own culturally situated understandings of strength and coping within Makoko. Therefore, rather than imposing predetermined definitions of strengths, the study examined how community members identified and experienced protective resources within their social and cultural context. Nevertheless, the framework may not fully capture all locally specific meanings and practices related to resilience and collective well-being, which represents an important theoretical limitation.

Despite the significant challenges and vulnerabilities experienced by residents of Makoko, community strengths were evident throughout participants' accounts. These included strong kinship and family relationships, religious and spiritual beliefs as sources of hope and meaning, informal networks of neighbours providing assistance during times of difficulty, and cultural practices that support perseverance and collective coping. These locally identified strengths demonstrate the value of examining community capacities alongside vulnerabilities when developing culturally responsive suicide prevention approaches.

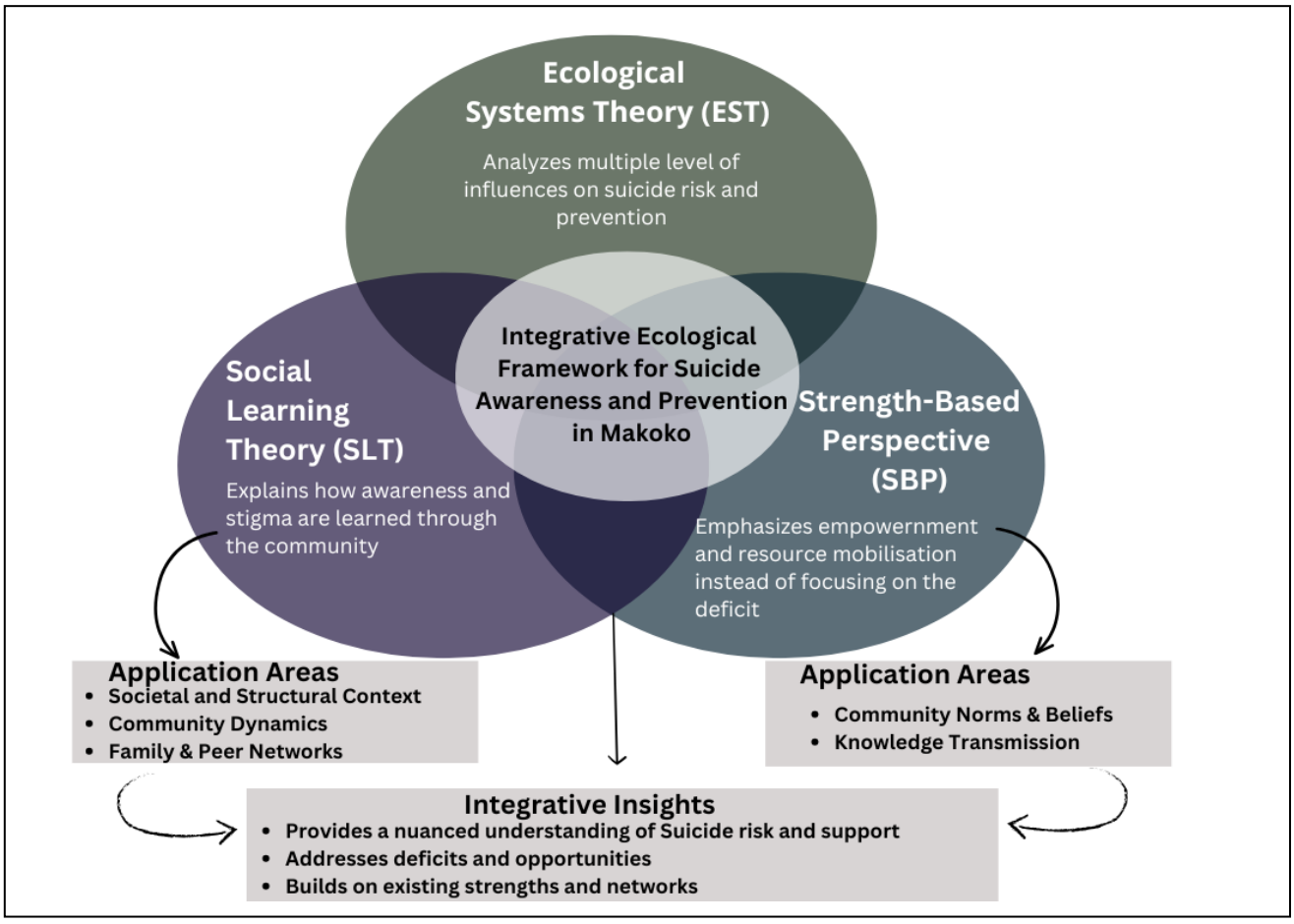
3.3 Integration of the Theories

Suicide is a complex phenomenon that should be understood and addressed through a comprehensive approach. In this study, three theories can provide complementary perspectives for understanding suicide awareness and prevention in Makoko. SLT and SBP are used to complement EST as a framework in this study. The EST offers a comprehensive framework for analyzing the multiple levels of influence on suicide risk and prevention. SLT helps explain how awareness and

stigma are learned within the community. The SBP ensures that interventions emphasize empowerment and local resources rather than deficits. In this study, these three theories are integrated (Figure 2) to create a nuanced understanding of suicide, the complex interplay of its suicidal risk factors and existing protective factors and support that can be harnessed to aid in the development of future community-based interventions that build on existing strengths and social networks.

Figure 3

Integrated Framework for Suicide Prevention in Makoko



The integrated theoretical framework guided the research process, helping ensure the study remained focused on both the multifaceted conditions influencing suicide behaviour and the

community resources that shape how distress is recognized and addressed in Makoko, rather than merely serving as interpretive lenses for discussing findings.

Conclusion

This chapter outlines the theoretical framework guiding the study. It begins by contrasting single-level explanations of suicide with multi-level approaches. Biological, sociological, cultural and psychological accounts, together with diathesis-stress and ideation-to-action models, each clarify particular risk factors, but they treat those factors in isolation and largely locate the problem within the individual. Since contextual conditions may predict suicide risk as strongly as individual psychopathology, frameworks that integrate multiple levels of influence are better suited to this study.

Three multi-level theories were examined. Among them, EST was chosen as the primary theory. Then followed by the introduction of two complementary theories. Taken together, the theories organize the levels at which risk and protection operate, explain how awareness and stigma are transmitted, and keep existing community resources in view.

Chapter 4: Research Design and Methodology

Introduction

Suicide rates are rising in LMICs, including Nigeria, with urban slum residents facing greater vulnerability. This highlights the need to study suicide, given the complex risk factors in these communities. Researchers have approached suicide mainly from a positivist perspective using quantitative methods (Hjelmeland & Knizek, 2017; Hjelmeland & Knizek, 2010; Kabir et al., 2023). Hjelmeland and Knizek (2010) note that quantitative approaches are limited because they cannot fully capture suicide's complexity and often focus on linear cause-and-effect relationships. Wilde (2002) argues that until issues such as unproven validity and insignificant results are addressed, qualitative research will better reflect the lived experiences of people in LMICs.

Qualitative methods give voice to those experiencing suicidal behaviour (Bantjes & Swartz, 2020), providing essential insights for prevention and intervention. Although qualitative research emphasizes these experiences, researchers suggest different ways to connect practical actions with insights from such studies (Lewin & Glenton, 2018). Oyetunji et al. (2021) recommend further qualitative research to better understand the social and cultural contexts of suicidal behaviour.

The purpose of this chapter is to present the research design and methodology used to explore the extent of awareness of suicide and community-based prevention approaches in the Makoko community. The chapter outlines the research paradigm, research design, and methodologies employed, and discusses ethical considerations.

4.1 Research Questions

This study aimed to explore the nature and extent of suicide awareness and community-based suicide prevention approaches among residents of the Makoko community in Lagos State to inform the development of culturally relevant, community-based suicide prevention strategies. The

research questions were therefore structured to explore the multidimensional nature of suicide awareness, examining not only what participants knew about suicide but also how they understood it, how they identified and responded to it, and the gaps in both their understanding and awareness of available support resources.

The primary research question was: What is the nature and extent of suicide awareness and community-based prevention approaches in Makoko?

Secondary or specific questions used in this study to guide data collection were:

(1) What is the nature and extent of suicide among residents of the Makoko community?

(2) Are Makoko residents aware of the support for suicide prevention in their community?

(3) What key gaps exist in the awareness that could be addressed in future community-based suicide prevention strategies?

4.2 Research Paradigm

The study employed a Constructivist paradigm. According to Creswell & Creswell (2018) and Morris (2006), several/fundamental principles define the theoretical framework of the paradigm. Firstly, constructivism posits the subjectivity of reality, asserting that individuals shape it through their distinct experiences and interpretations. This acknowledgment forms the basis for understanding that there are multiple subjective realities and diverse perspectives which can be applied to the concept of suicide. Additionally, recognizing multiple realities emphasizes the need for researchers to consider and respect how individuals construct meaning and the contextual influences that significantly shape individual experiences and interpretations.

The theoretical framework highlights that individuals and communities construct knowledge within a social context. This demonstrates the significance of understanding how individuals, through interactions with their social environments, actively create meaning and interpret their

experiences. Furthermore, the framework emphasizes participants' active role in constructing knowledge, perspectives, and meaning. It promotes a collaborative research approach that involves both participants and the researcher in co-creating knowledge and recognizing agency in shaping the research process. Collectively, these principles guide a dynamic, participatory, and contextual research approach.

The critical elements of a constructivist research design align with the study's objectives, fostering an approach that values subjective experiences, acknowledges diverse perspectives, and examines contextual influences. A participant-centred approach is integral to the constructivist paradigm. It ensures that participants actively shape the research process, lending authenticity and depth to understanding experiences and needs. Constructivism's call for comprehensive exploration aligns with a holistic approach that examines individual experiences and considers contextual factors that influence treatment engagement. Contextual sensitivity is another essential aspect of the constructivist paradigm, ensuring that the topic being explored is relevant (Morris, 2006).

Choosing the constructivist paradigm aligns with understanding residents' awareness of suicide, including their awareness of risk factors and community-based prevention approaches in Makoko. This constructivist paradigm influenced my role as a researcher, emphasizing that knowledge is co-created between participants and me. My position as both an insider and outsider played a key role in the research process, as elaborated in Section 4.10.

4.3 Research Approach and Design

4.3.1 Qualitative Approach

In line with the constructivist paradigm, this study employed a qualitative research approach. Qualitative research is an approach for exploring and understanding the meanings

individuals or groups ascribe to a social or human problem. The research process often involves flexible, iterative procedures, with data typically collected in natural settings, followed by data analysis and the researcher's interpretation (Creswell & Creswell, 2018). This approach allows the researcher to gain insight into participants' perspectives and rich experiences. Thus, using a qualitative methodology allowed the researcher to capture the participants' experiences and perspectives on suicide, including its associated risk factors and knowledge of suicide prevention approaches in Makoko.

4.3.2 Hermeneutic Phenomenological Design

Given the aim of this study to explore the experiences and perceptions of suicide within a given social and cultural context, a phenomenological research design was deemed suitable. Phenomenology is a qualitative research design that aims to understand a phenomenon from the perspective of those who have experienced it, focusing on its essence, meaning, and perception (Creswell & Creswell, 2023; Teherani et al., 2015). It seeks to understand how individuals experience and interpret a phenomenon, rather than examining a bounded case or system.

The study adopted a hermeneutic phenomenological design, which focuses on understanding human experience as it is lived and interpreted within the lifeworld. Hermeneutic phenomenology seeks to illuminate the details and seemingly taken-for-granted aspects of everyday experience to develop an understanding of the meanings individuals attach to their experiences (Wilson & Hutchinson, 1991). Within this approach, understanding is developed through an interpretive process in which the researcher engages with participants' accounts and continually reflects on and interprets their meanings within their contexts. Gadamer's hermeneutic philosophy emphasizes that understanding is developed through an ongoing interpretive process involving the

interaction among the interpreter, the text or account, and the context in which meaning is situated (Laverty, 2003).

In this study, a hermeneutic phenomenological approach enabled the researcher to explore participants' lived experiences and interpretations of suicide and suicide prevention within the social, cultural, religious, and community context of Makoko. Data were generated through in-depth, semi-structured interviews that incorporated open-ended questions, allowing participants to describe their experiences, understandings, and perceptions in their own words. The researcher subsequently engaged in an iterative process of reflection and interpretation to develop an understanding of the meanings embedded within participants' accounts. Although phenomenology traditionally focuses on individual lived experiences, hermeneutic phenomenology also recognizes that these experiences are situated within particular social, cultural, and historical contexts. Thus, phenomenological inquiry can illuminate how meanings are developed, understood, and negotiated within communities.

Qualitative research is frequently criticized for lacking rigour and being influenced by researcher bias. However, when well-designed, qualitative studies can be as trustworthy as quantitative research. Most qualitative researchers agree that practices such as triangulation, member checking, and reflexivity enhance the credibility of their research (Elo et al., 2014; Lincoln & Guba, 1985; Morgan, 2024). Triangulation can enhance the rigour and trustworthiness of qualitative research by enabling researchers to gain a deeper and more comprehensive understanding of the setting and participants (Bailey, 2018; Merriam & Tisdell, 2016).

Four types of triangulations exist: data triangulation, theory triangulation, investigator triangulation and method triangulation (Denzin, 1978; Morgan, 2024). Data triangulation is relevant to this study. It involves using as many relevant data sources as possible for the topic

under investigation (Morgan, 2024). Denzin (1978) distinguished triangulation by data sources from triangulation by data methods, noting that when researchers triangulate by data sources, the same method is used. In this study, two data sources were used: in-depth interviews with participants from different groups, including residents and key informants.

Additionally, member checking was conducted. This process involves sharing data transcripts with some or all participants for review to enhance credibility (Elo et al., 2014; Varpio et al., 2017). Often considered a participatory step in the research process, member checking allows participants to identify and correct errors or remove information they prefer not to be included in the transcript (Birt et al., 2016; Thomas, 2017). Presenting transcripts early ensures the researcher works with accurate data, reducing the risk of misrepresentation during analysis (Candela, 2019). To enhance the credibility of this study, the researcher used member checking prior to the data analysis phase.

4.4 Study Setting

4.4.1 Geographic and Socioeconomic Context of Makoko

The setting for this study was the Makoko community in Lagos State, Nigeria. Often described as the world's largest floating slum, Makoko is a vibrant and closely knit community situated on the swampy shores of the Lagos Lagoon complex, located within the Atlantic Gulf of Guinea, in the Lagos Mainland Local Government (Ajayi et al., 2019; Jolaosho et al., 2024; Oloko et al., 2022; Riise & Adeyemi, 2015). The community was estimated to have a population of approximately 85,840 as of the 2007 census, although the area was not officially counted in that census. The current population has been estimated to be significantly higher, exceeding 1 million in 2020 (Adeshokan, 2020). Makoko has a diverse population with distinct religious and ethnic

identities, including Egun, Yoruba and migrants from other parts of Nigeria and West African countries (Riise & Adeyemi, 2015).

The community is divided into two primary areas: land-based and waterfront. The waterfront area is predominantly occupied by the Egun, who primarily fish (Participedia, 2019; Riise & Adeyemi, 2015). Local geographic conditions and a fishing-based economy have given rise to distinctive features, such as stilt houses built over water and boats serving as the primary mode of transportation. The community is self-governed, overseen by eleven chiefs, known as *Baales*. These chiefs are the most respected figures in the community and are responsible for handling most internal matters (Participedia, 2019; Riise & Adeyemi, 2015).

Despite its population, Makoko has limited, mostly informal infrastructure. Access to public services like schools, healthcare, and basic amenities remains limited. The community has a few primary schools and informal learning centres often operated by NGOs or faith-based groups such as the FOMWAN. Only one formal government primary school exists, so residents typically attend secondary school outside Makoko. Healthcare access is primarily through small private clinics, with community members relying on patent medicine vendors or informal providers due to the lack of dedicated mental health facilities locally. Although two private clinics exist, residents mostly depend on nearby public hospitals outside Makoko for specialized care, including mental health services. The Federal Neuropsychiatric Hospital, Yaba (FNPHY), a nearby key mental health facility, offers formal support but is often difficult to access due to costs, stigma, and transportation challenges (Fayehun et al., 2022). Food needs are primarily met by informal markets and small vendors, reflecting the community's dependence on local, informal economic systems.

Makoko had existed before Lagos State was created. It was developed into a fishing village in the 19th century and later transitioned from a peripheral area to an urban slum within the bustling

city due to large-scale rural-urban migration and unregulated development (Akinsete et al., 2014; Barredo & Demicheli, 2003; Participedia, 2019). Following Nigeria's independence in 1960, Lagos State's rapid growth increased demand for land, exerting pressure on Makoko's housing and land markets due to its central location. Although the community is renowned for fishing, boat-making, and crafts, the limited presence of government, processing technology, educational opportunities, and expertise further complicates the problems faced by this low-income community (Participedia, 2019).

4.4.2 Urban Renewal, Demolition, and Displacement in Makoko

The World Bank, through the Lagos Metropolitan Development and Governance Project (LMDGP), planned to invest US$40.9 million in upgrading nine designated urban slum neighbourhoods, including Makoko. However, these projects were halted amid allegations that the funds had been misappropriated. During this period, the Lagos State Government planned to carry out extensive demolitions in the Makoko community to prepare the area for new development as part of its urban renewal strategy. However, no arrangements were made for the resettlement or compensation of community residents (Akinsete et al., 2014; Participedia, 2019).

On July 16, 2012, the Lagos State Ministry of Waterfront Infrastructure, just four days after issuing a 72-hour eviction notice, set fire to targeted structures in Makoko and deployed armed police, who reportedly fired shots indiscriminately to disperse residents protesting the government's decision (Participedia, 2019). The incident reportedly resulted in a resident's death, after which demolition workers ceased work, and the confrontation between citizens and the Lagos State Government culminated in a court injunction halting the demolition (Akinsete et al., 2014; Participedia, 2019; Riise & Adeyemi, 2015). The outcome was a lasting deterioration of trust, with

residents and informal institutions pitted against the government and formal structures (Akinsete et al., 2014; Participedia, 2019).

The demolition displaced over 30,000 people, and Makoko was cleared again in 2017 (OHCHR, 2026). UN Special Rapporteurs have described the use of fire to clear informal settlements as a practice not uncommon in Lagos State, deployed in parallel with forced eviction (OHCHR, 2024). This pattern did not end in 2017. Makoko and the adjoining Sogunro and Oko-Agbon settlements were subjected to a further demolition drive beginning on 23 December 2025, on the stated basis of clearing 30 metres around a high-tension power line, which was then extended well beyond it, destroying homes, shops, schools, churches and healthcare facilities. UN Special Rapporteurs report over 40,000 people displaced, police firing tear gas and torching homes when residents protested, people, including children, reportedly killed and hospitalized, and families sheltering in makeshift structures and in canoes among the debris (OHCHR, 2026). Civil society estimates of displacement are considerably lower, at around 10,000, compared with a population that has never been officially enumerated. The state suspended the operation on February 3, 2026, though questions of compensation, resettlement and restitution remained unresolved at the time of writing.

4.4.3 Rationale for Selecting Makoko as the Study Setting

Makoko was selected as the study setting because residents face multiple, intersecting forms of socioeconomic adversity, marginalization, displacement, and limited access to essential services. These conditions include poverty, overcrowding, housing insecurity, limited availability of public services, unsafe drinking water, substance abuse, crime, and inadequate infrastructure, including healthcare, sanitation, and formal education (Adewuya, 2016; Ajayi et al., 2019; Akindejoye et al., 2021; Oduwaye et al., 2011; OHCHR, 2026). As stated in Chapter 1, such

conditions can intersect with established risk and protective factors for suicidal distress and constrain access to resources that support prevention. In Makoko, these challenges are further compounded by recurrent demolitions and displacement, disruption of livelihoods and community services, and strained relationships between residents and formal institutions. These contextual characteristics make Makoko particularly relevant for examining how residents understand suicide, the factors they perceive as contributing to suicidal behaviour, and the community-based resources available in a marginalized urban informal settlement.

4.5 Study Population and Participants

4.5.1 Target Population

The target population comprised two groups: (a) residents, defined as individuals aged 18 years and older living in Makoko; and (b) key informants, comprising community leaders, healthcare workers, traditional healers, and religious figures. The decision to sample both residents and key informants was intended to examine the phenomenon from the perspectives of those who live it directly and those who hold formal and informal support and leadership roles. This two-group design served two purposes. First, it enabled data-source triangulation, whereby convergence and divergence across the groups could be examined to strengthen credibility, and it captured a fuller range of positions within the community's ecology of awareness and response. The researcher required at least one participant from each subgroup.

Residents who met the inclusion criteria in this respective group were recruited to reflect on everyday experiences and what suicide meant to them. At the same time, key informants who met the inclusion criteria were recruited to offer leadership, guidance, or support. Taken together, these groups offer insight into various perspectives within the community.

4.5.2 Inclusion and Exclusion Criteria

Participants who met all inclusion criteria were included; those who met any exclusion criteria were excluded. Recruitment continued until 10 eligible residents and 10 eligible key informants had been recruited.

Inclusion Criteria

Resident:

• Adults who are 18 years and older.

• Individuals who have resided in Makoko for at least one year.

• Can communicate in English, Pidgin English, or Yoruba.

• Willing to provide informed consent.

Key Informant*:*

• Individuals who are professionals (healthcare workers), religious leaders, or traditional healers.

• Have experience working on mental health, suicide prevention, or community well-being with the Makoko community members.

• Willing to share professional insights in an interview.

• Can communicate in English, Pidgin English, or Yoruba.

• Willing to provide informed consent.

Exclusion Criteria*:*

Residents

• Individuals below the age of 18 years.

• Non-residents or those who have not resided in Makoko for at least one year.

• Cannot communicate in English, Pidgin English, or Yoruba.

• Unwilling to provide informed consent.

• Currently experiencing a suicidal crisis.

Key Informants:

• Individuals without a professional or leadership role in the community

• No experience working on mental health, suicide prevention, or community well-being

• Unwilling to discuss professional perspectives on suicide prevention or mental health health issues.

• Not able or unwilling to provide informed consent.

4.6 Sampling and Participant Selection Strategy

4.6.1 Sampling

Qualitative research often involves the intentional selection of participants who are best positioned to provide rich, relevant insight into the phenomenon under study (Johnson et al., 2020). According to Polit and Beck (2017), purposive sampling involves selecting participants with specialized or expert knowledge of the phenomenon under study. These individuals are willing to share their information and insights with the researcher. In the Makoko context, the residents and the key informants have knowledge about suicide, which they were willing to share, given their everyday experiences within the community.

Given the heterogeneity of the Makoko community, maximum variation purposive sampling was employed to capture diverse perspectives and experiences relevant to the study. Maximum variation sampling involves deliberately selecting participants with diverse characteristics and experiences related to the phenomenon under investigation, thereby enhancing the breadth of perspectives represented in the data (Nyimbili & Nyimbili, 2024). In this study, variation was sought in participants' personal or familial exposure to mental health concerns or suicide, as well as demographic characteristics such as age, gender, socioeconomic status, and

level of community involvement. Participants were also selected from both the land and waterfront areas of Makoko to reflect the community's geographical diversity. These considerations enabled the researcher to recruit participants with varied experiences and perspectives relevant to the research objectives, consistent with the principles of purposive sampling.

In addition to purposive sampling, snowball sampling was also used. Snowball sampling is another non-probability sampling method in which participants interviewed may be asked to suggest additional individuals who meet the study's criteria (Nikolopoulou, 2023). Through this method, researchers have gained access to vulnerable social groups that might otherwise be difficult to identify (Nikolopoulou, 2023). In this study, the researcher provided already-recruited participants with recruitment information and asked them to share it with their networks, who may have specific insights into suicide-related issues, to encourage participation. Ethically, this minimizes pressure on prospective participants by allowing them to make independent decisions about whether to participate.

4.6.2 Entry to the Research Setting

To establish important and meaningful connections and gain access to the Makoko community, the researcher employed a community connector familiar with the community before collecting data. This provided a preliminary opportunity to meet, network with, and, most importantly, learn more about the Makoko residents, one of the targeted populations for this research study. The community connector played a vital role in facilitating entry into the community and communication with residents and key informants who met the inclusion criteria. The community connector was compensated with an honorarium for their time and assistance, funded by the Faculty of Social Work for this study.

4.6.3 Recruitment of Participants

Prospective participants were identified by first engaging two community leaders (*Baales*), who served as gatekeepers. The two *Baales* who represented the land-based and waterfront communities were easily identifiable by their prominent roles. The researcher met with them in person and explained the study's purpose. They later connected the researcher to a community member who serves as a representative for all the *Baales* in the community, and he became the new gatekeeper. The researcher explained the study's aim to the new gatekeeper and requested his assistance in disseminating information to key community figures, including imams, pastors, traditional healers, community health workers, youth leaders, and representatives of various organizations.

Recruitment posters (Appendix A: Poster–Resident & Appendix B: Poster–Key Informant) detailing the study, including inclusion criteria, study duration, and the researchers' contact information, were provided for him to share with interested participants. The representative did not provide the researcher with personal information about potential participants; instead, they informed individuals about the study and allowed them to contact the researcher by phone if they were interested. The researcher collected contact details only from participants who voluntarily expressed interest in the study. No identifiable participant information was shared with the representative.

In addition to engaging the gatekeeper, the recruitment posters were displayed in visible locations, including community health centers, the nearest general hospitals, churches, mosques, and other public spaces. The posters invited interested participants to contact the researcher directly using the provided contact details. Additionally, using the snowballing method, the researcher encouraged participants already recruited to the study to share the researcher's contact

information with others they believed might be interested in participating. This helped identify additional participants.

Once interested participants contacted the researcher by phone or in person, the researcher screened them to determine their eligibility. When found eligible, the researcher obtained their names and mobile phone numbers and added them to the master list of participants. As a multilingual English and Yoruba speaker, the researcher explained the study in detail to participants in either language, based on their preference. This included informing them about the study's purpose, voluntary participation, confidentiality, available counselling support, and the honorarium for their time. Interviews were then scheduled at convenient times and places within the community. This recruitment approach balanced ethical considerations, participant privacy and voluntary participation.

4.6.4 Sample Size

Consistent with qualitative research and the principles of hermeneutic phenomenology, this study did not seek statistical representativeness or generalizability. Rather, the sample size was guided by the methodological approach, the depth and detail of information required, the availability of participants with relevant experiences, and the researcher's methodological judgement (Denzin & Lincoln, 2018; Lichtman, 2006; Merriam, 2009). In hermeneutic phenomenology, the emphasis is on developing a rich, contextualized understanding of participants' lived experiences and the meanings they ascribe to a phenomenon rather than on obtaining a statistically representative sample.

The sample for this study comprised 20 participants, including 10 community residents and 10 key informants. An equal allocation across the two participant groups was used to ensure balanced representation of the distinct yet complementary perspectives of community residents

and key informants. The sample size was determined through a two-stage process that combined doctoral committee guidance with an iterative assessment of thematic sufficiency during fieldwork. At the outset of the study, the researcher's doctoral committee recommended an initial target of 20 participants, based on its experience with comparable qualitative studies in community health research and the study's depth-oriented nature and scope. This target was also considered feasible within the research timeline and provided a practical basis for planning recruitment and data collection.

Although the initial target of 20 participants was established before fieldwork, the adequacy of the sample was not assumed. Instead, the researcher engaged in an iterative process of data collection. Following each interview, the researcher reviewed the account in relation to previous interviews and reflected on the meanings participants attributed to suicide, suicidal distress, and prevention within their social, cultural, religious, and community contexts. This iterative process enabled the researcher to assess whether subsequent interviews contributed substantially different dimensions to the developing understanding of the phenomenon or primarily deepened and enriched meanings already identified.

This interpretive assessment was considered separately for community residents and key informants to ensure that the experiences and perspectives of both groups were sufficiently understood. Among community residents, by the eighth interview, the researcher was no longer encountering substantially different dimensions of the phenomenon. Two additional interviews were conducted to further develop and confirm the depth of the emerging interpretation. Among key informants, a similar point was reached by the ninth interview, and the tenth interview further enriched and confirmed the developing interpretation rather than substantially altering it.

Across the two participant groups, the later interviews primarily deepened understanding of existing meanings, including religious and cultural interpretations of suicide, economic and social sources of distress, reliance on informal support networks, and uncertainty about pathways to formal support and referral. The researcher therefore determined that the final sample of 20 participants provided sufficient depth and breadth to develop a rich interpretive understanding of the phenomenon under investigation.

4.7 Ethical Considerations

The conduct of academic researchers is guided by research ethics, which are essential for protecting participants' dignity and rights. To ensure adherence to these ethical standards, studies involving human subjects must be reviewed by an ethics committee that assesses potential risks (Hasan et al., 2021). Central to ethical principles are beneficence, equality, and autonomy (WHO, 2016).

Since this study involves human participants, ethics approval was necessary. Data collection commenced only after obtaining approval from the University of Manitoba Research Ethics Board 2 (REB 2) (ID: HE2024-0357) in February 2025 (see Appendix J: Ethics Approval Letter).

4.7.1 Privacy and Confidentiality

The interviews were conducted only after written informed consent was obtained. Two separate consent forms were prepared for the two groups: one for the residents (Appendix C: Informed Consent Form − Resident) and another for the key informants (Appendix D: Informed Consent Form – Key Informant). The forms were developed separately to reflect participant roles, levels of involvement, and the nature of information shared. In addition, the forms were kept separate to respect the role each group had. As part of the informed consent process, the researcher

explained to the participant that it was important to protect their identity and maintain confidentiality throughout the study. They were informed that their privacy would be protected, including the use of a pseudonym, the removal of identifying information from study documents, and the secure handling of audio recordings and data. They were also informed of the limitations of confidentiality during and after the interview. In accordance with current laws, this study complied with two laws: the Lagos State Safeguarding and Child Protection Policy (which protects the rights of children in Lagos State, Nigeria) and the Lagos State Mental Health Law (which aims to protect Lagos residents from stigma and discrimination, ensuring better access to mental health services). Throughout the study, the researcher encountered no issues with violating these laws.

4.7.2 Potential Risk and Benefit

The risks anticipated in this study included the possibility that participants might feel distress, sadness, or emotional disturbance, as people sometimes do when they talk about suicide or, as with those who have had suicidal ideation, experience suicide loss, or family-related trauma. To mitigate this, participants were provided with a list of free counselling services in Lagos State to contact if needed. This list was attached to the informed consent form (Appendix C−1: List of Free Counselling Services in Lagos State−Resident and D−1: List of Free Counselling Services in Lagos State–Key Informant). Participants were informed that if they felt sad or depressed, they could call any of the numbers on the list to talk to a counsellor for a free counselling service. Additionally, the informed consent process emphasized that participants could withdraw from the study at any time without any consequence. This was also mentioned to the participants at the end of the interview. Participants were also informed of the potential direct benefits of participating in the study, including access to information about mental health services available within Lagos State.

4.7.3 Compensation

In addition to contributing to knowledge about suicide prevention, participants were compensated for their time. Each resident group and key informant group participant received an honorarium of 15,000 naira and 20,000 naira (approximately $14 and $18), respectively, for their contributions to the study. These compensations were intended to recognize participants for their time in the interviews. The key informant group participants received a higher honorarium for sharing professional insights into the study. Each participant received compensation after providing consent to participate in the study and signing receipts (Appendix E: Honorarium Receipt Form)

4.8 Data Collection Methods

Data were collected from two sources to ensure rigour in the study: these included one-on-one, in-depth interviews with the residents' group and the key informants' group.

4.8.1 Semi-Structured Interview Guide

The semi-structured interview method enables the researcher to become a visible knowledge-producing participant rather than conceal themselves behind rigid, preset interview guidelines (Denzin & Lincoln, 2018). The researcher engaged participants in open-ended conversations using a semi-structured individual interview guide and a key informant interview (KII) guide (Appendices H & I, respectively) to gain comprehensive insight into the issue from both groups. The two instruments were pretested for logic, comprehensibility, and completeness with two non-Makoko residents who shared cultural and linguistic backgrounds similar to those of the study participants. This aimed to retain potential Makoko participants for formal recruitment while ensuring that the phrasing and flow of questions remained clear and culturally appropriate.

The semi-structured interview guides were developed to explore four interrelated dimensions of awareness: definitional awareness (how participants understood and described suicide); risk-factor awareness (what they identified as risk factors); prevention awareness (what community-based responses they recognized or practiced); and resource awareness (what formal and informal support options they were aware of and could access). The theoretical perspectives further shaped the development of interview questions. EST-informed questions focused on how suicide understanding is shaped by interactions across multiple levels of the social environment. SBP guided understanding of how community resources could address suicide and psychological distress. SLT informed how residents of Makoko learn about suicide, how it is discussed within community networks, and how cultural and religious beliefs influence attitudes towards suicide and help-seeking.

The individual interview guide focused on residents' perspectives and experiences, divided into two sections: demographic information (Appendix F: Demographic Information Form−Resident) and nine questions that addressed suicide awareness, associated risk factors, community-based approaches, and gaps in awareness that could be addressed in future prevention strategies (Appendix H: Interview Guide−Resident). The KII guide focused on the perspectives and experiences of the key informants and was similarly divided into two sections: demographic information (Appendix G: Demographic Information Form−Key Informant) and eight questions on knowledge of suicide awareness and prevention approaches, as well as recommendations for developing future strategies (Appendix I: Interview Guide−Key Informant). Both interview guides contained open-ended questions and associated probes, allowing participants the flexibility to elaborate and share their thoughts freely.

4.8.2 Procedure for Data Collection

Data collection began after completion of the informed consent process, which was conducted prior to the interviews. This process took 10–15 minutes. Participants who could communicate in English were asked to read and sign the document if they wished to participate. The researcher answered any questions the participants raised. For participants who could not communicate in English, the researcher read the informed consent to them and explained it in Yoruba. All the participants signed the informed consent forms (Appendix C: Informed Consent Form−Resident, & Appendix D: Informed Consent Form–Key Informant). After obtaining informed consent, the researcher handed out a list of resources (Appendix C−1: List of Free Counselling Services in Lagos State−Resident and D−1: List of Free Counselling Services in Lagos State–Key Informant) to the participants. The researcher also offered the participants the cash honorarium and asked them to sign to confirm receipt. All the participants signed the receipts (Appendix E: Honorarium Receipts). However, the honorarium was not contingent on completing the study, as participants could withdraw at any time after receiving it.

Next, the researcher administered the questionnaire (Appendices F: Demographic Information Form−Resident & G: Demographic Information Form−Key Informant), designed to elicit participants' demographic information. The researcher guided them through the questions to ensure their answers were clear and complete. For participants who could not communicate in English, the researcher read the questionnaire aloud in Yoruba and assisted in accurately recording their responses. The questionnaire took between 10 and 15 minutes to complete. The interview process commenced after this and lasted 45-60 minutes.

With participants' permission, all interviews were audio-recorded using a password-protected voice recorder. The purpose of recording the interview was to enable the researcher to

accurately capture spoken content without being distracted by taking notes. This facilitated the creation of an accurate interview transcript for data analysis. Moreover, it served as validation that the researcher was attentive to participants' shared experiences. Additionally, it saved time by allowing the interviewer to focus on the interview, knowing that a device was recording to facilitate transcription (Biaggi & Wa-Mbaleka, 2018).

In addition to the interviews, the researcher observed participants' nonverbal cues and emotional responses and recorded these observations in field notes. Field notes are a crucial component of rigorous qualitative research, serving multiple functions, including aiding in the construction of thick, rich descriptions of the study context, observations, encounters, interviews, and focus groups, and documenting valuable contextual data (Phillippi & Lauderdale, 2018; Patton, 2002).

4.8.3 Data Handling

Coded and indirectly identifiable data were collected. The researcher's advisor reviewed selected recorded interviews that contained indirectly identifiable information to ensure transcription accuracy and alignment with the study objectives. From the digital voice recorder, the interview recordings were transferred to the researcher's University of Manitoba OneDrive folder, which was created for this study, via a secure account with password-protected access restricted to the researcher. The researcher transcribed the twelve English interviews using Microsoft's transcription tool. The eight Yoruba interviews were transcribed manually because no effective software is currently available for Yoruba transcription. The researcher removed participants' names and replaced them with pseudonyms prior to coding to maintain confidentiality. For example, the acronyms R-P and KI-P, followed by the serial numbers, were used to represent participants in the resident and key informant groups, respectively. The

recordings in the digital voice recorder were permanently deleted immediately after transcription on July 5, 2025.

The transcripts were stored in a folder within the researcher's secure University of Manitoba OneDrive account. They will be saved for 2 years after data collection and the completion of the final research report (until August 2028). The paper questionnaire, the honorarium receipt form, and the signed informed consent forms were stored securely in a locked file cabinet when not in use and handled only by the researcher. The forms were later scanned and securely transferred to the researcher's University of Manitoba OneDrive folder, which was created for this study. The paper copies of the forms were destroyed immediately after scanning. This was done by shredding them and disposing of the shredded material in the trash. The electronic copies of the demographic forms and the informed consent will be permanently deleted three years after the final report is written (August 2029). Electronic copies of the honorarium receipts will be retained for 7 years (until August 2032). Field notes and reflective journals will be kept till after the final report is written.

4.9 Data Analysis Procedures

Data analysis for this study was organized around the multidimensional aspects of suicide awareness, with reflexive thematic analysis guided by attention to how cultural, religious, and structural conditions shaped community members' constructions of suicide awareness, consistent with the study's constructivist position. The integrated theoretical framework further informed the analysis. Rather than focusing solely on risk factors or community deficits, the analysis examined structural factors, community resources, and coping strategies present in Makoko.

The data were analyzed using reflexive thematic analysis (RTA). This is an interpretive approach to qualitative data analysis that helps identify and examine patterns or themes within a

given dataset (Braun & Clarke, 2019). RTA is viewed as a reflection of the researcher's interpretive analysis of the data carried out at the intersection of (1) the dataset, (2) the theoretical assumptions of the analysis, and (3) the analytical skills/resources of the researcher (Braun & Clarke, 2019). In this approach, the coding process (and theme development) is flexible and organic, often evolving throughout the analytical process. RTA is highly appropriate given this study's underlying theoretical and paradigmatic assumptions. It ensures that the researcher examines qualitative data in ways that respect and reflect participants' subjectivity in their accounts of suicide awareness and community-based prevention methods, while also recognizing and accepting the reflexive influence of the researcher's interpretations. The analysis in this study followed the six phases proposed by Braun and Clarke (2019).

4.9.1 Phase 1: Familiarisation with the Data

The data analysis was conducted sequentially, with residents' data analyzed first and key informants' data second. However, reflexive thematic analysis is inherently iterative. The researcher familiarized herself with the dataset by first listening to each interview recording. The residents' datasets were listened to first, followed by the key informants' data. Each interview was listened to immediately after it was conducted, rather than waiting until all data collection was complete. The first playback was conducted with active listening to develop an understanding of the primary areas addressed in each interview prior to transcription. While listening, the researcher noted inflections, breaks, pauses, tones, and other aspects of both the interviewer's and the participant's speech. The researcher later transcribed the English interviews using Microsoft Word's Transcribe function. Interviews conducted in Yoruba were first transcribed and later translated into English.

Once all interviews had been transcribed and translated, the researcher reviewed the transcripts for accuracy and subsequently conducted member checking. Member checking was conducted in June 2025 through telephone follow-up sessions with participants. The process aimed to enhance the study's credibility by giving participants the opportunity to clarify, verify, correct, or add to their accounts. Rubin and Rubin (2005) note that although telephone interviews are not generally the preferred method for conducting qualitative interviews, telephone contact can be useful for follow-up questions after a face-to-face interview.

In this study, telephone interviews were used for member checking because the researcher had returned to Canada after completing face-to-face fieldwork in Nigeria, making further in-person contact impractical. Telephone interviews therefore provided a feasible way to maintain contact with participants and verify their accounts without requiring additional travel. Because the purpose of member checking was to allow participants to clarify, correct, or add to information from their original interviews, telephone contact was considered an appropriate and practical approach for this stage of the study. The researcher completed this process with 16 of the 20 participants. The four participants who did not complete the verification process could not be reached during the designated member-checking period, despite attempts to contact them. Their non-participation was therefore due to difficulties in re-establishing contact rather than a decision to exclude them from the process.

The 16 participants contacted were invited to clarify, correct, or add to the information from their original interviews. Each telephone session lasted approximately 30–45 minutes. Although member checking was not conducted with all participants, responses from 16 participants provided an opportunity to assess the accuracy and intended meaning of the accounts in the dataset. However, these responses did not establish participant validation of the researcher's higher-order

interpretations, coding decisions, or final thematic constructions. Consistent with the interpretive nature of hermeneutic phenomenology, the development of the broader interpretation remained the researcher's responsibility.

4.9.2 Phase Two: Generating Initial Codes

In the second phase, the researcher imported the interview transcripts into Delve, the qualitative data analysis software used throughout the study. The transcripts were organized by participant type, namely residents and key informants. The researcher began coding the residents' interviews, reading each transcript carefully and coding the data line by line. Initial codes were developed by asking questions of the data in relation to the research questions and the integrated theoretical framework. As coding progressed, the researcher kept reflective notes to document initial impressions, questions, and ideas that emerged from the data. Codes were reviewed and refined as the researcher became more familiar with the participants' accounts.

After completing the initial coding of the residents' interviews, the researcher proceeded to the key informants' interviews and applied the same coding process. The codes developed from the residents' data served as a starting point for examining the key informants' accounts, but they were not treated as fixed. The researcher remained open to modifying existing codes and developing new ones when the key informants' data revealed meanings not adequately captured by the initial codes. This process allowed the researcher to consider each participant group's accounts carefully while remaining attentive to connections among them.

As the analysis progressed, a considerable degree of similarity emerged between the two groups. Residents and key informants frequently discussed similar issues, including religio-cultural understandings of suicide, economic and relational stressors, reliance on informal support networks, and gaps in referral pathways. Participants also sometimes discussed issues that

extended beyond the focus of their respective interview guides. For example, residents sometimes provided information on matters explored more directly with key informants, while key informants similarly discussed issues raised with residents. These similarities became increasingly apparent as the researcher compared the developing codes across the two groups.

When codes from the two groups conveyed the same underlying meaning, they were grouped during the subsequent coding review. Codes that captured distinct perspectives or experiences were retained. This sequential coding process enabled the researcher to identify both the shared and distinctive aspects of participants' accounts. The resulting integrated set of codes formed the basis for the next phase of the analysis, in which the researcher began developing and reviewing candidate themes across the full dataset.

4.9.3 Phase 3: Searching for Themes

After generating and refining initial codes across both participant groups, the analysis shifted from examining individual coded extracts to identifying broader patterns of meaning across the dataset. The researcher reviewed the codes and considered how related codes could be grouped by shared meanings, conceptual connections, and relevance to the research questions. Codes from both residents' and key informants' interviews were reviewed collectively to develop potential themes and sub-themes that captured patterns across the full dataset.

During this phase, the researcher collated relevant coded extracts under candidate themes. Candidate themes were preliminary groupings of related codes and data extracts that appeared to reflect a broader pattern of shared meaning relevant to the research questions. For example, codes related to unemployment, financial hardship, and debt were grouped under the broader theme of vulnerability and risk, while codes related to neighbour support, peer assistance, and informal monitoring were grouped under the theme of community-based prevention practices. The

researcher continued to examine relationships among codes and potential themes, assessing how individual codes contributed to broader patterns of meaning and whether additional codes or extracts belonged within each developing theme.

4.9.4 Phase 4: Defining and Naming Themes

The themes were reviewed multiple times to ensure they worked with the coded extracts (Level 1) and the entire dataset (Level 2). Redundant and overlapping categories were merged, especially between the two groups' codes, and sub-themes were identified where appropriate. For example, under the theme 'awareness of risk and vulnerability', the sub-themes included i) socioeconomic hardships, ii) relational and family stressors, iii) limited access to healthcare services, and iv) youth vulnerability.

Following this process, the specifics of each theme were refined and precise names assigned. A thematic 'map' of the analysis was then generated to demonstrate the relationships between the themes (Figure 2).

4.9.4 Phase Five: Reviewing Themes

During this phase, all themes and sub-themes were integrated to create a coherent narrative regarding the research questions. The theme names were also subjected to a final revision at this point. Vivid and compelling extracts were chosen as representative quotes.

4.9.5 Phase Six: Producing the Report

This final phase involves producing the report and writing up the analysis. This was achieved through a reflexive analysis that centred on participants' voices and was closely aligned with the research objectives and the existing literature. The interpretation of findings was guided by the study's constructivist and ecological theoretical orientation, incorporating insights from EST, SLT, and the SBP to capture multiple layers of meaning and context.

4.10 Trustworthiness and Rigour

Establishing rigour and trustworthiness of results is critical to qualitative research. Lincoln and Guba outline four criteria for establishing the overall trustworthiness of qualitative research results: 1) credibility involves the researcher ensuring and providing the reader with supporting evidence that the results accurately represent what was studied. 2) transferability: the researcher provides detailed contextual information such that readers can determine whether the results apply to their or other situations, 3) dependability: the researcher describes the study process in sufficient detail that the work could be repeated, and 4) confirmability, the researcher ensures and communicates to the reader that the results are based on and reflective of the information gathered from the participants and not the interpretations or bias of the researcher (Lincoln & Guba, 1985). To ensure rigour in this study, the researcher employed these four criteria to ensure that the findings accurately reflected participants' views.

4.10.1 Credibility

A key strength of this study was the inclusion of multiple perspectives through interviews with residents and key informants. This method allowed for the integration of diverse viewpoints and experiences, offering a more complete understanding of suicide awareness in the community. Additionally, the researcher conducted member checking during phase one of data analysis by sharing the interview transcripts with participants to confirm the accuracy of the recorded information, especially the translated transcripts, to allow for clarification or correction where necessary. This process enhanced the credibility of the data.

Participant debriefing was conducted immediately after each interview to give participants an opportunity to reflect on their experiences, ask questions and address any emotional discomfort

arising from discussions of sensitive topics. They were reminded to use the resources provided to them before the interview began.

Furthermore, the research gained credibility through reflexivity. Reflexivity involves critical thinking that addresses issues of identity and positionality by making the researcher's assumptions explicit and questioning them (Lazard & McAvoy, 2017). Reflexivity is vital in qualitative research because it acknowledges the researcher's role and addresses the issue of objectivity in research findings. In qualitative research, the researcher is an active participant, and their prior experiences, assumptions, and beliefs shape the research (Creswell & Creswell, 2018). Reflexivity is especially significant for qualitative researchers, as they do not take a neutral or objective stance as mere observers, but rather engage actively and interactively in the research process. This allows researchers to identify and challenge their biases, limitations, and influences, thereby enhancing the quality and validity of their work (Knox & Burkard, 2009).

According to Roger et al. (2018), reflexivity is often viewed as a process by which researchers understand their broader "worldview" of the data and take specific steps. However, Ormston and colleagues described the outcomes of qualitative research as not being entirely value-free or objective but rather as "empathic neutrality", a way of recognizing and managing the unavoidable subjectivity and reflexivity involved in qualitative research (Ormston et al., 2014, p. 8). In this study, the researcher regularly reflected on her positionality, assumptions and potential influences on the research process. These reflections were documented in field notes kept throughout the data collection and analysis process.

4.10.2 Transferability

In this study, detailed descriptions of the setting, participants, and results were provided, enabling readers to determine if the findings are relevant to similar urban slums in Nigeria and

elsewhere. While the results are not statistically generalizable, they offer valuable insights that can be applied to communities facing similar socio-economic and cultural challenges, such as Makoko.

4.10.3 Dependability

To maintain dependability in the research study, the researcher maintained a clear audit trail, documenting decisions made during data collection and analysis. This transparent record enables others to follow the study's logical progression and see how conclusions were derived. Additionally, the researcher consulted with her advisor throughout the data collection process.

4.10.4 Confirmability

Confirmability was addressed through reflexivity rather than by attempting to eliminate researcher influence. To support this, the researcher kept field notes throughout the study to document assumptions and potential biases. Johnson et al. (2020) highlight that detailed, comprehensive notes enhance accuracy and utility in data analysis and auditing, thereby strengthening the rigour of interpretation. Incorporating direct quotes from participants further grounds the interpretations in the participants' perspectives.

4.10.5 Positionality and Reflexivity

The literature highlights the importance of positionality in conducting research (Savin-Baden & Major, 2023; Wilson et al., 2022). It is the researcher's responsibility to reflect on how the research is conducted and to explain the research process to readers, thereby producing a more trustworthy and honest account (Corlett & Mavin, 2018). Positionality refers to the stance a researcher adopts within a specific study (Savin-Baden & Major, 2023). It involves the researcher deliberately examining their identity so readers can assess how their characteristics and perspectives influence the study population, the topic under investigation, and the research process. This study explored suicide awareness and community-based approaches to prevention in Makoko.

My positionality straddles both insider and outsider roles. Explicitly addressing my positionality enhanced the transparency, credibility, and ethical integrity of the research while supporting a more reflexive and contextually grounded understanding of suicide prevention in the Makoko community.

Researcher as an Insider

I identify as a Yoruba Muslim, born and raised in Epe, a Yoruba town in Lagos State. The Yoruba, one of Nigeria's main ethnic groups, have a worldview rooted in the belief in *Olodumare* (God) and the connections between the physical and spiritual realms. The Yoruba strongly condemn suicide, which, in Yoruba thought, is often associated with evil possession, spiritual attacks, curses, and can bring misfortune to the individual's family and the community. However, the Yoruba also value dying with dignity, emphasizing autonomy and competence. Their concept of dying with dignity (*iku ya j'esin*) allows a competent individual to choose their own path in life, including death. They recognize that, in some cases, suicide may be viewed as an escape from suffering, even though it is often seen as irrational (Aborisade, 2015; Atilola & Ayinde, 2015). Similarly, the Islamic faith, which I embrace, also condemns suicide, and individuals are not permitted to consider it under any circumstances. This background shaped my early understanding of life's challenges, mental health, and suicide.

Like many African communities, Makoko is influenced by Christianity, Islam, and Traditional spiritual beliefs that continue to shape how residents perceive suffering, resilience, and suicide. This insider knowledge has enabled me to connect with participants in ways that foster trust and openness. I quickly built rapport and trust. However, I was careful not to let my biases distort the local perspectives in Makoko. I remained open-minded and used reflexivity to regularly recheck my assumptions against participants' actual experiences.

Language and communication were central in shaping my interactions during data collection. Although English was used, participants often relied on local slang, pidgin English, and cultural expressions. My knowledge of these linguistic nuances enabled me to accurately interpret meanings that might otherwise be missed. For instance, “depression” was rarely understood as a medical condition; instead, people described feeling “heavy,” “stressed,” or “tired of life.” Likewise, “suicide” was rarely spoken aloud; residents used euphemisms like “do something funny” or “tired of life. This insider understanding of cultural and linguistic codes helped me uncover hidden meanings and highlighted the stigma and silence about suicide.

Researcher as an Outsider

At the same time, I approached this study as an outsider. As a non-Makoko resident, I was trained as a social worker and researcher and was introduced to psychological, social, and structural frameworks that diverged from the community’s dominant cultural views. This academic perspective could have overshadowed the participants’ voices if I had not been cautious. I constantly reminded myself that, although I offered a different outlook, my role was not to “explain away” their perspectives but to allow their realities to inform the understanding of suicide awareness. This delicate balance illustrates what Dwyer and Buckle (2009) refer to as the “space between” insider and outsider roles.

Secondly, my experience as a former social worker with the Lagos State Government added another layer of complexity. The Lagos State government is present in Makoko, yet its authority is widely challenged there. It is seen as a regulator and provider of occasional services, but also associated with distrust, eviction threats, and neglect of social services. My previous role with the government put me in a delicate position, both an insider, familiar with policy, and an outsider, due to community distrust of government officials. This duality required careful

negotiation of trust, especially during interviews when residents voiced grievances about governance.

Being both an insider and an outsider created tension that proved helpful. As an insider, I connected on a deeper level. As an outsider, I maintained the necessary distance for critical reflection. Before entering the field, I was concerned that the severe hardships faced by Makoko residents, combined with the sensitivity and stigma surrounding suicide, might make participants guarded or reluctant to share their experiences. However, this expectation was challenged during data collection, as participants engaged openly and provided rich accounts of their experiences and perspectives. I balanced these dual roles by engaging in honest discussions with my advisor and taking time to recognize when my cultural beliefs or academic frameworks influenced my interpretations.

It is worth explicitly noting how my expectations entering the field compared with what I came to understand by the end of the study, as this contrast shaped my analytic stance. I began the study anticipating that the severe material hardship in Makoko, combined with the stigma and silence surrounding suicide, would make participants guarded and reluctant to discuss such a sensitive topic. I expected thin, cautious accounts. I also expected, given the absence of formal mental health services, that community awareness of suicide would be minimal and that residents would have little to offer beyond acknowledging the problem. Both expectations were displaced by the data. Participants engaged openly and often at length, offering reflective, sometimes deeply personal accounts, and demonstrated a rich, if informally acquired, awareness of the drivers of distress and the community's protective practices.

I came to realize that I had underestimated both the community's willingness to speak about suicide when approached with cultural respect and trust, and the depth of the knowledge and

support systems already operating within it. This realization reoriented my analysis away from a deficit framing (what the community lacks) toward a strengths-based reading of what the community already knows and does, reflected in the prominence of community-based prevention practices in the findings and in the design of the proposed framework. Recognizing this gap between my initial assumptions and the realities participants described was itself an act of reflexivity, and it reinforced my commitment to treating residents as knowledge-holders rather than as passive subjects of study.

Conclusion

This chapter restates the study's purpose and outlines the research design and methodology. The study employed a constructivist paradigm with a phenomenological, qualitative research design. The discussion covered the target population and sampling, participant recruitment details, data collection procedures, and strategies for validity. Additionally, the chapter explained how the data were analyzed and addressed ethical considerations.

Chapter 5: Results

Introduction

The purpose of this qualitative, phenomenological study was to explore the extent of awareness of suicide and community-based prevention approaches in Makoko to inform the development of culturally appropriate interventions. This chapter presents the results from the semi-structured, in-depth interviews. It begins with an overview of the respondents' socio-demographic characteristics. Tables 1 & 2 summarize this analysis for residents and key informants. The research questions are presented in Table 3, linking the themes and sub-themes. The thematic map of the results is presented (See Figure 3). This is followed by the presentation of the qualitative results, organized around the research questions and responses regarding awareness of suicide and community-based prevention approaches in Makoko. Lastly, the chapter's conclusion was presented.

5.1 Socio-Demographic Characteristics of Participants

As shown in Tables 1 and 2 below, 20 community members, comprising residents (N = 10) and key informants (N = 10), participated in this study. The socio-demographic characteristics of the two groups are discussed.

5.1.1 Socio-Demographic Characteristics of Residents (See Table 1)

Of the ten participants in the resident group, gender was evenly distributed, with 50% male and 50% female. Most participants fell within the age ranges of 18–24 (30%), followed by 35- 44 (20%), 45–54 (20%), 25- 34 (10%), 55- 64 (10%), and 65 and above (10%). This table indicates that youth are well represented in the study. Educational attainment varied: 20% had completed only primary education, 20% had completed secondary education, and 60% had completed tertiary-level qualifications. The term "tertiary education" as reported by the residents refers to any

level of post-secondary education, e.g., a diploma, a National Certificate of Education (NCE), or a degree. Some of them have yet to complete their education, and those who have completed it later returned to the community. Additionally, the high proportion (60%) of tertiary education reflects the characteristics of the resident participants rather than those of the broader Makoko community.

Regarding employment, the majority (60%) identified as self-employed, while the remaining 40% were employed in formal roles or engaged in other occupations. This reflects limited job opportunities in the community where informal economic activity is more readily available than stable, salaried employment. Although most residents (80%) reported having no access to healthcare services in Makoko, only a few (20%) indicated they could access services through a private clinic in the community, primarily because they could afford the services. Additionally, 70% responded yes to either personally experiencing or knowing someone who experienced mental health challenges, and the remaining 30% responded 'no'. This shows the prevalence of mental health issues in the community. The table below summarizes residents' demographics.

Table 1: Socio-Demographic Characteristics of Residents

Characteristics of Respondents	Category of Respondents	Number of Respondents (N)	Percentage (%)
Gender:	Male Female	5 5	50 50
Age (years)	18-24 25-34 35-44 45-54 55-64 65 and above	3 1 2 2 1 1	30 10 20 20 10 10
Marital Status	Never Married Married Widowed	3 6 1	30 60 10
Religious Affiliation:	Islam Christianity	6 4	60 40
Educational Level	Primary Secondary Tertiary	2 2 6	20 20 60
Current Occupation	Self-employed Formal-Employment Casual Labourer Other Prefer not to answer	6 1 1 1 1	60 10 10 10 10
Access to Healthcare Services	Yes No	2 8	20 80
Experience of Mental Health Issues	Yes No	7 3	70 30
Length of Stay in Makoko	Over 20 years Less than 20 years	7 3	70 30

5.1.2 Socio-Demographic Characteristics of Key Informants (See Table 2)

In the key informant group, males accounted for 60% of participants, and females 40%. The age groups 18-24 and 35–44 had the most significant proportion (30%) of the sample. This was followed by the age group 45–54 (20%), the 25–34 age group (10%), and the 55–64 age group (10%). Healthcare institutions were the predominant organizational type (60%), followed by faith-based and community organizations (20%), with NGOs and community organizations each accounting for 10%. Only 20% of the participants had received formal training in community-

related suicide prevention and mental health. Respondents reported varied levels of engagement on suicide prevention and mental health issues, with 50% reporting "sometimes," 30% reporting "very frequently," and 20% "rarely." This indicates that some are actively involved in mental health discussions or support, while others reported minimal involvement. The table below summarizes the demographics of the key informants.

Table 2: Socio-Demographic Characteristics of Key Informants

Characteristics of Respondents	**Category of Respondents**	**Number of Respondents (N)**	**Percentage (%)**
Gender	Male	6	60
	Female	4	40
Age (years)	18-24	3	30
	25-34	1	10
	35-44	3	30
	45-54	2	20
	55-64	2	20
	65 and above	0	0
Organization Type	Healthcare	6	60
	Faith-based	2	20
	NGO	1	10
	Community organization	1	10
Formal Training on Mental Health and Suicide Prevention	Yes	2	20
	No	8	80
Engagement with the Community Mental Health/Suicide Related Issues	Very frequently	3	30
	Sometimes	5	50
	Rarely	2	20

5.2 Results of the Qualitative Data

This section presents the qualitative results on exploring suicide awareness and community-based approaches in the Makoko community. The reflexive thematic analysis led to the conceptualization of five overarching themes and fifteen sub-themes. See Table 3: Research Questions linked to Themes and Sub-Themes. Themes include 1) Community Awareness and Understanding of Suicide, 2) Risk and Vulnerability Factors, 3) Community-based suicide

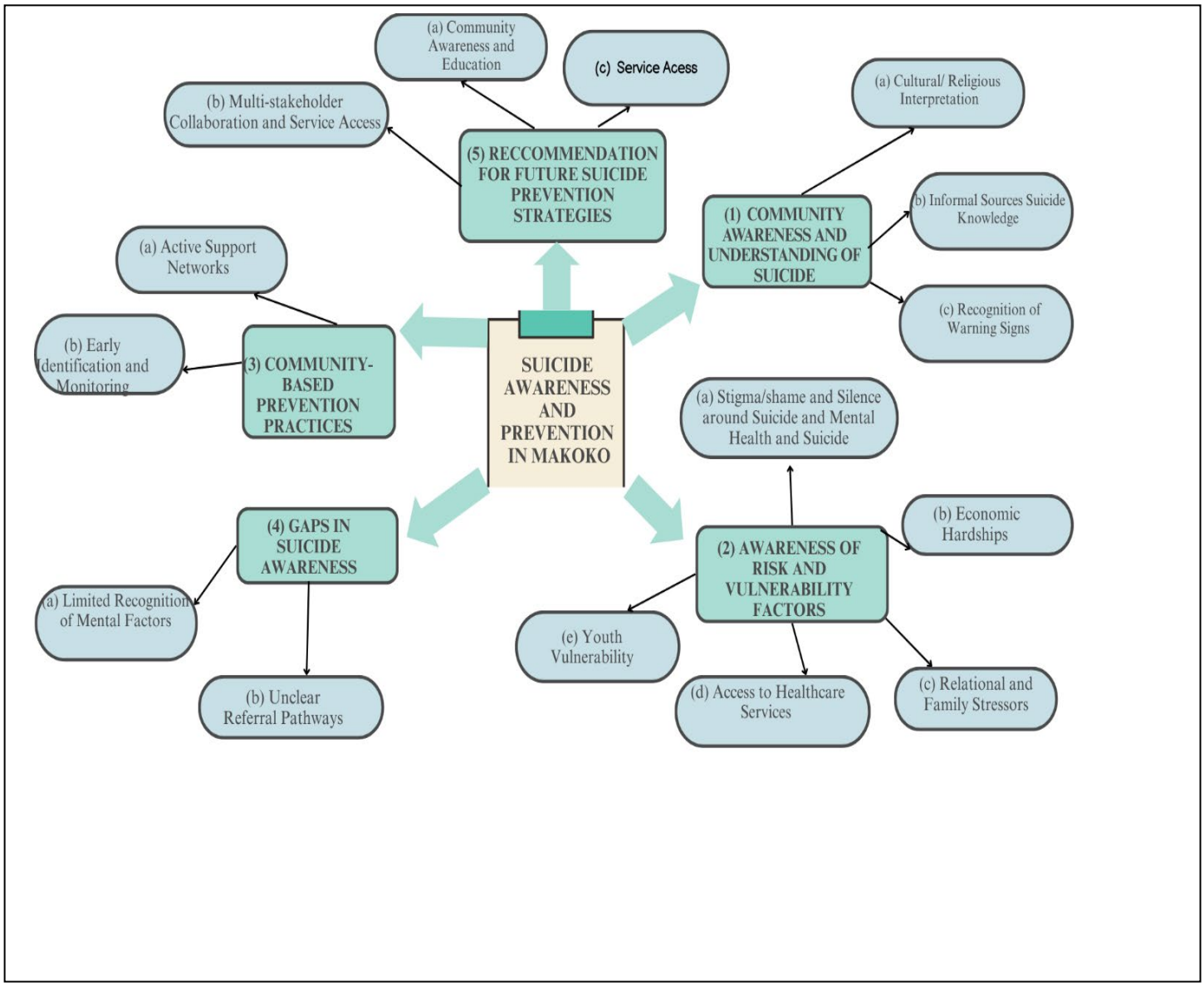
prevention practices, 4) Gaps in Suicide Awareness and 5) Recommendations for future prevention strategies. These themes resided in and cut across individual, relational/family, community, and policy levels. Each theme is discussed and supported by direct, representative quotes from both groups.

Table 3: Research Questions Linked to Sub-Themes and Themes

Research Questions	Themes	Sub-Themes
Question One What is the nature and extent of suicide awareness (including its associated risk factors) among residents of the Makoko community?	Community Awareness and Understanding of Suicide	- Religious/Cultural Interpretations - Recognition of Warning Signs - Informal Sources of Suicide Knowledge
	Awareness of Risk and Vulnerability Factors	- Economic Hardship - Family and Relational Stressors - Limited Access to Healthcare - Stigma and Silence Around - Mental Health and Suicide - Youth Vulnerability
Question Two Are Makoko residents aware of the support for suicide prevention in their community?	Community-Based Prevention Practices	- Active Support Networks - Early Identification and Monitoring
Question Three What key gaps in awareness could be addressed in future community-based strategies?	Gaps in suicide Awareness	- Limited Recognition of Mental Health Factors - Unclear Referral Pathways
	Recommendations for Future Prevention Strategies	- Community Awareness and Education - Multi-Stakeholder Collaboration – Improved Service Access

Figure 4

Thematic Map



5.2.1 Theme 1: Community Awareness and Understanding of Suicide

The participants acknowledged that suicide exists in their community and demonstrated their varying awareness of it. Three sub-themes were developed from the data, including religious/cultural interpretations, recognition of warning signs, and informal sources of awareness about suicide. Some participants interpreted the concept as a phenomenon of religio-cultural

beliefs, often attributing it to spiritual attacks, punishment for violating traditional norms or moral failure, rather than a mental health-related phenomenon. Furthermore, while some of them recognized the warning signs, others reported that the sources of their awareness about suicide were through informal means, including community experience, observation, and social media.

Sub-Theme 1: Religious/Cultural Interpretations of Suicide.

The meaning of suicide in Makoko is significantly shaped by cultural and religious beliefs rather than by psychological or medical interpretation. Participants pointed to faith in God as both a source of strength and a reason why some individuals might consider taking their own lives, suggesting that individuals without belief in God and who are not thoughtful about God, can decide to end their lives. One respondent stated that:

> "….it is simply a lack of thoughtfulness…. I believe that any challenges one encounters in life are from God, and that if a person holds on to God, the problem shall be overcome. But a lack of faith in God and not being close to God enough would always make one feel there is no headway, and they would conclude on killing themself." (R-P9).

Another participant interpreted suicide through religious beliefs concerning sin and accountability before God. She questioned how a person who died by suicide could stand before God, stating:

"I can't imagine how the suicide victim will stand in front of God because I believe that whoever dies by suicide has sinned. So why would one kill themself for whatever reason they may have." (R-P7).

Participants directly linked suicide to spiritual, supernatural forces or cultural beliefs, particularly spiritual attack, bewitchment or the violation of spiritual or cultural traditions, such as the disregard of ancestral expectations or the abandonment of traditional obligations, suggesting

that suicide is an act that could be inflicted on a person by malicious spiritual entities or enemies. One resident remarked:

> … maybe some people from somewhere or some spirits are like pushing the person to do what he or she does not want to do, like…it's some people that control the person to do what the person, maybe the person could even want to take his life. So, there are things like that—some spiritual things (R-P4).

Another resident linked mental instability to spiritual attack arising from interpersonal conflict, and described the remedy prescribed by a herbalist:

> When someone is sick, we always hear that they were spiritually attacked. For example, it is like saying that your stepmother and your mother are enemies.… or a person who thinks that someone offended them, and the way they can punish them is to attack them spiritually. So… they should be mentally unstable.… When I consulted the herbalist, they told me that his case was a spiritual attack, and to recover, he would do certain things, which the Yoruba call *Etutu* (sacrifice). (R-P2)

This interpretation is supported by one key informant, who explained that suicidal behaviour or severe distress may be understood in the community as stemming from violations of spiritual or cultural traditions, such as disregarding ancestral expectations or abandoning traditional obligations. This framing reflects a cultural explanatory model in which suicide is interpreted as spiritually rooted. One participant stated:

> "… cultural way is the major part that is even very, very dangerous. Them, always think negative that before this thing is happening now, that maybe the person has offend the tradition, that is why this thing is happening to the person." (KI-P1).

Sub-Theme 2: Recognition of Warning Signs of Suicide

Participants described some warning signs of suicidal behaviour. They described observable warning signs such as changes in mood, withdrawal, and isolation, which they observed among certain community members, as possible indicators of suicidal thoughts. Although participants could identify observable changes in community members, their understanding was limited by a lack of mental health framing and an appropriate way to respond to such signs. A resident indicated that:

> …. someone has asked me before…I wasn't... meaning to commit suicide. I was just sad and moody….I didn't want to talk to anybody, just to myself. So, you know people that were there just come in, once they see your mood change "what happened, what is wrong with you…"say what is wrong with you, what is bothering you", and I speak it out. And they were like, that is not the end of live try and move on. (R-P4).

Key informants support this. One stated:

> … somebody that has been joking, someone that in the, maybe from morning till night, you'll find the person playing. You just see the person apart from sick. You just see the person; you observe the person staying alone, sitting alone… You see this person, that something is wrong… someone that you greeted; he embraces you, you talk, you just greeted, he passes by. You would suspect that something is wrong… know that that person is trying to go and *do something funny.* (KI-P2).

Another one mentioned that:

> "… we notice a kind of changes in somebody's… maybe moody. They are trying to withdraw." (KI-P6).

Sub-Theme 3: Informal Sources of Suicide Knowledge

Participants described multiple ways through which they have knowledge of suicidal behaviour, indicating that community experiences, observation, rumours and social media primarily shape awareness. These revealed informal communications rather than structured education or formal awareness campaigns. Some respondents emphasized that their knowledge of suicide originated directly from community encounters and shared experiences. As one participant explained:

> I went to his place….I saw that the door was locked…. So, I saw that there's light in his room. So, I was banging the door….I noticed that someone is inside……. I call on the neighbours, too. I think that maybe something happened to him or something like that…..So, when the banging increases. He later opened the door, but he was crying. And then….we saw that he has already tied rope and he had prepared to hang himself. (R-P6).

Another participant described learning about suicidal behaviour through word of mouth in the community:

> "If anything happen, you know, there will be rumours…. people will be saying, this person just killed himself." (R-P4).

Other participants highlighted the role of media and social media as additional sources of knowledge about suicide. Their accounts suggest that while community experiences are central, external sources like the media play a supplementary role in reinforcing awareness of suicide. One respondent reflected:

> "I learned about suicide through seeing, hearing it in the community, through the media." (R-P7).

A second respondent stated knowing about suicide through their encounter with a suicidal

Individual and through social media:

"I have seen someone who had suicidal thoughts before because she was in debt. I have also heard about suicide on social media." (R-P10).

5.2.2 Theme 2: Awareness of Risk and Vulnerability Factors

This theme demonstrated participants' awareness of potential risk and vulnerability factors that contributed to suicidal thoughts and behaviours within the community. Five sub-themes emerged from the data, including (1) economic hardship, (2) family and relational stressors, (3) stigma/shame, silence around mental health and suicide, (4) limited access to care, and (5) youth vulnerability. In the presentation of the sub-themes below, youth vulnerabilities are presented last, as it was perceived that these issues are best understood after the other sub-themes that explored risk and vulnerability at different system levels.

Sub-Theme 1: Socio-Economic Hardship

Residents identified poverty[1] within the broader community context. They described how chronic financial hardship affects daily life in Makoko, particularly by preventing them from providing food for themselves and their families. The hardship can contribute to feelings of distress and hopelessness, which may heighten vulnerability to suicidal thoughts. Participants noted that:

"… poverty…can actually make somebody to commit suicide in this community…..… it is responsible too. Yeah, because whereby someone woke up and then to not be able to have at least three-square meal, even not three-square meal you have two-square meal a day. But to have one is actually for, it is actually like struggle to get that one". (R-P6).

A key informant supported this finding by emphasizing that a lack of financial capability can lead to distress and a person's decision to end his life:

[1] The term poverty here refers to pronounced deprivation in "well-being," reflecting households or individuals lacking sufficient resources to meet their needs (World Bank b).

"It is true that whoever does not have money, they don't have any food to cater for their many children, definitely, they would think of harming themselves." (KI-P10).

Participants also described medical services as extremely costly, as there is no government-owned health centre in the community, and they have to pay out of pocket for services at private hospitals. In addition, formal services outside the community are not free, but they are relatively cheaper when government-owned. This leaves many residents without treatment options, making community members vulnerable to suicide. One participant stated:

> … if you take someone to the hospital, the test fee is almost killing them. The government doesn't allow them to test someone for free. If they take someone to the hospital, and there is no one to provide financial support for the person's treatment, you see that it's a problem. (R-P2).

Participants also identified increasing living costs, which led to increasing house rents, as key factors contributing to suicide vulnerability in Makoko. They reported that increasing rents, led by developers, were forcing families into financial hardship, and this may be a key vulnerability factor contributing to suicide risk in Makoko. One participant remarked:

> … the developers have taken over, our rent has increased. It is now unaffordable. A room and a parlour are now for 1 million plus. How would a person who earns 20,000 naira, who would feed a wife and send his children to school, afford such an amount of rent? So, the housing problem is one of the problems we are facing. (R-P3).

The key informant participants further highlighted the absence of income-generating opportunities, leaving community members with limited options. They explained that formal jobs are scarce in the community, which means many people rely on irregular, low-paying work to survive. With government support unavailable to vulnerable individuals, some individuals

engage in immoralities such as "adultery"[2] as a survival strategy to generate income. Over time, the economic stressor can create feelings of hopelessness and exhaustion, which in turn lead some to consider suicide as a way out. A key informant stated:

> In this Makoko… there are little to what people can do to earn money and that contributes a lot to why people try to, you know, 'I'm tired of this life. Let me just die and go. I've tried my best'.... and there are some parents whereby they don't have the power to give their children the privilege to go to school, and they involve, engage themselves in other sorts of, you know, immoralities. They go as far as, you know, committing adultery to provide money for their children. (KI-P8).

A resident lamented how, despite their efforts, they feel trapped by the restricted opportunities which do not allow them to either further their education after the free secondary education or find a job:

> "I went to school, I did finish... I finished my secondary school since 2022. But because of money, financial, money from my parents to continue to university level, we don't have that money, so for me not to have that money, I'm still in the hood [3]looking for one or two things to do." (R-P4).

The burden of debt and financial responsibilities was a common risk factor in the community. Participants described indebtedness as a significant source of psychological stress, especially when a specific loan, '*Lapo*[4]', is involved. This loan is commonly used by community members to finance their micro-businesses. Based on lived experience, a participant shared a

[2] In this context, the term "adultery" was used to denote transactional or survival-based sexual relationships rather than consensual extramarital affairs.
[3] Slum slang for neighbourhood.
[4] *Lapo* is a microfinance loan which involves bank interest.

narrative about how a community member ingested Sniper (an insecticide made of synthetic organophosphate) due to debt that the person could not repay:

> She was the one I said ingested Sniper on Friday when we were praying *Jumaah*[5]…..some days before the incident, two banks came on Monday and Tuesday, but were persuaded and left. Another micro-finance bank (*Asha or Lapo*) came on Wednesday. They threatened to return the following day and disgrace her within the community…. Without letting anybody know, she ended her life to save herself from the embarrassment of the microfinance bank (R-P2).

Sub-Theme 2: Family and Relational Stressors

Family and relational stressors include emotional strain connected to family relationships, responsibilities, and interpersonal challenges. Participants highlighted negative family dynamics, including the burden of family responsibilities, marital problems, relationship problems, and family-related crises, especially relating to children. In the Makoko community context, it is the socially acceptable responsibility for men to provide for their families, and this perceived failure to meet the cultural expectation leaves them feeling unworthy and diminishes their dignity, leading to shame and emotional distress. One respondent recalled an encounter that captured how overwhelming this pressure can become:

> "A man came to me and said, 'I'll kill myself because I can't feed my wife and five children.' He was crying and hopeless." (R-P1).

This finding is further supported by a key informant who emphasized the emotional and psychological stressors associated with the inability to meet family responsibilities.

[5] Jumaah refers to the special prayer observed in congregation by Muslims on Friday

"When you have family, you cannot feed them. You have a lot of things that you cannot attend to. You just start giving excuse; when you get to the level, you start thinking, you cannot control yourself again." (KI-1).

Participants also highlighted how family issues emerged as a significant source of emotional strain, particularly for women. In the Makoko context, because job opportunities are limited, many women bear the financial burden when their husbands are unemployed, or their husbands' income cannot support the family. The reversal of traditional roles can put pressure on women in such homes, leaving them overwhelmed. If this continues, it could trigger emotional distress, making them vulnerable to suicidal thoughts. One participant explained the situation women face and shared women's experiences of traditional role reversals regarding paying the house rent, which is the husband's responsibility. This causes emotional distress in women and makes them vulnerable to suicide:

…some women's husbands are not financially stable. However, rent rates have recently increased…. This poses pressure on women as they must struggle to pay the rent while their husbands move in to live with them. Their husbands would just add a little amount to it or nothing at all. Some pay children tuition fees in addition to other expenses. If such women are not careful, they could get overwhelmed and they can have suicidal thoughts. (R-P7).

Another resident highlighted the commonality of marital problems, such as divorce, in the community, which stem from financial difficulties, and noted how these issues are leading to emotional distress among families, making them vulnerable to suicide. One participant noted:

Financial issues cause marital problems. If a man becomes financially handicapped, it may lead to matrimonial matters, which may lead to domestic violence, which in turn might lead to divorce. Divorce could lead either of the spouses to kill themself. (R-P3).

A key respondent who is a young adult supported this with how romantic relationship problems, which are common among young people, can create psychological distress for individuals, making them vulnerable to suicidal thoughts and behaviours:

> …. the boyfriend broke up with her and was making a video with another lady where they were making out and sent it to her. Because of that, she drank sniper…. I think the main focus should be on we the young adults. (KI-P8).

Participants highlighted how a family-related crisis, especially relating to children, can lead to psychological distress, which creates feelings of hopelessness, making individuals vulnerable to suicide. One resident noted how frustration from a parent led to a young person's suicide attempt:

> …..the cause was frustration from the mother.....the mother became angry and punished her by beating her and locking her up at home…... and she used the money to buy a sniper and ingested it. She did this because she felt disappointed…..So, frustration is the leading cause of suicide among the younger people.. (R-P3).

A key informant supported this finding and gave an account of a community member who attempted suicide by drinking hypo[6] as a result of their child's involvement with the law. The stress caused by this situation can create the feeling of emotional distress, which can lead to suicide vulnerability.

> They told the man that the boy cannot come outside again. They have sent him to life imprisonment. The dad was now worried that he cannot be alive while his own son would be in prison. So, the man just bought hypo and took…so the man took hypo, and he was fainting on the floor. (KI-P2).

[6] Hypo is a chemical substance that is used for cleaning

Sub-Theme 3: Limited Access to Healthcare and Mental Health Services

Participants repeatedly emphasized that healthcare and mental health services were limited within the community. Limited or absent healthcare infrastructure emerged as a significant vulnerability factor, leaving residents without access to professional mental health support. As one participant noted:

> "There is no health center where one can get free treatment… there is no such health centre…There is no mental health support in this community. Everybody must carry their cross (*Onigba, ni o n ran igba e*)." (R-P3).

Another participant highlighted the absence of formal mental health support in the community as an issue, noting that: "…we don't have any health center or any counselling center that they can go to here." (R-P5).

Key informants also confirm limited access to care as an issue, highlighting that the lack of mental health professionals in the community leads to reliance on informal and traditional healing systems instead. One of them remarked:

> In this whole of Makoko… there is no mental health professional. Unless there are herbal people that deal with people with mental issues, or something happens to them and, you know, they are not in their mind their right state of mind. So, there are these places they take them to, you know, do herbs for them, do all this traditional stuff on them, and they get well. (KI-P8).

Sub-Theme 4: Stigma, Shame and Silence around Mental Health and Suicide

Mental health stigma persists within everyday social interactions and contributes to silence for those who experience mental health issues, including suicidal thoughts. Even after recovery, individuals with a history of mental illness remain subject to labelling, where ordinary conflicts

are attributed to their condition or presumed non-adherence to medication. Such interpretations reinforce stigma and foster silence, which may discourage help-seeking. One resident remarked:

> If there is someone who has experienced such a problem before and has recovered, if they do a little wrongdoing, people will respond by saying that it is not their fault; it is because they have not taken their medications, 'that thing has come over you'...people do not feel free to talk about mental health issues…. (R-P2).

Another participant, who is a resident, shared an incident illustrating how individuals conceal suicidal thoughts. The participant commented:

> People do not talk about it. Only those whom God wants to save will say it out loud and later have someone come to their aid. For example, the person who I shared her story about ingesting Sniper, it happened in just a day. People saw her when she went to buy the sniper, but they thought she wanted to use it for another purpose. If she had said it out, people would have rescued her. (R-P10).

Individuals with specific health issues face compounded challenges related to mental health. Those with medical conditions such as HIV experience stigma and discrimination, which affect their overall mental well-being and increase their risk of suicide. They often face ongoing distress due to their condition, which over time can become overwhelming, particularly in a setting like Makoko, where access to care is limited. A key informant observed:

> "Social stigma might be there. Like, let me give an example, somebody that is having HIV now, will look up and said, let him or her ends this thing straight away so that people will not know." (KI-P6).

Stigma affected not only individuals but also their families, who frequently hid suicide-related problems to prevent shame. As one respondent explained:

"… the families would prefer to keep it an issue within their own family because it can bring a massive shame to them. If the affected person passes by, people will start pointing at the person, describing their situation. That was the reason people would not speak out." (R-P9).

Another common concern was fear of ridicule, as one participant mentioned:

"… they don't speak up because they have the belief that when you're speaking out your mind, another person will make jest of them. So, they prefer keeping it to themselves." (R-P8).

The stigma surrounding mental health and suicide is reinforced through cultural and religious interpretations. Such interpretations contribute to abandonment and social exclusion, particularly when individuals are labelled as "mad" or spiritually afflicted. These culturally embedded stigmas reinforce silence, discourage help-seeking, and may lead to eventual suicide. A key informant reported that:

maybe the person has offend the tradition….. until they go for their tradition Ifa and as to..... know what is wrong with the person before they interfere positively…..I can even say some churches….they don't use to notice on time…..They used to abandon those kinds of people…people think maybe they are mad or something is at their *back*. Maybe the devil is disturbing them (KI-P2)

Sub-Theme 5: Youth Vulnerability

Young people are especially vulnerable because of unemployment, social pressures, and risky behaviours. Participants mentioned that the lack of job opportunities not only leaves many youths idle but also drives them towards harmful coping mechanisms, making them vulnerable to suicide. One respondent observed:

"There are no jobs in this community; most youth are jobless and idle and are joining bad gangs. The few ones who have jobs are also joining bad gangs, leading them to abandon their careers and kill themselves. They do drugs, take Colorado.[7]" (R-P10).

The voices of youth themselves further highlighted the significance of these struggles, including survival, limited educational opportunities, and insecure employment prospects. Their narrative showed frustration and uncertainty about the future. This situation can create hopelessness if it persists over time and increases the vulnerability of suicidal behaviour in an individual. A participant shared:

… a lot of people, especially our youth… I'm also a youth o… I don't have anything I'm doing….. my parents were like…..…I should go find something to eat, to feed myself. They can't be feeding my younger ones and also be feeding me. So, I have to go on the street, look for what to eat…..unemployment is really affecting people. (R-P4).

Another participant shared how the experience of limited educational and employment opportunities contributes to a stressor that takes an emotional toll on young people, making them vulnerable to suicide:

"They feel like, oh, there's nothing else to do than to kill themselves. There's no any job in this community… So, there's no any job for you, you just have to fight for yourself to make sure that you get the job for yourself." (R-P5).

[7] This is the Nigerian local name for a group of potent synthetic cannabinoids that have been linked to hallucinations, seizures, mental health disorders, and even deaths, commonly taken by young people. Sometimes referred to as 'Colos'

5.2.3 Theme 3: Community-Based Prevention Practices

Despite structural challenges, community members described informal prevention practices which exist in social networks and cultural norms. Two sub-themes describing this include peer and group support, and community surveillance.

Sub-Theme 1: Active Support Networks

This refers to intentional peer-based emotional and practical support. Neighbourhoods often rallied around those in distress. Religious and cultural groups, as well as peers, offered encouragement, advice, companionship, and support in meeting basic needs, rather than professional counselling and formal support. Community-based care was reported to be crucial for early intervention. Although stigma and silence often hinder open discussions about mental health, participants highlighted a culturally embedded way of recognizing distress. Instead of verbal disclosure, community members observe behavioural cues and provide support through shared daily interactions. For clarity, the term "depression" here refers not to clinical depression but to a locally understood sign of emotional distress, sadness, or feeling overwhelmed. Unlike the clinical definition, which involves a specific set of symptoms and functional impairment (American Psychiatric Association [APA], 2022), these participants saw these experiences as everyday struggles related to hardship and stress, not as a diagnosable mental health disorder. This reflects a cultural understanding of distress rather than an acknowledgment of depression as a mental illness. In a similar vein, "counselling" in this context refers to informal emotional support, such as attentive listening and giving advice, common among community members, rather than professional counselling. One key informant who provides informal healthcare services shared how they provide emotional support to distressed individuals:

"… when I found out someone is depressed, especially…, we try to counsel them, talk to them, ask questions, make them trust you at first so they'll be able to pour out their mind to you and tell you what exactly is going on with them". (KI-P8).

Neighbour-to-neighbour support was common in Makoko. Suppose one notices that a neighbour or acquaintance becomes withdrawn and unusually quiet. Community members interpret this as "something is likely wrong," and they can offer advice, guidance, and assistance with material needs. As one resident mentioned:

By questioning the person, one can determine if they are experiencing depression. We can support the person by talking to them frequently and counselling them to remain hopeful…. to prevent them from experiencing depression. (R-P10).

Role models are often sources of inspiration and hope, especially among young people. They serve as protective factors that can help prevent suicide by inspiring hope, resilience and future certainty. In contexts like Makoko, where poverty and limited opportunities, especially for youth, are common, exposure to individuals who have overcome adversity can help counter feelings of hopelessness.

"I read story of more people that came from slums like this and yet they're living and doing well in the world. So, I take that as my challenge, and I feel it positive vibe to keep me going." (R-P6).

Young people further described building resilience through leisure activities and friendships. These experiences can provide emotional relief despite the significant socioeconomic challenges they face. One resident commented:

> What I enjoy most is, uh, how I'm going into the water and swim with my friends because we always use, go to that water. There is one, uh. Uh, we call it a *Gedu*[8]. It is always been on water, so we use a net catching fish around with guy…. . we use a drum, like we will be dancing. In fact, I enjoy all those things. (R-P1).

This shared identity fostered a sense of belonging and emotional safety:

> "…we grew up here and nothing happened that bothered us, we have the opportunity to live in this community…and nothing has harmed us here…. I noticed that the people who understood me were here with me". (R-P2).

The suicide crisis in Makoko often prompts a collective response rooted in the community's culture of mutual care and communal care. Participants emphasized that community members sometimes mobilize as a group when someone is perceived to be in distress. Groups within religious communities sometimes form, enabling members to offer one another support or collectively support outsiders. One resident remarked:

> If anything small happen to anyone like this, even for example, this is my house now and I loss someone, and I'm crying and just one person hear now. They will like, people will, just come here. They'll fill the house, to talk to you, to counsel you, to make sure you don't do any harm to yourself. (R-P4).

Participants reported that spiritual interventions by the spiritual and traditional healers play a crucial role in community responses to suicide crises. Participants reported that individuals in distress often turn to their places of worship for spiritual support. One resident noted:

[8] In Makoko, *Gedu* refers to pieces of the Mahogany wood tree that float on the water as they are being transported through the waterways in the community

"When people are actually down psychologically, what they actually do, some of them, they go spiritual. Like we pray…those that go to mosque, those that go to church seek counselling from their pastor." (R-P6).

These interventions come in various forms from religious and traditional leaders representing different groups, including traditionalists, Muslims, and Christians. The interventions may include those that foresee future calamities that could befall a person and lead them into distress. Interventions are provided quickly to prevent problems. This is evident from a key informant who commented:

Cultural leaders, they believe in this *Ifa* (oracle) of a thing and, um, I believe it's something like that want to occur…. They have their own way of worshiping their idols as well. I think the person in charge, once they pray, is going to see something like that to the person, before or try to say that you have this kind of thoughts in your mind, and they know…the ways to eradicate the impression. (KI-P2).

Interventions are also offered through prayers, which are believed to relieve individuals' distress. The pastors or imams offer these prayers. Imams, who are the leaders of the Muslim groups, frequently assist in this area by supporting individuals in distress with prayers, as one resident noted:

"People often seek support from their Imam, requesting prayers from them. People do that a lot in Makoko here." (R-P9).

In addition to spiritual interventions, participants mentioned that religious groups offer tangible support to those in need within the community. This support helps alleviate hardships that could otherwise lead to feelings of hopelessness and suicidal thoughts. Such assistance is offered in the church. A key informant participant said:

…. in church, you know, there's some church that they, I can see that we have people that they lack of food……they knows going there, they'll usually come back with something to feed the family. So, most times the church are playing their role by giving them free access to financial support. And they're really touching lives. (KI-P2).

Muslim communities also offer support through charity networks based in mosques, where Muslim faithful worship. Members often donate collectively to help those in need. This material aid is crucial for individuals at risk of suicide because it addresses their basic needs. By meeting these needs and reinforcing a sense of belonging and moral support, these networks may mitigate some of the conditions associated with suicidal distress. Such support is extended not only to community members but also to outsiders, as one participant noted:

"…they usually come to the mosque. When they come to the mosque, we announce to the congregation without mentioning their name. The charity donors will contribute money to the person." (R-P2).

Sub-Theme 2: Early Identification and Monitoring

This refers to informal community monitoring, in which behavioural changes are observed and sometimes reported or acted upon. Participants noted that through constant interaction and observation, community members can help identify individuals at risk. Early detection through such local vigilance often prompted communal efforts to provide help or spiritual support. A resident highlighted how observing behavioural changes, such as being withdrawn, may be a sign of psychological distress, which the community members may swiftly address. One resident explained that:

If one notices that a neighbour or acquaintance becomes withdrawn and unusually quiet, 'something is likely wrong'. By questioning the person, one can determine if they are experiencing depression. (R-P10).

A key informant also shared that:

"Once we detect…that this person wants to commit, the solution is, how they're going to eradicate their impression……. people around you traditionally will have to do something because we don't want to loose anybody in our community. (KI-P2).

Another key informant recalled how the life of a suicide attempter who wanted to jump into the river under the Third Mainland Bridge[9] was saved through early identification and monitoring, stating that:

I noticed that this person didn't know water, the way he was doing. So, I need to turn back and rescue him from the water to inside my boat….. I took him to *Baale,* so we called the police station……. they sent someone to come and pick him up and I followed them up to write my statement on how I met him inside water. (KI-P1).

5.2.4 Theme 4: Gaps in Suicide Awareness

This theme results from the participants' accounts of notable gaps in their awareness of suicide. Two sub-themes emerged from the data, including the limited recognition of mental health in suicide and unclear referral pathways.

Sub-Theme 1: Limited Recognition of Mental Health Factors in Suicide

Participants demonstrated limited understanding of the role of mental health in suicide. This suggests that suicide is not universally conceptualized as a mental health issue, reflecting an

[9] The long bridge that connects the Lagos Mainland to Lagos Island, under which the Makoko community is situated.

important gap in awareness of the psychological aspects of suicide, where emotional distress and mental health conditions are not recognized as contributing factors. One participant stated:

"I do not think that mental illness is the cause of people killing themselves. I don't see suicide as a mental health issue" (R-P9).

The limited understanding of the role of mental health is further confirmed by another participant who mentioned that: "…I do not see suicide as a mental health issue." (R-P4).

Other participants expressed uncertainty about the role of mental health, demonstrating partial or tentative awareness, where mental health is acknowledged as a possible factor but not clearly understood. A participant noted:

"…maybe it's a mental health issue, we don't know." (R-P2).

Sub-Theme 2: Unclear Referral Pathways

This sub-theme focuses on providing clear guidance on how and where at-risk individuals can be linked to formal mental health services once their risk is identified. Some community members are aware that they can refer distressed individuals to the two private clinics in Makoko, to the nearby FNPHY, or to other external formal services. Others' understanding of this process was inconsistent, as their accounts varied. While most lacked specific knowledge of where to refer people, only a few were aware of informal services, and even fewer understood this aspect. One resident remarked:

"I have not heard or know of any place in this community where they can be referred to for support." (R-P10).

Another resident stated that they could refer such individuals to informal social networks that can provide support. They stated that they could refer to pastors or Alfas[10]:

[10] This is a term used to refer to Muslim clerics

"…. the place that can come to my mind, these people that we know they're in, they know more… like pastors are, um, Alfas." (R-P5).

A resident remarked:

> If I see anyone having suicidal thoughts, I will just refer the person to the psychiatric hospital at Yaba. There are counsellors there. Then, some hospitals have counsellors... since there are no counsellors in the community, if we have a case now and we know that the person is a Muslim, we will refer them to an elderly person who can talk to them... we have a group named Al-Muminat... we refer within our organization. (R-P7).

This is supported by a key informant who explained how suicidal individuals are referred to outside the community for formal support. Most, however, were unaware of the formal supports available. One key informant mentioned that:

> "We refer to the Neuropsychiatric Hospital, Yaba. We refer to the Federal Medical Centre at their mental health departments. …they have the access to consultants over there, experienced nurse with the mental health training…". (KI-P4).

5.2.5 Theme 5: Recommendations for Future Suicide Prevention Strategies

Participants proposed several context-specific recommendations to strengthen suicide prevention efforts in Makoko. They emphasized the importance of community-based awareness programs, culturally relevant mental health education, and leader training to raise awareness. These suggestions reflect residents' desire for locally appropriate, sustainable methods that respect cultural beliefs and promote mental well-being. Additionally, they suggested multi-stakeholder collaboration and access to services.

Sub-Theme 1: Community Awareness and Education

The participants emphasized the importance of religious and traditional leaders in promoting mental health and in leveraging existing media. Through these media, the leaders can incorporate mental health education into their regular activities, especially during sermons, prayer sessions or community gatherings. This shows participants' trust in faith and traditional institutions as trusted spaces where community members can freely discuss issues of distress. As one resident expressed:

> Religious or traditional leaders can play a role in preventing suicide by continuous counselling[11] in the churches. You know, when they are having service, and the members are around, they can continue counselling them. And talking to them about suicide and how to prevent it, and they continue counselling them (R-P4).

A key informant further supports this awareness and education initiative:

> "… through churches, and through mosques. When the churches, when they're giving sermon, they should make it a point; when they're in church, they should make it a point. When they're in a traditional…environment, they should make it a point so those heads can make, uh, those things work." (KI-P6).

Furthermore, participants highlighted that successful suicide-prevention strategies need to be linguistically inclusive and culturally appropriate to foster broader community understanding and support. They emphasized that awareness and educational campaigns should be conducted in the various local languages spoken in Makoko, not just in English. This reinforced how culturally and linguistically appropriate communication improves understanding, reduces stigma, and encourages community participation. As one participant explained:

[11] The participant is referring to awareness or education

… continuous sensitization about it… I think it's gonna work. It's going to go far in the language they understand, because we have Eguns, in the language they understand, not English alone, language... they understand. We have different types. We have Yoruba, we have Egun, we have Ibo, we have Hausa." (KI-P2).

Participants highlighted the need to focus suicide-prevention awareness and education on young people, who are seen as the most at-risk group in the community due to unemployment, poverty, peer pressure, and limited access to opportunities. One resident specifically pointed out:

"I want to say that the main focus of this educational awareness should be on the young adult, on the young upcoming ladies and men, guys." (KI-P8)

Sub-Theme 2: Multi-Stakeholder Collaboration

The need for a collaborative approach involving local leaders (such as the *Baale*s), NGOs, and government agencies was emphasized. In this way, many participants called for this collaboration. Furthermore, they suggested youth empowerment initiatives and well-established referral networks to foster a more responsive mental health support structure. One key informant recommended collaborating with the *Baales* and community leaders in the mental health and suicide prevention programs:

"If anything is to be done, we have *Baales* in the community, as well as boys and youth leaders, who can collaborate with the government to achieve any project." (KI-P9).

Participants emphasized collaborations where either the government or NGOs raise awareness to educate community members about mental health and suicide. A key informant said:

"...educational awareness where the government or NGOs can, you know, send people to the community, talk to individuals, ask them questions, because they are in the best position to give the answer." (KI-P8).

Beyond awareness and education, participants also emphasized the importance of structured collaboration to sustain prevention efforts. One key informant proposed a train-the-trainer education program, in which the collaborators can select community members to train. These individuals will then return to the community to provide early intervention and raise awareness among community members.

> … on suicide prevention in Makoko, we need awareness…..You know some people in the community, they cannot go to school again but what they just need is awareness. They can do it this way. They can also select some set of people. Go and train them…. and those people will come back to the community and start their awareness... (KI-P1).

Economic empowerment initiatives and culturally appropriate mental health programmes reinforce one another and cannot be implemented in isolation. Participants suggested that through collaboration, youth empowerment initiatives, including vocational training, mentorship, and entrepreneurship, can be established to address one root cause of young people's hopelessness and increased risk of suicide. One key informant mentioned:

> "Makoko is a slum. The level of poverty over here is very high….So, we have to think of how to eradicate poverty in their programs… empowering people." (KI-P4).

Sub-Theme 3: Improved Service Access

As part of a coordinated, multi-stakeholder collaboration, participants highlighted the need for accessible, community-based mental health support services, such as professional counselling for community members in distress. Although community members identified existing sources of support, including family networks, religious institutions and informal community structures, these supports may not always be sufficient for individuals experiencing significant psychological

distress. Participants suggested that establishing counselling services in Makoko would reduce barriers to seeking professional help. One respondent stated that:

> "Counselling would be helpful too. If the government can establish a counselling centre with counsellors, where people who are depressed or have suicidal thoughts can receive support within the community, it would be good." (R-P10).

They further proposed establishing a dedicated community-based mental health support unit within the community to provide timely, culturally sensitive assistance to individuals in distress. Such a unit should be easily accessible and embedded within familiar community spaces, such as the *Baale's* palace, local churches, or other centrally located institutions. One key informant described this idea as follows:

> "Then you now find a suitable place. Just to form a unit in the community. Which is it might be palace. It might be a nearby church. So, so close circle…That's people that have, have been trained. They will be there. People that will provide mental health support should be stationed there within the community. So, that would be a, serve as a close circle." (KI-P2).

Conclusion

This chapter summarizes findings on participants' socio-demographic characteristics and qualitative data. The socio-demographic details reveal diversity across personal, socio-economic, and professional backgrounds. It discusses the five main themes that emerged from the qualitative analysis. The key themes identified include community awareness and understanding of suicide, awareness of risk and vulnerability factors, community-based prevention practices, gaps in suicide awareness, and recommendations for future prevention strategies. Participants demonstrated varying levels of understanding of suicide, viewing it through a cultural and spiritual lens. They showed some awareness of risk and vulnerability factors at both the individual and contextual

levels. They reported community prevention efforts, primarily informal and rooted in community expectations regarding the provision of care. Furthermore, the findings highlighted important gaps that can be targeted in future prevention initiatives. Lastly, specific recommendations, which are culturally appropriate for suicide prevention in the Makoko community, were suggested.

Chapter 6: Discussion of Findings

Introduction

The purpose of this study was to explore the nature and extent of suicide awareness and community-based prevention approaches in the Makoko community to inform the development of culturally relevant, community-based suicide prevention approaches. Three specific research questions guided the study:

(1) What is the nature and extent of suicide awareness (including its associated risk factors) among residents of the Makoko community?

(2) Are Makoko residents aware of the support for suicide prevention in their community?

(3) What key gaps exist in the awareness that could be addressed in future community-based strategies?

The current chapter interprets the study's results and connects them to the broader literature and the theoretical framework that informed the study. The discussion is organized thematically to reflect the five themes identified in the study:

(1) Community Awareness and Understanding of Suicide

(2) Awareness of Risk and Vulnerability Factors

(3) Community-Based Prevention Practices

(4) Gaps in Suicide Awareness

(5) Recommendations for Future Suicide Prevention Strategies

Each theme is examined in light of the study's research questions, theoretical frameworks, and relevant national and international literature.

6.1 Theme 1: Community Awareness and Understanding of Suicide

This theme addresses the first research question, which sought to explore the community's level of awareness and understanding of suicide. Three sub-themes capture community members' awareness of suicide, reflecting how they conceptualized suicide and related issues. These include (1) religious and cultural interpretations, (2) limited recognition of warning signs, and (3) informal sources of knowledge about suicide.

6.1.1 Sub-Theme 1: Religious and Cultural Interpretations

The findings reveal that Makoko residents recognized suicide as a phenomenon, often defining it as an act of self-killing. However, this understanding was shaped by religious and spiritual interpretations, with many viewing it as a sin, a spiritual attack, or a moral failing. These interpretations reflect deeply rooted cultural and religious beliefs that strongly condemn the act. The finding is consistent with previous studies showing that religious worldviews strongly shape how suicide is conceptualized in African contexts such as Kenya, Ghana, Uganda, and Nigeria (Aborisade, 2015; Adams et al., 2024; Atilola & Ayinde, 2015; Emedo, 2021; Gureje et al., 2015a; Jegede, 2005; Jidong et al., 2024; Knizek et al., 2011; Labinjo et al., 2020; Ohayi, 2019; Ongeri et al., 2022; Onu et al., 2020; Osafo, 2013; Udengwu et al., 2022). Similarly, the finding aligns with some international studies in Pakistan and Australia that have identified lay beliefs about suicide, such as attributing it to supernatural forces, personal weakness, or moral failing, which diverge from biomedical explanations (De Silva et al., 2015; Hoven et al., 2009; Pirani et al., 2023).

Religious and cultural beliefs are part of the macrosystem within ecological systems and influence the outcomes of suicidal behaviour (Bronfenbrenner, 1979), operating through mechanisms such as values, religious beliefs, and social norms (Eskin, 2020). Religion has historically shaped followers' understanding of suicide, and higher levels of religiosity are

associated with lower suicide risk, although some aspects of religion may increase suicide risk among certain followers across these major denominations (Gearing & Alonzo, 2018; Nwafor, 2024).

Nigeria is a deeply religious country, with core beliefs centred on Christianity, Islam, and traditional practices that shape how communities understand and address this complex issue (Nwafor, 2024; Participedia, 2019). Although the three faiths condemn suicide, in certain circumstances, taking one's own life is seen as a noble act to escape shame, humiliation, and disgrace (Atilola & Ayinde, 2015; Ele, 2017; Omomia, 2017). Christianity considers suicide a grave sin and a violation of God's law, as outlined in Exodus 20:13. Similarly, Islam prohibits suicide, with consequences in the afterlife (*The Clear Quran*, 2016, 4:29-30), while traditional religion regards suicide as taboo, a sin against the gods, witchcraft, or demonic forces (Emedo, 2021; Omomia, 2017; Onu et al., 2020; Udengwu et al., 2022). Despite the strong influence of religious beliefs that condemn suicide, high rates persist, suggesting a complex interaction between moral frameworks, social pressures, and structural vulnerabilities.

This dual character of religious belief was evident in the participant's own experience, and the Yoruba ontology of death helps explain it. Yoruba ontology frames suicide within a broader ethical perspective that highlights the concepts of "good and bad" death. A good death is achieved when an individual dies of old age, has had children and experienced life's milestones, such as marriage and raising children, and is believed to have departed in a dignified manner, joining their ancestors after a complete funeral ritual (Aborisade, 2015). Such a death is regarded as blessed and is celebrated with feasting and rejoicing. In contrast, dying young is seen as a bad death, characterized by incomplete funeral rites and a lack of happiness during burial.

Deaths that occur earlier in life, such as those resulting from illness or accidents, are generally regarded as tragic or untimely but still permit mourning and burial rituals, albeit sometimes in modified forms. Suicide, however, is viewed as a fundamentally different and more severe category of death. It is morally condemned and considered a violation of social and spiritual norms, leading to significant restrictions on funeral rites and public mourning. Rather than celebratory funerals, suicide deaths are often followed by purification rituals intended to restore communal balance and to prevent perceived spiritual contamination or the possibility of similar acts occurring within the family or community (Aborisade, 2015). These practices reflect not an absence of grief, but a culturally specific response shaped by moral judgement, stigma, and concerns about collective well-being.

Elebuibon argues that Yoruba do not support suicide as they believe that if somebody dies by suicide, they will be punished in the hereafter. They also believe that they would not be allowed passage into heaven; instead, their souls would wander until their natural time to die comes (Elebuibon as cited in Falade, 2013). This punishment also includes the belief that such souls cannot be reincarnated, another aspect of the Yoruba faith (Falade, 2013). However, Atilola and Ayinde (2015) trace the acceptance of suicide among the Yoruba in certain circumstances to the social cognitive processes of the group, whereby the choice of death (*'iku'*) reflects the judgement of the individual that it is a better alternative to shame (*'esin*').

The motivation to uphold personal dignity in the face of shame often drives individuals toward suicide (Fayemi, 2009; Lanre-Abass, 2010). According to Aborisade (2015), such a choice is frequently precipitated by harsh life circumstances in which the person is unwilling to compromise their honour or fears imminent public humiliation. Scholars have argued that where a person judges their own life to lack these qualities, such a life may be regarded as devoid of the

characteristics of a good life and therefore not worth living (Broome, 2006; Lanre-Abass, 2010). The Yoruba describe a worthwhile life as "*aye alaafia, irorun ati idera"* (a peaceful, comfortable and healthy life) and contrast it with a life not worth living, *"aye inira, irora ati aini alaafia"* (a life of hardship, pain and lack of peace) (Aborisade, 2015).

While cultural and religious frameworks clearly play a central role in shaping explanations of suicide, this does not necessarily mean that experiences associated with mental illness are absent. Rather, such experiences may be understood and communicated through different cultural and linguistic frameworks. This finding highlights the need for a more careful understanding of how suicide and psychological distress are conceptualized, expressed, and communicated in Makoko. It also suggests that suicide prevention efforts should recognize and engage with existing cultural and religious understandings rather than treating them as separate from mental health perspectives.

6.1.2 Sub-Theme 2: Recognition of Warning Signs of Suicide

This study found that participants could recognize many observable changes which indicate warning signs of suicide, including social withdrawal, mood swings, and sudden behavioural changes. This aligns with Rudd's (2008) approach, which highlights "observable markers of intent to die" (p. 90). The wider community typically uses warning signs to prevent various health issues (Rudd et al., 2006). Participants' ability to recognize early warning signs demonstrates the potential for informal "gatekeeping". Different individuals may be designated as potential gatekeepers across various populations. For instance, school gatekeeper programs have focused on training teachers and staff, with some also training students to act as gatekeepers for their peers (Wyman et al., 2008). In medical settings, primary care providers and emergency department staff are trained to serve as gatekeepers (Matthieu et al., 2008; Tsai et al., 2011). Gatekeepers may also

include first responders, such as police, paramedics, firefighters, correctional officers, and other emergency personnel, who not only play a role in suicide prevention but may also experience increased suicide risk due to exposure to trauma as part of their work (Isaac et al., 2009).

Previous research has demonstrated the effectiveness of gatekeeper training (GKT) in reducing suicide rates in HICs (Isaac, 2009; Zalsman et al., 2016). The training teaches specific groups to identify individuals at high risk for suicide and refer them for treatment (Isaac et al., 2009). It is often incorporated into suicide prevention strategies that educate social and community facilitators to recognize signs of suicidal behaviour and refer individuals to appropriate services (Cross et al., 2010). According to Burnette et al. (2015), the content of gatekeeper training can vary widely across programs. It can focus on two types of knowledge: (1) declarative knowledge − the ability to recall relevant information (risk factors for suicide) accurately; or (2) perceived knowledge about suicide, depression, and resources available for at-risk individuals−the extent to which individuals believe they know about a particular area ("Do you know how to ask someone if they are considering suicide?"). Additionally, they noted that knowledge about suicide is expected to impact gatekeeping behaviour by enabling potential gatekeepers to identify those at risk of suicide and/or assist at-risk individuals in seeking help (Burnette et al., 2015).

In Nigeria, gatekeeping is emerging as a potential suicide prevention strategy, with some researchers suggesting that professionals such as police officers, community pharmacists, and social workers could serve as gatekeepers (Chike-Obuekwe et al., 2022; Olibamoyo et al., 2023; Omokhabi & Omokhabi, 2023). Although community members in Makoko have been performing gatekeeper roles, their understanding was limited by a lack of mental health framing. They also lack formal training, as demographic data show that only 20% have received formal training in mental health or suicide prevention. Additionally, their ability to identify at-risk individuals does

not result in referrals for formal mental health support. This finding highlights a significant opportunity for a structured community-based suicide prevention program in Makoko. It is crucial to provide formal gatekeeping training to key community members so they can refer individuals who need support.

6.1.3 Sub-Theme 3: Informal Sources of Knowledge about Suicide

Additionally, the findings indicate that community members' basic recognition of suicide as a phenomenon largely stemmed from informal sources, such as social media, personal experience, social conversations and community observations. This aligns with social learning theory, which holds that learning occurs through observation, modelling and everyday interaction (Bandura, 1977). While these informal explanations provide meaning, they also reinforce misconceptions and delay access to formal information and support. This finding contrasts with a study in an urban Nigerian context, where internet use and formal sources are prevalent (Obarisiagbon & Abu, 2021). However, such differences may reflect disparities in digital access, literacy and socio-economic conditions between slums and non-slums.

Some authors have argued that the lack of reliable mental health information contributes to the high prevalence of mental health issues, particularly in underserved communities (Joulaei et al., 2014; Kukoyi et al., 2023). Although many key informants reported engaging with the community on mental health and suicide-related issues to varying degrees, only a few had received formal training. This discrepancy underscores reliance on informal knowledge rather than health education or professional communication.

Evidence from slum settings in Nigeria shows that mental health education efforts often fail to reach residents effectively because of language barriers, low health literacy, and limited digital access (Adams, 2024). Rather than significantly improving attitudes, beliefs, and

behaviours related to mental health, these efforts have not curbed the rising prevalence of mental health disorders in slums (Sekoni et al., 2022). Effective suicide prevention requires accurate knowledge that recognizes suicide as a mental health issue and challenges stigma and misconceptions (Hoven et al., 2009). Public education that improves understanding of causes, risk factors, and warning signs, and that encourages help-seeking, is an essential component of effective suicide prevention (Mann et al., 2005).

6.2 Theme 2: Awareness of Risk and Vulnerability Factors

Participants identified several key risk and vulnerability factors that increase the likelihood of suicide. This theme also addresses Research Question 1. Although participants did not explicitly mention the ecological model in their accounts, their narratives reflect awareness of risks and vulnerability factors at both the individual and broader community levels. The identified risk and vulnerability factors are discussed under five sub-themes. These include

(1) socioeconomic hardships

(2) relational and family stressors

(3) stigma, shame and silence around suicide

(4) limited access to healthcare and

(5) youth vulnerability.

6.2.1 Sub-Theme 1: Socio-Economic Hardship

Participants identified socioeconomic hardships at both the individual and community levels in Makoko. They reported limited livelihood opportunities in Makoko. The sociodemographic data indicate that only 10% of residents are employed, underscoring the scarcity of job prospects and a reliable source of income. Previous research in Makoko indicates that educational attainment is low, with only 25% having completed education beyond secondary

school. One in five adults is unemployed, with most working as fishermen or at local sawmills. These precarious income sources contribute to chronic financial insecurity, with nearly 40% living on less than $1.25 USD per day (Participedia, 2019; Uriri et al., 2019).

Poverty in Makoko extends beyond financial deprivation to include inadequate housing and poor living conditions. Participants reported that rising living costs have worsened housing insecurity. These pressures create stressors that contribute to hopelessness and elevate suicide risk (Britton et al., 2014; Kwon et al., 2025). Housing hardship is increasingly recognized as a critical social determinant of mental health and well-being (Kim & Park, 2024; Swope & Hernández, 2019). Individuals and families facing challenges such as inability to pay rent or a mortgage, eviction, missed utility payments, or utility shut-offs experience significant financial strain that disrupts nearly every aspect of daily life (Kim & Park, 2024; Wetzstein, 2017). Such economic pressure often translates into chronic stress, which may compromise mental health (Deidda, 2015; Park & Kim, 2023). Most residents in the slums are low-income earners, immigrants, or unemployed, making them ineligible to rent in planned residential areas (Benard et al., 2025). Their limited economic means force them to rent substandard accommodations, perpetuating a cycle of deprivation and psychological strain.

Debt also stems from financial struggles, and unemployment is significant among residents of Makoko. In Makoko, debt primarily arises from microfinance loans that women in fishing rely on to finance their small businesses. However, they often face mounting interest and threats from banks if payments are not made on time. This financial strain can lead to hopelessness and increase the risk of suicide. As Rojas (2021) argues, debt can be perceived as a personal failure, bringing feelings of guilt and shame, as well as a desire to escape.

In the Makoko context, this dynamic takes on an added cultural dimension. Indebtedness and default are publicly visible failures, enforced by open threats and communal knowledge of one's circumstances. As a result, they expose the debtor to the very form of shame (*esin*) that, within the Yoruba moral framework discussed earlier, can make death (*iku*) appear an intelligible and even honourable alternative. For an indebted woman facing public humiliation, suicide may therefore present itself not as a transgression but as a culturally acceptable means of preserving dignity when the material conditions for an honourable life have collapsed. This convergence of economic hardship and cultural logic suggests that debt-related suicide risk in Makoko cannot be addressed through financial relief alone. In this sense, prevention must also disrupt the moral equation linking default, shame and death.

Overall, the participants' narratives of socio-economic hardship, reflected in the daily fight for survival and limited access to stable income, opportunities, and adequate housing, mirror broader national trends. Although no national census has been conducted in Makoko due to its informal status, existing evidence consistently highlights the severe socio-economic vulnerabilities faced by residents of urban informal settlements. At the national level, research indicates that profound hopelessness, often triggered by socio-economic hardship, plays a significant role in rising suicide rates, exerting psychological pressure and emotional distress on residents. The findings of this study align with other national studies that link socio-economic hardships to hopelessness and an increased risk of suicide (Abamara & Ozongwu, 2024; Abdu-Raheem & Alonge, 2021; Asogwa & Okafor, 2020; Oderinde & Oderinde, 2023; Oyafunke-Omoniyi et al., 2022). The finding is also consistent with numerous international studies, which suggest that economic hardship and financial insecurity contribute to increased risks of suicidal thoughts and behaviours (Haw et al., 2015; Gunnell & Chang, 2016; Mäkinen et al., 2021; Martin-Carrasco et

al., 2016; Mathieu et al., 2022; Renaud et al., 2022; Rojas, 2021; Santamaría-García et al., 2020; Subbaraman et al., 2014).

6.2.2 Sub-Theme 2: Family and Relational Stressors

Another finding concerns family and relational stressors related to suicide risk and vulnerability. Family dynamics and relationship issues are important contextual factors within an individual's microsystem. They emphasized that issues related to dysfunctional families and poor relationships can foster feelings of hopelessness and raise the risk of suicide. This aligns with national studies, which consistently link higher suicide risk to relationship problems, marital issues, divorce, family conflicts, and domestic abuse (Abdu-Raheem & Alonge, 2021; Ajibola & Agunbiade, 2021; Ojagbemi et al., 2013). Evidence from international studies shows that dysfunctional family dynamics can increase the risk of suicide (Agerbo, 2005; Fazel & Runeson, 2020; Mathew et al., 2021; Pitman et al., 2014).

Family members traditionally rely on one another for physical, mental, and financial support (Wuestenfeld, 2024). Strong, supportive family bonds provide guidance, care, and love, making them key sources of either stress or security. Persistent conflict, criticism, and overwhelming responsibilities are commonly reported as sources of distress. Fernandez et al. (2025) describe family dynamics as the behaviours and activities within a group that are influenced by shared norms and expectations. Material living conditions also shape these dynamics, as factors such as poverty, overcrowding, and housing instability can constrain how family members relate to and support one another. Many relationship problems with close family members have been linked to suicide (Wuestenfeld, 2024).

Research on youth suicide shows that family problems pose a significant risk for suicidal thoughts and behaviours (Sheftall et al., 2013). Parents play a crucial role in supporting adolescent

development, including emotion and behaviour regulation (Weissinger et al., 2023). Conversely, family systems research indicates that family conflicts are linked to internalizing symptoms such as depression and anxiety, as well as externalizing behaviours like impulsivity and suicide attempts (Fitzgerald et al., 2020). A lack of familial support, along with feelings of rejection, blame, and guilt, may lead adolescents to believe their family would be better off without them (Aiken et al., 2019).

A hostile family environment fosters feelings of thwarted belongingness and perceived burdensomeness, both of which increase suicide risk among adolescents (Cero et al., 2015). These negative family-related emotions further contribute to suicide risk in adolescents. Dieserud et al. (2010) found that the most common trigger for adolescent suicide was relational conflict, most often family conflict. Other research indicates that parental issues, maltreatment, and overall low-income family functioning are associated with current suicidal ideation and a history of suicide attempts (Forster et al., 2020). Furthermore, low-income family functioning is linked to recurrent thoughts of death, suicidal ideation, and suicidal actions among adolescents (Rytilä-Manninen et al., 2018).

Empirical evidence on adult suicide has linked economic hardship to suicidality. Rasool (2022) noted that families experiencing financial hardship often face heightened stress, which can disrupt nurturing interactions and create psychological strain among all members, thereby increasing vulnerability to suicide. Studies on low income and adverse financial events have shown that economic pressure among African American caregivers is associated with depressive symptoms, discouragement, and hopelessness (Landers-Potts et al., 2015). Similarly, research on rural low-income European American and African American mothers found that the low-income-

to-needs ratio predicted economic pressure, which in turn contributed to greater mental health issues (Newland et al., 2013).

Nigeria's collectivist culture strongly emphasizes interdependence within families and communities. While potentially supportive, pressures to conform to expectations can heighten hopelessness and suicidal ideation when obligations cannot be met amid adversity (Uwakwe et al., 2012). Men are generally expected to support their families financially; however, when they fail to meet these expectations, it can lead to guilt, lowered self-worth, and suicidal thoughts during times of economic hardship (WHO, 2021).

In Makoko, large household sizes are common, driven by high fertility rates and cultural and religious beliefs that discourage contraceptive use (Uriri et al., 2019). These demographic realities place additional strain on already limited resources. Women who serve as primary breadwinners, particularly in economically precarious informal work settings, may experience heightened stress and emotional burden. Together, these cultural expectations and socio-economic pressures create an environment in which individuals, especially those facing economic insecurity, are more susceptible to psychological distress and suicide risk.

6.2.3 Sub-Theme 3: Stigma and Silence Around Suicide and Mental Health

Participants reported that suicidal individuals often do not disclose their thoughts and plans due to shame and stigma. In Makoko, stigma manifests as both public and perceived stigma, with individuals contemplating suicide fearing being stopped, misjudged, and socially isolated if they openly share their thoughts or plans. This can delay help-seeking, leaving individuals vulnerable and potentially worsening mental health issues, which may lead to suicidal behaviour. This finding aligns with previous international research showing that stigma leads to isolation and reduced help-seeking, further increasing the risk of suicide (Feigelman et al., 2023; Fong & Yip, 2023; Maclean

et al., 2023; Oexle et al., 2020; Wyllie et al., 2025). Similarly, research in Nigeria found widespread stigma around mental health, including suicide, in Nigerian society, leading to delayed help-seeking and a heightened risk of suicide (Gureje et al., 2015a; Jidong et al., 2024; Labinjo et al., 2020; Oderinde & Oderinde, 2023).

Further, the researcher observed that some residents avoided using the terms 'suicide' and 'depression' during fieldwork, hesitating to mention them in interviews. This avoidance may reflect the community's strong stigma and moral disapproval of suicide and mental illness. The resistance to these terms mirrors what other scholars have described as language stigma, in which language itself reinforces stigma and maintains taboos (Padmanathan et al., 2019). Language plays a significant role in shaping public attitudes towards suicide, and phrases like "commit suicide" have been criticized for implying criminal or sinful connotations, which can heighten shame and hinder open discussion (Mishara & Weisstub, 2016; Padmanathan et al., 2019; Sampson et al., 2024). Therefore, global health organizations now advise using neutral expressions such as "died by suicide" or "took one's own life" to diminish stigma and promote help-seeking behaviour (Padmanathan et al., 2019).

Although suicide is criminalized in Nigeria, in the Makoko context, avoiding the term appears to serve a protective social function rather than reflect fear of legal repercussions. According to the Yoruba moral and religious worldview, suicide is regarded as an abomination and a spiritual transgression that dishonours the family and disrupts communal harmony (Aborisade, 2015; Atilola & Ayinde, 2015; Lanre-Abass, 2010). Consequently, linguistic avoidance may serve as a collective strategy for maintaining moral order and social cohesion. Evidence indicates that targeted awareness campaigns can enhance knowledge, reduce stigma, and encourage help-seeking, even in resource-limited contexts (Hegerl et al., 2013; Ongeri et al., 2022;

Plackett et al., 2025; Zalsman et al., 2016). However, for such campaigns to be effective, they must be complemented by strategies that address structural barriers, such as poverty and inequality (WHO, 2021; CDC, 2023).

6.2.4 Sub-Theme 4: Limited Access to Healthcare Services

Another risk and vulnerability factor identified in the broader community context is limited access to healthcare and mental health services. Findings indicate that many services are costly and largely unaffordable, leaving many residents without treatment options. Analysis of the study participants' demographic data showed that 80% of residents lack access to healthcare. This finding also highlights a significant unmet need, increasing vulnerability to mental health issues and suicide. This aligns with international studies that found an increased burden of suicidal behaviour among vulnerable populations, such as those who have difficulty accessing health care, including stigma, cost, difficulty getting into a treatment facility, and difficulty finding a physician (Goldsmith et al., 2002; Leung, 2020; Tondo et al., 2006).

This finding also aligns with evidence from national studies suggesting that restricted access to healthcare poses significant challenges to mental health (Mba-Oduwusi et al., 2024; Ogbolu et al., 2018; Labinjo et al., 2020; Ugochukwu et al., 2020). In Nigeria, the financial burden of healthcare is borne primarily by the population, as more than 70% of total healthcare expenditure is paid out of pocket. At the same time, only one in 20 people has health insurance (UN-HABITAT, 2019). This problem is compounded for slum dwellers by geographical isolation and poverty, which limit access to many services and prompt many to rely on traditional healers or informal care networks (Fayehun et al., 2023).

In addition, squalid living conditions in slums reduce the likelihood that formal healthcare facilities will be present, thereby encouraging the growth of informal health providers

(Onokerhoraye et al., 2014). Informal healthcare providers, including patent medicine vendors, traditional birth attendants, bone setters, and traditional medicine practitioners, are often the first and only point of contact for residents seeking care (Onuh et al., 2024; Onwujekwe et al., 2022). However, most informal healthcare providers lack professional training and comprehensive regulation, raising concerns about the safety and quality of care they provide (Benard et al., 2025; Sudhinaraset et al., 2013).

Early detection of risk is vital for suicide prevention. In HICs, most individuals who die by suicide have visited a healthcare provider within the year before their death, making medical settings prime locations for identifying those at heightened risk and connecting them to lifesaving care (Horowitz et al., 2023). Clinicians can proactively engage in suicide prevention through systematic screening, assessment, and management.

Suicide risk screening tools in healthcare settings provide evidence-based questions and encourage patients to disclose suicidal thoughts and behaviours (Horowitz et al., 2023). Beyond limited access to services, studies highlight challenges within healthcare in HICs. Few studies have demonstrated effective methods for identifying and referring at-risk individuals in general medical settings. Moreover, many people in need of help do not seek assistance for suicide-related concerns, often due to factors related to the healthcare system, such as beliefs about the effectiveness of care (O'Connor et al., 2014).

Stigma or shame experienced by individuals or their families can also limit intervention opportunities, primarily if outreach efforts do not address these emotional issues (Ahmedani et al., 2014). Even when individuals seek healthcare, most who die by suicide were seen in primary care settings, where risk is often under-recognized and undertreated (Vannoy et al., 2011). A key concern is that general medical providers frequently lack the training, knowledge, and time

necessary to identify and treat mental health issues and suicide risk (Hooper et al., 2012). These issues are particularly acute in low-resource settings, where systematic or universal screening is limited, leading to many undetected cases and increased vulnerability to suicide (Horowitz et al., 2023).

Despite Makoko's proximity to the Federal Neuropsychiatric Hospital Yaba (FNPHY), physical proximity does not translate into easy access, as financial barriers, stigma, a lack of referrals, and limited awareness of available services often prevent residents from seeking or receiving care. This situation reflects a broader global problem, especially in LMICs, where up to 85% of people with severe mental disorders remain untreated (WHO, 2018). The WHO highlights shortages of trained staff, poor infrastructure, and stigma as significant barriers.

In Lagos State, mental health services are delivered by the Ministry of Health through a three-tier system: primary (health centres [PHCs]), secondary (general hospitals), and tertiary (teaching hospitals). The state has 51 PHCs, 21 general hospitals, and one teaching hospital. Mental health care is available at three general hospitals across different districts and at the Lagos State University Teaching Hospital. The Lagos State Department of Social Development also operates a vocational rehabilitation centre, mainly for destitute individuals with mental illness. Additionally, Nigeria's federal government operates parallel mental health services via a specialist psychiatric hospital (FNPHY), the psychiatric department at LUTH, and a small psychiatric unit at the Military Hospital. These institutions aim to supplement Lagos State's services but are concentrated in the city centre (Coker et al., 2015). Across the country, there are approximately 300 psychiatrists and only nine federal neuropsychiatric hospitals serving a population of over 200 million, mostly in urban areas (Ogbolu et al., 2018; Labinjo et al., 2020; Ugochukwu et al., 2020;

Fadele et al., 2024). This results in limited access to specialized mental health care for much of the population.

Globally, health systems are shifting toward community-based mental health care, integrating mental health into primary health services to address these gaps (Jordans et al., 2019; Wainberg et al., 2017). However, in many LMICs, this transition faces significant challenges, including weak infrastructure, severe workforce shortages, limited community awareness, persistent stigma, and competing cultural explanatory models of mental illness (Collins et al., 2011; Hanlon et al., 2014). Notably, successful examples from initiatives such as the "Programme for Improving Mental Health Care" (PRIME) in Ethiopia, India, Nepal, South Africa, and Uganda demonstrate the feasibility of adapting mental health care to local contexts. These models emphasize collaborative care, task shifting, and quality improvement approaches to strengthen community-level access to mental health services in resource-limited settings (Lund et al., 2016).

Additionally, alternative modes of service delivery, such as telephone and web-based interventions, are effective for mental health conditions across various settings in HICs (Andrews et al., 2010; Mohr et al., 2012). In Makoko, reliable internet access is uneven, whereas mobile phone access is more common. As such, telephone-based or low-bandwidth approaches may be more feasible than web-based interventions to improve continuity of care in mental health services and, in turn, enhance suicide prevention.

6.2.5 Sub-Theme 5: Youth Vulnerability

The pervasive economic deprivation in Makoko has far-reaching intergenerational effects, disproportionately affecting young people. Participants noted a lack of educational and employment opportunities, which not only leaves many youths idle but also pushes them toward harmful coping mechanisms. This aligns with studies from Ghana and Nigeria, which show that

youth face significant barriers to employment, leading many to engage in unproductive activities (Eliasu et al., 2017; NBS, 2022; Okeke et al., 2020; Oshodi et al., 2020; Oweibia et al., 2025). Nigeria's population of more than 230 million is skewed toward youth, with a median age of 18.1 years and 58% under 30 (Worldometer, 2025; World Bank, n.da). While a youth bulge is often viewed as a potential driver of economic growth, current realities in Nigeria present a more complex and challenging picture, particularly because a significant portion of young adults are unemployed nationwide and lack the skills needed to boost economic productivity (Aina, 2024).

Nigeria faces a high youth unemployment rate: 35% of Nigerians aged 15 to 34 are unemployed, and 28% are underemployed, working 20–39 hours per week (Federal Ministry of Youth Development [FMYSD], 2022). Many young people are employed in informal work (International Labour Organization [ILO], 2023). Such informal work often leads to job instability, leaving families vulnerable financially. The country ranks 172nd out of 183 countries in the 2023 Global Youth Development Index, ranking second-to-last globally in youth employment opportunity and third-to-last in equality and inclusion. This condition often makes young people vulnerable to hopelessness (Commonwealth, 2024; Mbachu, 2025; NBS, 2021).

When young people face such constraints, they often turn to substance abuse as a coping strategy (Canadian Centre on Substance Abuse [CCSA], n.d). About half of Nigerian youth engage in substance abuse, including marijuana, cannabis, methamphetamine, and locally brewed millet-based alcoholic beverages (IOM Youth Strategy for Nigeria 2023-2027; Okeke et al., 2020). Substance use can increase disinhibition, impulsiveness, and aggression, which are associated with conduct problems that heighten suicide risk (CCSA, n.d). Empirical evidence demonstrates a strong positive link between substance abuse and suicidal thoughts (Anyama, 2022; Breet et al., 2018; Hesse et al., 2020).

Research further shows that young people who present to the emergency room after a suicide attempt and report substance use are approximately three times more likely to attempt again than those who do not report substance use (CCSA, n.d). Similarly, Akanbi and Olanrewaju (2024) found that substance abuse is a positive predictor of suicidal ideation among Nigerian university students, indicating that higher substance use is associated with an increased likelihood of suicidal thoughts. In Makoko, where economic deprivation, limited access to healthcare, and stigma intersect, these factors combine to heighten the youth's sense of vulnerability.

Assessing awareness of suicide risk and vulnerability factors revealed that residents have a good understanding of these factors, highlighting the ecological aspects of suicide risk, where broader social and structural deprivation interact with individual distress. This indicates that effective prevention strategies must extend beyond awareness campaigns and clinical treatments to tackle systemic inequalities that limit opportunities, dignity, and a sense of belonging for youth in marginalized communities.

In sum, although participants showed some awareness of the risk and vulnerability factors associated with suicide, their overall awareness was fragmented, characterized by partial knowledge, culturally shaped interpretations, and limited recognition of warning signs.

6.3 Theme 3: Community-Based Prevention Practices

This theme addresses Research Question 2, which explored community members' awareness of prevention strategies in Makoko. Community members described existing strategies within informal, community-based prevention practices, organized into two sub-themes. These include

(1) Active Support Networks

(2) Early Identification and Monitoring

6.3.1 Sub-Theme 1: Active Support Networks

Despite significant barriers such as poverty, stigma, and limited formal care, residents engage in community practices that support mental health and protect against suicide. The findings revealed a strong reliance on informal support networks, including peers, groups, and the broader community. A proactive response is offered to distressed individuals once distress is identified. Support is provided through material aid (such as food or money) and informal counselling. These helping relationships are provided by family, neighbours, cultural leaders, or religious figures rather than formal service providers. This finding aligns with previous research in Nigeria, which has shown that individuals in distress often turn to their social networks for informal support (Nwafor, 2024; Salami & Onuegbu, 2019; Urigwe, 2010).

Evidence from international studies also confirms that many individuals prefer informal support when facing emotional difficulties, including suicidal thoughts, often turning to their social networks rather than seeking formal services and support (Amato & Bradshaw, 1985; CDC, 2022; Jidong et al., 2024; Junus & Yip; Mojaverian et al., 2013; Wong et al., 2024; Sekoni et al., 2022). Strong family and social cohesion have been shown to protect against suicide by providing a sense of belonging and purpose and acting as a buffer against stress, as shown in research in several African countries, including Nigeria, Ghana, and Uganda (Atilola, 2017; Hjelmeland et al., 2008; Kizza et al., 2012). International studies also confirm that programs promoting connectedness are globally beneficial in reducing suicide rates, especially among vulnerable populations (Calear et al., 2016; CDC, 2022; Junus & Yip, 2022; Standley, 2019).

Individuals turn to their social networks for support, depending on the importance of those networks; as such, they seek formal support only when support from family, friends, and community networks is no longer sufficient or available (Cantor, 1979). Triandis (1995)

emphasizes that in collectivist societies such as Nigeria, helping others is seen as a moral obligation rather than an optional act. Mutual reliance, shared identity, and community obligation shape help-seeking behaviour, often making formal services a last resort. Research shows that individuals from collectivist cultures are also less likely to seek external social support when distressed, view help-seeking more negatively, and are more influenced by the expectation to care for family members (Fung et al., 2008; Kim et al., 2008). This strong social cohesion is associated with better mental health, suggesting that more homogeneous communities may protect against mental disorders (Daoud et al., 2016; Williams et al., 2020).

For example, in HICs, higher ethnic density within migrant communities is linked to lower rates of mental disorders (Becares et al., 2018). Ethnic density enhances mental health by strengthening an individual's sense of self, which is often shaped by others' perceptions in the community. When individuals identify closely with those around them, their self-esteem tends to improve (Das-Munshi et al., 2010; Shaw et al., 2012). Denneson and colleagues have highlighted the significance of a sense of connection for suicide prevention at the community level. In their study, respondents emphasized the importance not only of one-on-one relationships but also of feeling trust and comfort with community members more broadly, consistent with the concept of psychological sense of community (Denneson et al., 2025; Sarason, 1974). This includes a feeling of interdependence, the sense that group members matter to one another, and the ability to rely on one another.

While these findings highlight the protective role of social cohesion and collective identity across many settings, the present study suggests that these benefits are neither automatic nor universal. In Makoko, despite evident social networks and collective norms, the protective potential of these networks was constrained by the setting's socioeconomic conditions.

Consequently, the sense of community described in the literature did not consistently translate into protection against mental health challenges or suicidal distress in this context.

Along with peer and social connections, the findings indicate that religious beliefs and practices significantly influence mental health in Makoko. This finding aligns with research showing that reliance on traditional and spiritual healers is common in LMICs and often leads to delays in accessing clinically appropriate care, even when urgently required (Adewuya et al., 2017; Jidong et al., 2024; Knipe et al., 2022; Oderinde & Oderinde, 2023; Ongeri et al., 2022). Like many Yoruba communities, Makoko relies on traditional healers for informal mental health support. These include herbalists, rainmakers, and diviners, with the diviner (Babalawo) being especially influential for their use of Ifa (an oracle) for diagnosis (Payne, 1992).

Jegede (2005) notes that illness and emotional distress are often understood through spiritual and cultural lenses, where destiny and mystical forces shape understanding and responses. Treatment approaches vary by perceived cause: herbalists typically treat natural conditions, while diviners address issues believed to have mystical or supernatural origins. Treatments involve incantations, rituals, and sacrifices, which are viewed as restoring balance between the self and the body, similar to psychotherapy (Jegede, 2005).

In addition to the Makoko traditional healers, religious institutions also play a central role in providing protective benefits, particularly through moral objections to suicide. This aligns with broader evidence that religion and spirituality are associated with lower suicide rates, often by fostering a sense of meaning, belonging, and moral discouragement of the act (Austin, 2017; CDC, 2022; Ishor & Iorkosu, 2022; Junus & Yip, 2022; Nwafor, 2024; Ogbolu et al., 2020b; Salami & Onuegbu, 2019; Standley, 2019; Wu et al., 2015).

The protective role of religiosity has been found to operate through several mechanisms. Gearing & Alonzo (2018) note that all major religions discourage violence, including suicide, and advocate peace and unity, which are values that support life. Participation in organized religion also provides a support network through congregation members and clergy, serving as a protective factor against suicidality (Benute et al., 2011; Caribe et al., 2012). Many religions also condemn behaviours such as substance abuse and smoking (Hilton et al., 2002; Martin et al., 2003), which are associated with suicide. As a result, high religiosity may indirectly lower suicide risk by discouraging substance use (Hilton et al., 2002).

Furthermore, religious beliefs and moral objections to suicide have been associated with increased optimism and self-esteem, which may support individuals' decisions to continue living (Benute et al., 2011; Pinto et al., 1998). However, evidence suggests that this protective effect may be primarily attributable to the social support associated with religious participation. For example, Price and Callahan (2017) found that the association between religious attendance and reduced suicidal thoughts was no longer significant after accounting for levels of social support.

6.3.2 Sub-Theme 2: Early Identification and Monitoring

Makoko's distinctive protective feature is early identification and monitoring, in which community members quickly notice changes in a person's mood or behaviour. This finding shows that community members actively monitor signs of distress and sometimes report or act early by informing family or involving traditional leaders. Doing so prevents the problem from worsening and leading to suicidal behaviour. This aligns with studies showing that community members often serve as informal safety nets, monitoring vulnerable individuals and intervening early when signs of distress are detected (Cwik et al., 2021; WHO, 2022).

The WHO emphasizes the importance of community surveillance systems for detecting and monitoring suicide and self-harm, especially in areas where official records are weak or missing. It advocates involving third-party informants, such as elders, religious leaders, doctors, pharmacists, health workers, teachers, coaches, business owners, and other culturally appropriate figures. These systems help measure the scope of the problem, identify vulnerable groups, and recognize emerging trends (WHO, 2022). Successful examples include the White Mountain Apache Tribe in Arizona and the Gujarat model in India (Cwik et al., 2014; Vijayakumar et al., 2020).

Collaborative community networks or partnerships have long been recognized as effective strategies for addressing public health issues by connecting formal services with informal groups that share common interests or goals. Grattidge et al. (2023) note that empowering local groups to use existing resources and social capital could help fill prevention gaps, especially in settings where stigma and service shortages limit access to formal care. Cultural norms of communal care in Makoko reinforce surveillance. This system highlights key community actors in Makoko as potential gatekeepers involved in surveillance, thereby contributing to suicide prevention. However, it may also lead to stigma if suicide is misunderstood among them. Makoko already has connections that serve as essential resources and social capital, which can be leveraged to develop and implement community-based suicide prevention programmes that support their community.

Overall, the findings on the community's awareness of existing community-based prevention strategies showed higher awareness of community practices that rely mainly on informal methods to address mental health issues among individuals at risk of suicide. This result differs from other studies, which found that participants were more aware of formal support

services than of informal ones (De Silva et al., 2015; Tsai et al., 2020; U.S. Department of Veterans Affairs, 2018).

6.4 Theme 4: Gaps in Suicide Awareness

The analysis identified key gaps in suicide awareness that can be addressed in future prevention strategies. These include the ***limited recognition of mental health factors in suicide*** and unclear referral pathways.

6.4.1 Sub-Theme 1: *Limited Recognition of Mental Health Factors in Suicide*

Participants' understanding of suicide often did not extend to broader mental health concepts. Suicide is a complex, multifactorial phenomenon that involves many interacting variables that change over time (Cramer & Kapusta, 2017; Hagen, 2022; Hegerl et al., 2019; WHO, 2018). Mental disorder is a significant factor among these variables, and empirical evidence from international studies has established that individuals with psychopathology are susceptible to suicidal behaviours (Bachmann, 2018; Fazel & Runeson, 2020; Renaud et al., 2022; WHO, 2020). Similarly, studies conducted in Nigeria have consistently identified mental disorders as significant risk factors for suicidal behaviours (Adewuya et al., 2018; Aloba, 2018; Ladi-Akinyemi, 2023; Okoro & Okhakhume, 2017; Tolulope, 2021; WHO, 2020).

This finding highlights the importance of mental health literacy within the community. Mental health literacy, defined as knowledge and beliefs that help recognize and manage mental disorders (Jorm et al., 1997), plays a vital role in preventing suicide. Research indicates that higher levels of mental health literacy are linked to better recognition of suicide risk and increased help-seeking behaviour (Goldney et al., 2002). However, low mental health literacy has been associated with misconceptions, stigma, and limited understanding of suicide (Oliffe et al., 2016). In this study, participants' responses, which ranged from rejection to uncertainty about the role of mental

health in suicide, reflect gaps in recognizing psychological factors. This aligns with evidence suggesting that mental health literacy influences how individuals interpret suicide-related information and respond to distress (Neto & Maugi, 2022).

Overall, this notable gap in suicide awareness presents an opportunity to develop prevention approaches that bridge cultural, religious, and mental health perspectives

6.4.2 Sub-Theme 2: Referral Pathways

Although some participants could recognize warning signs or encounter individuals at risk, most lacked clear information on where or how to refer individuals for formal mental health support. This highlights a critical gap in clear referral pathways between informal social support and formal support systems. In many contexts, formal pathways include general practitioners (GPs), primary health care clinics, general and regional hospitals, paramedics, nurses, pharmacists, drug stores, psychiatrists, and tertiary mental health hospitals. Informal pathways often include traditional and religious healers, as well as patent medicine vendors (Kamau et al., 2017; Williams et al., 2025). Empirical evidence from Western Africa shows that traditional or faith-based healers play a significant role in connecting individuals with formal mental health care pathways, underscoring the need for collaboration between formal and non-formal services (Ae-Ngibise et al., 2010).

Some authors suggest that integrating traditional or faith-based healers into referral systems has been successful, like other public health programs, such as TB and HIV, where a collaborative model encourages early detection and streamlines referrals (Audet et al., 2013; Peltzer et al., 2006; Williams et al., 2025). However, concerns have been raised about the safety of specific practices and ongoing human rights abuses in both traditional and formal mental health settings (WHO, 2013, 2018). Another issue is the belief that Western medicine is superior to traditional healing

methods and that the latter should not be recognized (Van der Watt et al., 2017). A collaborative model aims to foster a working relationship between the two care systems and establish a clear referral pathway. It will also serve as a platform for investigating and understanding the reasons behind 'unsafe' interventions, and for implementing appropriate solutions and behavioural changes (Williams et al., 2025).

Studies suggest that, without referral linkages, at-risk individuals in slums remain within informal care circles, where interventions may be delayed or inappropriate (Benard et al., 2025; Sudhinaraset et al., 2013). To strengthen referral pathways, Benard et al. (2025) emphasize identifying key community actors and understanding their roles in establishing these pathways. In urban slums, community leaders are highly influential and can facilitate referrals, serving as intermediaries between residents and external institutions. They are seen as essential gatekeepers for health initiatives (Akwanalo et al., 2019; Seale et al., 2023; Sekoni et al., 2022). Their involvement can improve awareness, encourage help-seeking, and facilitate timely referrals.

In Makoko, where residents have limited access to both general healthcare and mental health services, they depend primarily on informal healthcare services and informal social networks. Developing community-based referral pathways that leverage trusted local actors would strengthen early intervention and may ensure at-risk individuals are linked to appropriate care. This perspective aligns with the strengths-based approach and broader suicide prevention frameworks that emphasize community engagement, gatekeeper training, and multilevel intervention strategies (WHO, 2021).

6.5 Theme 5 Recommendations for Future Prevention Strategies

Participants emphasized that suicide prevention in Makoko must begin with the community itself. Despite significant socio-economic challenges, family pressures, limited access to formal

healthcare, and cultural stigma around mental health, residents also benefit from strong social networks, close community bonds, and a tradition of mutual support. These strengths provide a solid foundation for future prevention initiatives. Participants offered tailored recommendations to strengthen suicide prevention in the community, categorized into two sub-themes:

(1) community awareness and education.

(2) multi-stakeholder collaboration and improved access to services.

6.5.1 Sub-Theme 1: Community Awareness and Education

Participants highlighted the importance of community-driven awareness programs, culturally appropriate mental health education, and training leaders to raise awareness. These recommendations align with global best practices that emphasize community ownership and cultural adaptation in suicide prevention. The WHO's *Community Engagement Toolkit for Suicide Prevention* highlights that communities play a pivotal role in reducing stigma, supporting vulnerable individuals, and mobilizing collective action through participatory processes (WHO, 2019). A variety of studies have shown that culturally adapted interventions can have a greater impact on marginalized populations, thereby increasing cultural and contextual relevance (Jones et al., 2018; Marsiglia & Booth, 2015; Mongelli et al., 2020). A meta-analysis of 76 studies by Smith and Griner (2006) underscored the importance of culturally grounded interventions, showing that mental health treatments tailored to clients' cultural backgrounds were notably more effective than generic approaches.

In resource-constrained settings such as Makoko, where formal health infrastructure is limited, community-based awareness programs are particularly vital. They leverage existing social networks and trusted figures to disseminate information and foster dialogue. The call for culturally relevant mental health education is supported by evidence that interventions in LMICs must be

tailored to local languages, belief systems, and lived realities to be effective. Abamara and Ozongwu (2024) note that stigma and spiritual interpretations of mental illness in Nigeria significantly shape help-seeking behaviours, underscoring the need for culturally sensitive education that resonates with community values. Using familiar communication channels, such as community radio, religious gatherings, and storytelling traditions, can enhance accessibility and sustainability. Evidence from LMICs shows that culturally adapted public education campaigns can improve mental health literacy, reduce stigma, and increase help-seeking when aligned with community norms (Ongeri et al., 2022).

However, cultural insensitivity, particularly when mental health awareness campaigns in slum communities fail to consider the beliefs of non-elite residents about the causes of mental health conditions and appropriate care strategies, as well as language barriers, significantly hinders effective communication in these communities. Many residents are not fluent in English, the primary language used in mental health campaigns (Adams, 2024; Sekoni et al., 2022). According to Salawu (2006), the language of communication is crucial because every language reflects a people's culture and carries their knowledge and identity. Scholars note that indigenous languages often lack standardized vocabulary to fully express biomedical mental health concepts (Olaoye, 2013; Owolabi & Nurudeen, 2020). For example, machine translation of a mental health message from English to Yoruba rendered "anxiety" as "*aibale*" and "depression" as "*ibanuje*," while "psychotherapy" was left untranslated, indicating a lack of a Yoruba equivalent. However, a Yoruba speaker would know there is a way to express it, though it requires a deep understanding of the language (Adams, 2024). These issues signal an urgent need to further develop indigenous languages to improve the interpretation and translation of mental health messages from English into Egun, Yoruba, and other local languages spoken in Makoko.

Participants also emphasized training leaders to build awareness, consistent with findings that religious and traditional leaders serve as gatekeepers in suicide prevention. Nwafor (2024) notes that religious leaders in Nigeria wield significant influence, can normalize conversations about mental health, lend legitimacy to prevention initiatives, and reduce stigma. Equipping these leaders with mental health literacy strengthens community resilience and extends the reach of prevention efforts. Consistent with community-driven approaches highlighted in the broader suicide-prevention literature, empowering local actors to engage in awareness-raising, early detection, and support is an essential next step (Lestari & Fitriyah, 2024). According to Willging et al. (2016), when religious leaders are engaged in mental health advocacy and suicide prevention, they become powerful conduits for stigma reduction and help-seeking encouragement. Through sermons, counselling, and community engagement, these leaders can reshape narratives around mental illness from shame to support, compassion, and communal responsibility. Their involvement lends moral and cultural legitimacy to mental health interventions, thereby increasing acceptance and effectiveness within religiously inclined populations.

6.5.2 Sub-Theme 2: Multi-Stakeholder Collaboration

The suggestion for multi-stakeholder collaboration emphasizes the importance of coordinated responses across the health, education, civil society, and governance sectors (WHO, 2018). Similarly, the Nigeria Suicide Prevention Advocacy Working Group underscores that NGOs, civil society groups, and grassroots organizations play vital roles in connecting communities with formal health systems (Adams, 2024). These partnerships help integrate suicide prevention into broader public health and social development efforts, preventing isolation. International evidence supports multisectoral collaboration and shows that when mental health experts collaborate with cultural leaders, educators, elders, and community members to co-design

interventions, the result is both cultural adaptation and cultural co-creation. This teamwork enhances the intervention's relevance to the local context, increases flexibility, supports scalability, and maintains local relevance. Such partnerships lead to programs that are more trusted, widely accepted, and sustainable over the long term, as they address communities' needs, strengths, and aspirations (Lestari & Fitriyah, 2024; O'Keefe et al., 2018).

Scholarly evidence from LMICs further underscores the importance of collaborative, community-driven approaches. Giebel et al. (2024) found that community-based psychosocial interventions in LMICs are most effective when co-designed with local communities and developed with broad stakeholder input, including community members, care providers, religious and community leaders, NGOs, and local government officials, from the earliest stages of program development. Without cultural and contextual adaptation, established interventions such as Cognitive Behavioural Therapy (CBT) often fail to achieve meaningful impact in LMIC settings. Early involvement fosters a thorough understanding of local needs, builds community ownership, and ensures that interventions are meaningful, culturally appropriate, and acceptable. This aligns with findings in Makoko, where participants emphasized the importance of culturally sensitive awareness, partnerships with formal institutions, and coordinated efforts among key local stakeholders.

These initiatives highlight the value of embedding prevention efforts within existing social networks, enabling residents to serve as decentralized "alert systems" that quickly identify warning signs and respond in culturally appropriate ways (Lestari & Fitriyah, 2024). Evidence further indicates that when community members, local leaders, NGOs, health workers, and policymakers jointly contribute to program development, interventions are more likely to be accepted, sustained, and aligned with local realities. Capacity-building through ongoing training, mentorship, and

resource support remains essential to ensuring that community actors can confidently respond to mental health crises (Lestari & Fitriyah, 2024).

6.5.3 Sub-Theme 3: Improved Service Access

Participants recommended strengthening access to mental health and suicide-prevention services in the Makoko community. Despite the community's proximity to the Federal Neuropsychiatric Hospital, Yaba, participants emphasized that care remains effectively inaccessible because of financial constraints, transportation barriers, limited mental health literacy, and a lack of clear information on where and how to seek help. This reflects broader patterns in LMICs, where over 75% of individuals with mental health conditions receive no formal treatment despite living near major urban centres (WHO, 2021; Patel et al., 2018). The absence of accessible, culturally responsive services leads to delayed help-seeking, untreated distress, and increased vulnerability to suicidal behaviour (Benard et al., 2025; Osafo et al., 2020).

Participants advocated for establishing community-based mental health access points, a recommendation consistent with global evidence that decentralizing services to primary care and community settings increases early detection and engagement (WHO, 2018; Thornicroft et al., 2016). Examples include mobile mental health clinics, task-shifted counselling services delivered by community health workers, and periodic outreach by NGOs and PHCs. Research in informal settlements across sub-Saharan Africa shows that bringing services closer to residents, thereby reducing direct costs, time burdens, and stigma, significantly improves utilization (Sudhinaraset et al., 2013; Abbo et al., 2019).

Finally, participants stressed the need for culturally and linguistically appropriate service models, noting that most mental health messaging is delivered in English, a language many Makoko residents do not speak fluently. This concern aligns with evidence indicating that

language barriers impede effective communication, reduce symptom comprehension, and discourage help-seeking (Adams, 2024; Olaoye, 2013; Owolabi & Nurudeen, 2020). Research among Indigenous and minority populations demonstrates that culturally adapted interventions yield better engagement, retention, and mental health outcomes than non-adapted programs (Griner & Smith, 2006; Benish et al., 2011). Therefore, services must incorporate Egun and Yoruba linguistic frameworks, local idioms of distress, and community concepts of causation to be accepted and effective.

Conclusion

This chapter examined the results on awareness of suicide and community-based prevention approaches in the Makoko community. It presents the qualitative results, highlighting five themes that emerged. Although general awareness of suicide as a phenomenon in Makoko remains fragmented, shaped by religious and cultural beliefs, there is a good understanding of awareness of its risk factors and signs of vulnerability. Suicide prevention methods in this community are mainly informal, grounded in communal obligation, with social networks playing a vital role. Key gaps identified in the study can be targeted in future prevention strategies. Participants' recommendations emphasized that suicide prevention in Makoko must be community-owned, culturally grounded, and supported by multi-stakeholder collaboration across different sectors. Additionally, participants emphasized services that are accessible to those most at risk.

Chapter 7: Conclusion and Recommendations

Introduction

This study explored awareness of suicide and community-based prevention in the Makoko community. It expands existing research by providing evidence-based, culturally rooted insights into how suicide is understood, experienced, and addressed in a marginalized, low-resource urban setting. This area remains underexplored in suicide research. This final chapter synthesizes the study's conclusions and proposes a framework for suicide prevention in Makoko and similar contexts in the global South. It begins with a summary of the key findings regarding the research questions. This is followed by the implications for social work (practice, education policy and future research). The study's contributions to social work knowledge are then discussed. Further, it presents the strengths and limitations, followed by the proposed framework for suicide prevention in Makoko. The chapter then provides recommendations grounded in participants' voices to improve mental health and suicide prevention in Makoko. Lastly, it outlines dissemination strategies to ensure the findings reach relevant academic, professional, policy, and community audiences.

7.1 Summary of Key Findings

This study explored awareness of suicide and community-based prevention approaches in Makoko, an urban slum in Lagos, Nigeria. The findings revealed a fragmented suicide awareness shaped mainly by informal sources of knowledge about suicide, cultural and religious interpretations, stigma, the absence of formal mental health education and geographical isolation. Suicide was frequently understood through a religio-cultural lens rather than as a mental health issue. Without formal mental health education and correct information about suicide and mental illness, such explanations tend to reinforce judgment, fear, and blame, making open discussions

and seeking help more difficult. Although the participants demonstrated some awareness of observable warning signs, they did not link these indicators with mental health issues. This reflects a broader gap in mental health literacy.

Participants demonstrated a strong understanding of the risk and vulnerability factors, highlighting socioeconomic hardship, family and relational stressors, limited access to health care and mental health services, and silence and stigma around suicide as key contributors to hopelessness, which can lead to suicidal thoughts. This awareness was shaped by participants' lived experience of the daily struggle rather than by formal mental health education.

The study further revealed a limited recognition of mental health factors in suicidal behaviour, and referral pathways were fragmented, informal, and inconsistent. Despite these gaps, the community exhibited strong social cohesion, reliance on informal support networks, and willingness to support vulnerable individuals, demonstrating strengths that can be leveraged for future prevention strategies. Participants recommended community-based awareness programs, culturally relevant education, multi-stakeholder collaboration, and improved access to care.

7.2 Implications of the Study for Social Work

Social work is a rights-based discipline that promotes the social well-being of individuals and communities globally, helping to explain and address the problems faced by oppressed and marginalized groups. The profession is committed to social justice, community engagement, and systemic change, positioning it to make meaningful contributions to suicide prevention in underserved settings (Khandagale, 2024). The findings of this study have implications across social work practice, policy, education, and research.

7.2.1 Implications for Practice

Social workers frequently engage with vulnerable and marginalized populations and are therefore well-positioned to encounter individuals at risk of suicide. They work with people experiencing suicidal ideation across diverse practice settings, including psychiatric wards, schools, correctional institutions, community agencies, and family-based services. Beyond clinical roles such as counselling, psychotherapy, and case management, social workers are uniquely positioned to support suicide prevention through community-based and systems-level interventions, as well as broader health promotion, advocacy, and policy-related initiatives (Dimmrothová et al., 2024; Singer et al., 2019; Wallace et al., 2021). Omokhabi and Omokhabi (2023) identify a wide range of suicide prevention roles for social workers, including serving as gatekeepers, counsellors, clinicians, caseworkers, community workers, researchers, trainers, and advocates. These roles reflect the breadth of social work practice and highlight the profession's potential to contribute meaningfully to suicide prevention efforts beyond hospital-based or psychiatric settings.

Empirical evidence indicates that suicide-related encounters are common in social work practice (Rasnayake et al., 2024; Sanders et al., 2008). Feldman and Freedenthal (2006), for example, reported that over 90% of social workers had worked with at least one client experiencing suicidal thoughts. Similarly, Scheyett (2020) further emphasizes that social work remains one of the largest professions on the frontline of suicide prevention and intervention. Although it is generally accepted that clinical social workers' expertise is best suited to addressing suicide, many scholars agree that social workers, regardless of setting, including family, community, and generalist practice, can also effectively contribute to combating suicide with the necessary skills (Heckert, 2022; Levine & Sher, 2020; Rasnayake et al., 2024; Scheyett, 2020;).

The findings of this study reinforce the importance of culturally appropriate and strengths-based approaches to suicide prevention. Although culturally appropriate practice lacks a single, universal definition, it is commonly understood as practitioners' and service systems' ability to respond effectively and equitably to the cultural contexts, meanings, and needs of service users (Fisher-Borne et al., 2015; Jani et al., 2011). This includes integrating cultural knowledge into assessment, engagement, and intervention in ways that affirm service users' identities and resist assimilationist assumptions. In suicide prevention contexts such as Makoko, where suicide is often interpreted through religious and socio-cultural lenses, culturally grounded practice becomes essential. The findings indicate that help-seeking occurs primarily through informal networks and community-based actors, suggesting that suicide prevention interventions must engage with existing cultural meanings rather than attempting to replace them with externally imposed biomedical explanations. This calls for social workers to practice cultural humility and incorporate indigenous ways of knowing. This includes attending not only to cultural beliefs about suicide, but also to the language and expressions through which distress is communicated.

A practical implication of this study is the need for culturally grounded mental health literacy initiatives. Social workers can contribute by developing community-based awareness programs that educate residents about warning signs of suicidal distress, risk and protective factors, and the stigma that often prevents individuals from seeking help. These initiatives should be delivered in locally meaningful language and incorporate community explanatory models of distress and illness. In doing so, social workers can help normalize conversations about mental health, reduce shame, and increase community readiness to respond to suicidal behaviour. Importantly, awareness programs should also provide clear information about available support

resources and pathways for seeking help, particularly in contexts where formal services are limited or poorly understood.

Community participation is another key implication for social work practice. Social work interventions are grounded in the principle that meaningful change requires engaging the voices and lived realities of those most affected (Khandagale, 2024). Authentic community participation involves building trust, developing rapport, and creating opportunities for community members to actively shape the design and implementation of interventions (Gelman et al., 2021). This is especially important in slum communities, where residents may be excluded from formal institutions and distrust external systems. Social workers must therefore engage respectfully with local values, norms, and power relations, ensuring that interventions reflect community priorities and lived realities rather than externally defined assumptions.

Research indicates that community engagement can strengthen the effectiveness of interventions and build collective resilience (Harris & McGee, 2022). Social workers can support this process by partnering with community stakeholders, including religious leaders, youth groups, and women's associations, such as Al-Muminat, to develop locally relevant suicide prevention strategies. Participants from Al-Muminat identified as already playing an informal role in monitoring distress, providing social support, and mobilizing community responses among their members. These collaborations could result in the development of community education, peer support initiatives, and gatekeeper training programs that enhance early identification of distress and encourage timely support. When interventions are co-developed with community members, they are more likely to be trusted, sustained, and culturally meaningful (Lestari & Fitriyah, 2024).

To implement these practice implications, it is important to situate suicide prevention strategies within the Nigerian social work context. In Nigeria, social work functions as both an

academic discipline and a field of practice, yet it remains only partially formalized as a regulated profession (Akintayo, 2021; Gray & Amadasun, 2023). Historically, social work has developed within broader social welfare and social development structures rather than through strong professional regulatory systems (Gray & Amadasun, 2023). Despite these limitations, social workers are often embedded in communities and derive their legitimacy through close relationships with families, community leaders, and religious institutions. This embeddedness positions social workers as credible intermediaries between community support systems and formal services.

In this context, social workers can strengthen suicide prevention by acting as connectors between informal community supports and formal mental health care systems. Their relational positioning enables them to support community gatekeepers, facilitate peer-based support initiatives, and strengthen referral pathways to available services. Evidence suggests that gatekeeper training and peer support approaches can improve early detection and increase timely support for individuals experiencing suicidal distress (Hegerl et al., 2019). This intermediary role aligns with WHO's recommendations, which emphasize task-shifting, community engagement, and strengthened referral systems as key strategies for improving access to mental health care in low- and middle-income countries (WHO, 2014).

Taken together, the person-in-environment orientation of social work aligns strongly with suicide prevention strategies that address suicidal behaviour as a complex outcome shaped by psychological, social, cultural, and structural influences. This reinforces the need for ecological and multi-level approaches that combine individual-level intervention with community engagement and structural advocacy. While suicide risk assessment and screening remain important prevention strategies (Bennett et al., 2015; Hong et al., 2011; Standley, 2019, 2020),

such assessments must be embedded within a holistic understanding of the client's lived environment, including poverty, unemployment, stigma, and unstable housing. In this way, effective suicide prevention requires both direct support for individuals and broader efforts to strengthen community capacity, reduce structural vulnerability, and advocate for accessible and culturally meaningful mental health services.

7.2.2 Implications for Policy

Social work is fundamentally committed to addressing social problems at the structural and systemic levels, including the broader conditions that shape mental well-being. Coordinated, comprehensive policy responses across poverty alleviation, mental health, substance use, housing, and school health are needed to establish a macro-level framework that supports mental well-being (Morris & Crooks, 2015; Onyemelukwe, 2020). Social workers, therefore, play a critical role in advocating for policies that promote mental well-being and reduce suicide risk among marginalized populations.

In Nigeria, mental health policy has long promised more than it has delivered, and the National Mental Health Act 2021 is the clearest recent example. The *Act* was passed in 2021 but only signed into law in January 2023. Fadele et al. (2024) observe that its implementation has been weak, hampered by inadequate education, funding, and resources. The *Act*'s reforms are ambitious in design. Some of it's achievement were that it swept away the colonial-era Lunacy Act of 1958, created a Department of Mental Health Services within the Federal Ministry of Health, along with a dedicated Mental Health Fund, and for the first time prohibited discrimination against persons with mental health conditions in housing, employment, and healthcare, while requiring informed consent and community-based care (Akanni & Edozien, 2023; Eze et al., 2023). The difficulty lies in what has happened since. The Mental Health Fund lacks a sustainable financing mechanism, so

funding remains grossly inadequate (Fadele et al., 2024), and the acute shortage of mental health specialists discussed earlier further narrows the *Act's* reach. Akanni and Edozien (2024) point out that most states have yet to adopt the law, leaving implementation concentrated at the federal centre, and Oyinlola (2025) adds that the bodies charged with monitoring and enforcement lack clear sanctioning powers, making it difficult to secure accountability for the *Act's* rights-based provisions.

For suicide prevention, one omission matters most: the *Act* left the criminalization of attempted suicide untouched. A person in suicidal crisis in Nigeria can still be prosecuted rather than cared for, a contradiction that pushes distress into hiding and deters help-seeking (Ogunwale et al., 2024), though a decriminalisation bill introduced to the Senate in February 2025 suggests the tide may be turning. For residents of underserved communities such as Makoko, the *Act* remains largely a promise on paper.

The findings of this study, therefore, point to the policy attention the *Act* has so far failed to deliver. These include support for community-based mental health literacy initiatives, the integration of culturally appropriate approaches into primary health care and expanded access through task-shifting to trained non-specialists, in line with global mental health recommendations (Patel et al., 2018; WHO, 2016).

While social workers can play an important role in advocating for and coordinating these policy directions, the study recognizes that social work in Nigeria remains only partially formalized and is constrained by workforce shortages and limited statutory authority (Gray & Amadasun, 2023). As such, these policy actions should not be understood as responsibilities placed solely on social workers, but rather as part of a broader, intersectoral approach involving health professionals, community-based organizations, religious institutions, traditional leaders, and

government agencies. Within this broader framework, however, social workers are well positioned to advocate for policies that promote community participation and the co-production of mental health interventions, so that interventions are developed and implemented in partnership with affected communities.

The findings further highlight the need for policies that formalize referral pathways between informal community supports and formal health services, particularly in low-resource urban settings where access to mental health care is fragmented and informal referral pathways are predominant (Bolton et al., 2023). Where available, social workers can help develop and navigate these pathways, but their practical implementation requires institutional backing, adequate resources, and cross-sector collaboration. Addressing structural vulnerabilities such as unemployment, poverty, and inadequate housing is also essential for reducing suicide risk, underscoring the importance of social protection and social development policies beyond the health sector.

Taken together, these implications show that suicide prevention in Makoko is not a matter for the health sector alone. It also raises the question of whether Nigeria's policy architecture can support community-led and culturally grounded responses to distress.

7.2.3 Implications for Education

The findings also underscore the need to strengthen and consistently integrate suicide prevention, intervention, and postvention social work curricula, as several previous studies have shown that it is necessary to incorporate suicide content into social work degree programmes at both bachelor's and master's levels to increase the research interest of students and to prevent professional anxiety and negative attitudes toward the topic of suicide. Areas of knowledge gap for social workers include risk and protective factors, risk assessment, case management, suicide

crisis intervention, evidence-based prevention strategies, and postvention (Levine and Sher, 2020, 2020; Maple et al., 2017; Mirick, 2022; Scheyett, 2020).

While elements of suicide-related training are present in many programs, prior research suggests that coverage is often uneven and that students may feel insufficiently prepared to address suicide risk confidently in practice settings. In response, social work education programs should place greater emphasis on developing culturally sensitive competencies for working in diverse and marginalized contexts, including skills in suicide risk assessment, stigma reduction, and community engagement (Kourgiantakis et al., 2020; Pryor et al., 2024).

Beyond these technical skills, however, education programmes should build awareness that suicide itself is understood differently across societal and cultural contexts, and that these understandings shape how distress is expressed, recognized and responded to. The findings from Makoko illustrate this clearly. Residents conceptualized suicide not primarily as a clinical outcome but as a moral and spiritual matter, that is, a sin, a spiritual attack or a consequence of demonic influence. At the same time, the Yoruba honour-shame framework could make suicide comprehensible as an escape from public disgrace. In such contexts, distress is frequently communicated through religious and cultural idioms rather than biomedical language. This means that a person in suicidal crisis may present as “spiritually troubled” rather than “depressed,” and may seek help from faith leaders rather than formal services. A social worker trained only in biomedical models of risk may fail to recognize distress expressed in these terms, may dismiss culturally grounded explanations as ignorance, or may propose interventions which communities regard as foreign to their belief systems.

Curricula should therefore prepare students to recognize culturally specific idioms of distress and to understand how religious beliefs and communal norms shape both the causes

attributed to suicide and the pathways through which help is sought. In addition, students should be prepared to work respectfully alongside faith leaders and community actors, who are often the first point of contact for individuals at risk, rather than in their place.

Empowering social work instructors is also essential to this effort. In addition to classroom instruction, field components and training can be arranged with relevant professionals directly involved in suicide-related issues at various levels, providing social work students with the necessary knowledge and skills (Rasnayake et al., 2024). Studies have emphasized the importance of training in chronic risk factors, acute warning signs, protective factors, case management options, and universal and selective practices for clinical social workers to enhance their contribution to suicide prevention (Pisani et al., 2011; Rasnayake et al., 2024; Sanders et al., 2008).

Expanding training beyond clinical settings to include social workers in schools, prisons, colleges, the media, correctional institutions, and families could be beneficial (Rasnayake et al., 2024). For instance, in the US in 2021, 41.2% of 708,000 social workers (approximately 292,329) were clinical social workers (Zippia, 2023). In England, there were 124,400 social workers, with only 8.7% working in adult mental health and 51.1% serving children and families (British Association of Social Work [BASW], 2023). Although the term “clinical social work” is not uniformly used across countries, including Canada, where social workers in mental health settings are not formally categorized as such, these figures show that a substantial proportion of social workers practise outside specialized mental health roles. Providing formal suicide prevention training for them could help address this critical issue.

Despite the seriousness and urgency of suicide, many nations face shortages of qualified professionals, including social workers, to handle this crisis. For example, America is projected to have a deficit of more than 195,000 social workers by 2030 (Lin et al., 2016). The growing demand

for specialized social work skills presents a significant challenge. Beyond professional training, the findings also highlight the value of broader educational systems that incorporate age-appropriate mental health education to support suicide prevention across the life course.

7.2.4 Implications for Future Research

Based on the findings of this study, which revealed fragmented suicide awareness and reliance on informal prevention mechanisms in Makoko, future studies should build directly on these findings and should explore suicide awareness and prevention across multiple urban informal settlement communities to determine whether the religio-cultural framing of suicide, informal surveillance systems, and limited referral pathways identified in Makoko are consistent across other marginalized settings or are context-specific.

The findings also showed that many residents rely on traditional and religious leaders as first points of support, often interpreting suicide through moral and spiritual lenses rather than biomedical frameworks. Future research should therefore examine how traditional and religious healing systems can be systematically integrated with formal mental health services, particularly in contexts where stigma and structural barriers deter engagement with clinical care.

Participants emphasized the importance of community ownership and culturally grounded strategies. Building on this, future research should use Community-Based Participatory Research (CBPR) to co-develop and evaluate suicide prevention interventions with residents, ensuring that prevention strategies reflect local idioms of distress, multiple languages, and community-defined priorities. Future intervention and participatory research should engage social workers from the formal Lagos service system as external collaborators and as the supervisory and bridging layer envisioned in the community-centric framework. Because no such professionals are based within Makoko, their role would not be to represent the community but to help connect it to the formal

services that lie beyond it, testing and refining the framework's referral pathways and task-sharing arrangements against the real constraints of service delivery and supporting the community gatekeepers who carry out frontline prevention. Their involvement would help translate the framework from a conceptual model into an implementable, practitioner-informed program of work, while keeping community actors at its centre.

Given that this study identified language barriers and the absence of structured programs in the Makoko community, additional research is needed to examine the feasibility and effectiveness of culturally adapted prevention strategies, peer-support models, and Indigenous language communication tools in informal settlements. Finally, because participants consistently linked suicide vulnerability to poverty, youth marginalization, unemployment, and structural exclusion, future research should further investigate the pathways through which economic hardship and youth precarity contribute to suicide risk in slum contexts. Longitudinal and mixed-methods studies may help clarify how structural determinants interact with cultural meanings and informal support systems over time.

7.3 Contribution of the Study to Social Work Knowledge

This qualitative study advances social work knowledge by reconceptualizing suicide prevention as a culturally grounded, community-embedded process shaped by social learning, cultural meanings, and structural hardship in marginalized urban informal settlements. Although social work scholarship has made important contributions to suicide prevention through its emphasis on professional risk assessment, clinical intervention, and individual-level risk and protective factors, particularly within Western and institutional contexts (Baril, 2020; Kourgiantakis et al., 2020; Maple et al., 2017; Mirick, 2022; Standley, 2022), suicide is still often framed as an individual mental health outcome. A key limitation of this dominant

psychopathological approach is that it often underemphasizes the broader socio-cultural and structural realities that shape suicidal distress, including poverty, gendered expectations, stigma, power relations, and ecological deprivation (Cover, 2016; Haw et al., 2013; Standley, 2022).

Additionally, much of the existing empirical literature relies heavily on quantitative methodologies that prioritize linear explanations of suicide and reinforce assumptions about the primacy of mental illness in suicidal behaviour (Hjelmeland & Knizek, 2017; Kral & White, 2017). As a result, suicide prevention strategies often become overly individualized, psycho-centric, and insufficiently attentive to the lived realities of marginalized communities. Scholars have therefore advocated for more integrated approaches that engage communities, practitioners, policymakers, and local actors in developing contextually grounded responses to suicide (Baril, 2020; Kral & White, 2017).

Within social work, research on suicide has tended to focus predominantly on clinical practice. Scholars have emphasized the need for stronger social work contributions to suicide prevention that extend beyond clinical settings and address stigma, postvention, and suicide prevention in marginalized populations (Levine & Sher, 2020; Maple et al., 2017). Scheyett (2020), for example, argues that social work must expand its engagement with suicide beyond clinical practice to include broader community and structural intervention roles. However, despite these calls, suicide prevention in marginalized Global South settings, particularly urban slum communities, remains under-theorized in the social work literature, with communities often positioned as sites of intervention rather than as producers of knowledge.

This study addresses this gap by highlighting Makoko residents' interpretations of suicide as legitimate and valuable social work knowledge. The findings show that in Makoko, suicide is mainly understood through religious, moral, and socio-cultural perspectives rather than biomedical

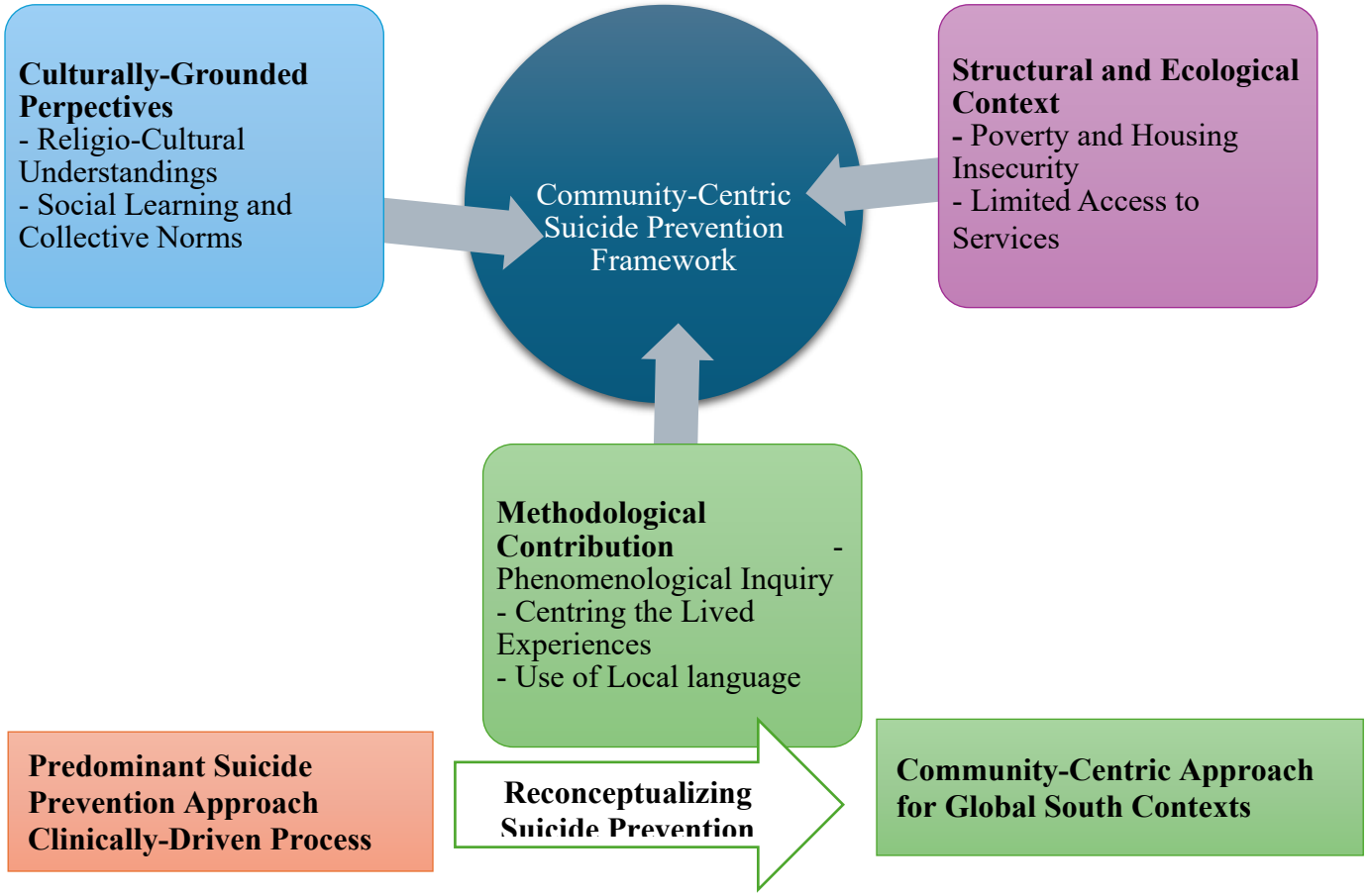
or psychiatric explanations, revealing the limitations of prevention models that rely solely on psychiatric understandings of suicidal behaviour. These locally rooted interpretations influence how distress is recognized, how stigma and silence are maintained, and how help-seeking decisions are made. By emphasizing these meanings, the study demonstrates that suicide prevention is not just a clinical issue, but a relational and culturally embedded process rooted in everyday social life. This challenges dominant assumptions in suicide prevention literature that focus on clinical intervention while overlooking the importance of culturally appropriate approaches that engage with, rather than dismiss, local belief systems.

Culturally appropriate practice involves integrating cultural knowledge into assessment, engagement, and intervention in ways that affirm clients' identities and avoid assimilationist models (Attipoe, 2024). In line with this perspective, the study demonstrates that effective suicide prevention in marginalized contexts requires approaches that build on community realities, values, and informal support systems rather than relying solely on externally imposed clinical frameworks.

The integrated framework demonstrates how different theories can be merged to provide a multi-level understanding of suicide awareness and prevention in marginalized urban settings. This synthesis broadens social work's analytical tools for understanding suicide beyond just individual issues. In summary, these contributions reposition suicide prevention within social work as a community-based and structurally aware practice, rather than merely a clinical intervention.

Figure 5

Unique Contribution of the Study to Social Work Knowledge



7.4 Strengths and Limitations of the Study

7.4.1 The Study's Strengths

This study explored awareness of suicide and community-based strategies in Makoko. It has several strengths. One of this study's strengths is its commitment to centring the lived experiences, perspectives, and knowledge systems of Makoko residents. Rather than imposing external frameworks or treating community members solely as subjects of study, the research positions residents as knowledge-holders whose cultural and religious interpretations of suicide

are analytically meaningful and worthy of serious engagement. This approach aligns with social work values of cultural humility, community engagement, and participatory practice (Fisher-Borne et al., 2015; Jani et al., 2011). By conducting interviews in both English and Yoruba and using member checking to validate translations and interpretations, the study demonstrates respect for linguistic and cultural diversity while ensuring participants' voices are accurately represented (Creswell & Creswell, 2018). This culturally responsive methodology strengthens the authenticity and relevance of the findings, particularly in contexts where community members' perspectives have historically been marginalized in formal research.

Using a phenomenological research design is another key strength. It enabled an in-depth exploration of how community members in Makoko subjectively perceive and experience suicide. Phenomenology focuses on detailed, rich descriptions of lived experiences and aims to uncover the meanings individuals assign to phenomena (Creswell & Creswell, 2018; Wilson & Hutchinson, 1991). This method was particularly suitable given the study's goal, which was not to document behaviours or assess prevalence but to understand the cultural, religious, and social aspects of suicide and prevention. Since suicide is a sensitive issue often associated with stigma, silence, and fear, the semi-structured interviews allowed participants to share personal stories, elaborate on their views, and express subtle nuances that more rigid data collection methods might miss. The depth of interpretation gained is reflected in the richness of participant quotes and the complex themes, such as the relationship between religious fatalism and moral responsibility in how suicide is understood.

The integration of ecological systems theory, social learning theory, and a strengths-based perspective is a key strength, enabling a thorough, multi-level analysis of suicide awareness and prevention. Instead of relying on a single theoretical approach, the study employs complementary

frameworks that address different aspects of the issue: ecological systems theory examines structural influences; social learning theory examines how knowledge about suicide spreads through social networks; and the strengths-based perspective emphasizes community assets and resilience. This combined theoretical approach deepens the analysis and aligns with social work's holistic, person-in-environment focus (Bandura, 1977; Bronfenbrenner, 1979; Saleebey, 2006). Additionally, this multi-framework method enhances the study's contribution to social work by illustrating how these theories can be integrated to understand complex social phenomena in culturally diverse, low-resource settings.

Lastly, the study's strength is that the recommendations are not developed solely by the researcher. Instead, they are drawn directly from participants' lived experiences and suggestions. During the interviews, participants offered clear, practical ideas for improving suicide prevention in Makoko, including community-based awareness programs, culturally relevant mental health education, stronger collaboration among community stakeholders, and more organized referral pathways. By grounding the recommendations in community voices rather than relying solely on academic perspectives, the study increases the likelihood that the proposed strategies will be realistic, culturally acceptable, and responsive to the community's actual needs and priorities (Harris & McGee, 2022). This participant-driven approach strengthens the practical value of the findings. It reflects a collaborative form of knowledge generation that aligns with social work's emphasis on empowerment, partnership, and participatory practice (Khandagale, 2024).

7.4.2 The Study's Limitations

Despite the study's strengths, several limitations should be considered when interpreting the findings. Purposive and snowball sampling may have introduced selection bias, since both tend to overrepresent people who are easier to reach or already connected through community networks

(Smith & Noble, 2025). Twenty participants from a single settlement cannot represent Makoko as a whole, let alone other informal settlements, so the findings are better judged by their transferability to comparable communities than by statistical generalizability. The educational profile of the resident sample raises a related concern. Sixty percent had attained tertiary-level education, which is unlikely to reflect the wider Makoko population, and residents with fewer educational opportunities or less exposure to formal health information may therefore be underrepresented here.

A significant number of resident interviews were conducted in Yoruba, and the researcher transcribed, translated, and coded them alone. Her linguistic and cultural familiarity helped in recognizing culturally specific expressions, but without independent back-translation or a second analyst, the possibility that translation choices shaped the material cannot be ruled out. Makoko is also multilingual, and conducting interviews only in Yoruba and English excluded residents who speak neither language comfortably. The researcher kept reflexive notes, documented her analytic decisions, and used direct quotations throughout to make her reasoning visible. Involving bilingual collaborators would strengthen this process in future work.

Member checking was limited in three ways. Four of the 20 participants could not be reached during the verification period. Verification took place orally by telephone rather than through written review, which gave participants less opportunity to consider their accounts at their own pace and may have made agreement easier than disagreement, particularly given the status difference between researcher and participant. And because the process addressed what participants had meant, it did not test the researcher’s own coding decisions or thematic constructions. The corrections and additions participants did offer nevertheless show the value of the exercise alongside the study's other credibility strategies.

The sensitivity of the subject may have shaped both who took part and what they said. Residents who were socially connected or comfortable discussing suicide were probably more willing to be interviewed, and some may have emphasized communal solidarity to present the community well. Accounts were broadly consistent across the two participant groups, offering some corroboration, but what is documented here reflects the perspective of those willing and able to speak. Both groups provided interview data only. Observation, community records, or policy documents would have added context on how prevention works day-to-day and how residents reach formal services.

Finally, no practising social workers took part in the study since none are based in Makoko, which itself reflects how little formal provision the community has, and practitioners in the wider Lagos service system were not sampled either. Their accounts would have added detail on referral routes, service constraints, and whether the framework is workable, given that it positions social workers as the link between community resources and formal systems. Future research should include them.

7.5 New Community-Centric Suicide Prevention Framework in Makoko

Consistent with the study's purpose and results, informed by the data analysis process, a framework is presented to guide culturally appropriate, community-based interventions in Makoko. The framework recognizes that suicide prevention in marginalized urban slum communities cannot be addressed solely through biomedical or individual-level mental health models. Instead, prevention must be understood as a multi-level process shaped by structural hardship, socio-cultural meanings, informal support networks, and limited access to formal mental health services. This proposed framework, therefore, emphasizes community participation,

culturally grounded engagement, and the integration of informal community resources with formal health and social service systems.

7.5.1 Fundamental Principles of the Framework

The proposed framework draws on ecological and strengths-based approaches, emphasizing that suicide risk and protection are shaped by interactions across individual, relational, community, and societal levels. A central assumption is that Makoko residents are not merely passive recipients of services but active holders of culturally grounded knowledge and informal strategies for responding to distress. Therefore, effective prevention must engage existing community strengths while addressing structural conditions that intensify vulnerability, such as poverty, unemployment, housing insecurity, and exclusion from services. The framework also recognizes that suicide in Makoko is interpreted through moral, religious, and socio-cultural lenses, and that these meanings shape stigma, silence, and help-seeking behaviour. Suicide prevention strategies must therefore work respectfully with community belief systems rather than replace them with externally imposed models.

7.5.2 Components of the Framework

The proposed framework includes the following:

1. Developing community mental health literacy and stigma reduction through linguistically accessible awareness and education initiatives to improve community understanding of suicidal distress, reduce stigma, and equip residents to respond. The initiatives should educate residents about warning signs of suicidal behaviour, risk and protective factors, and the importance of early support. In collaboration with religious leaders, traditional healers, and community elders, education could be delivered to ensure messages are culturally resonant and conveyed by trusted voices.

2. Strengthening and formalizing informal social support systems already present in Makoko, including neighbour surveillance, faith-based support, and elder-mediated intervention, through gatekeeper training, peer support networks, and community capacity building that builds on existing protective structures.

3. Establishing clear referral pathways and crisis-response mechanisms that connect community gatekeepers with available health and social services, equipping community members with specific knowledge of where and how to refer at-risk individuals, and developing locally adapted crisis-response protocols.

4. Integrating cultural and religious institutions, including mosques, churches, and traditional leadership structures, as core prevention partners by engaging them to deliver culturally grounded prevention messaging, provide compassionate responses to suicidal distress, and create culturally acceptable pathways for emotional and spiritual support.

5. Advocating for structural change and social development interventions that address the structural drivers of suicidal distress in Makoko, including poverty, microfinance debt, unemployment, housing insecurity, and absent social services, through community-based advocacy, multi-sector partnerships, and linkages to social development and livelihood-support programs.

Figure 6

A New Community-Centric Suicide Prevention Framework for Makoko

7.5.3 Role of Social Workers within the Framework

Social workers are key facilitators in this framework, drawing on training in person-in-environment perspectives, culturally responsive practice, and multi-level intervention strategies. Their role could include coordinating community engagement, supporting gatekeeper training, strengthening informal support networks, facilitating referrals, and advocating for structural change. In the Nigerian context, where social work remains only partially formalized as a regulated profession, the framework recognizes the importance of collaborating with community leaders, faith-based institutions, and primary health care systems. Social workers can bridge community-

based prevention efforts and formal health services, ensuring that suicide prevention strategies are both culturally grounded and practically feasible.

7.5.4 Feasibility, Resources, Partnerships, and Sustainability

The framework proposed in this study is intended for a community that has no resident mental health professionals, no social workers, and no accessible crisis service, and in which both the Lagos State response system and the FNPHY lie beyond the geographic and financial reach of most residents. In this sense, implementation cannot proceed by importing structures into Makoko but must be built upon what already exists there.

Most of the required resources are already present in the community. The gatekeepers are the people to whom residents already turn in moments of distress, so formalizing the role requires training rather than recruitment. Churches, mosques, market centres, and community halls provide meeting space at no cost. In addition, the WHO mhGAP intervention guide offers freely available training content for non-specialists that can be adapted rather than written from scratch (WHO, 2016). What remains are the costs of translation and adaptation, facilitator time, materials suited to varied levels of literacy, and coordination, and these are most plausibly borne by non-governmental organizations working in informal settlements.

Implementation further depends on partnerships at several levels. These include community and faith leadership within Makoko; primary health care facilities and community health workers, who constitute the first formal link; the FNPHY for acute referrals; and the Lagos State Ministry of Health, whose authorization any pathway would require. It is important to note that these partnerships would need to be formalized at the outset, since informal goodwill rarely survives changes in staffing or administration.

Sustainability rests on community ownership. A train-the-trainer model, proposed by a key informant in this study, enables trained residents to prepare others, and locating the work within established groups rather than parallel structures helps ensure its persistence. The greater threat, however, is displacement. A prevention network built on proximity, familiar leadership, and accumulated trust is highly vulnerable to demolition and eviction, which scatter the community and simultaneously produce the very distress the framework is designed to address. The implication is that structural advocacy should be treated as integral to the framework rather than supplementary to it, and this point cannot be overstated.

Finally, it should be acknowledged that the framework has not yet been implemented or evaluated. What is offered here is an argument for feasibility rather than evidence of feasibility, and determining whether the components can be delivered and sustained would require a pilot study with formal evaluation.

7.6 Recommendations

Building on this study's findings, suicide prevention in marginalized and resource-limited settings such as Makoko requires approaches that are culturally grounded, community-driven, and responsive to local realities. Participants in this study consistently emphasized the need for strategies that resonate with the community's lived experiences, social networks, and existing informal support structures. These insights align with global evidence showing that culturally adapted interventions tend to promote engagement and improve outcomes. The following recommendations have been made:

1. Develop Culturally Tailored, Community-Based Suicide Prevention Strategies

Health authorities, NGOs, and community leaders should co-develop prevention strategies that reflect local beliefs, languages, and ways of understanding distress. These strategies should

incorporate local and traditional knowledge, work through trusted community figures, and use communication methods familiar to residents. In Makoko, these interventions should be situated within the everyday community spaces, faith-based networks, and informal leadership structures that already anchor decision-making and emotional support.

2. Strengthen Informal Social Support Systems

Building on the protective practices already present in Makoko, including neighbour watchfulness, faith-based support, and elder-mediated intervention, community leaders and support organizations should formalize and resource these systems through gatekeeper training, peer support networks, and community capacity-building.

3. Increase Access to Culturally Informed Mental Health Education

Community organizations, schools, and faith networks should implement culturally informed mental health education to improve understanding of suicide, strengthen recognition of warning signs and risk factors, reduce stigma, and promote appropriate help-seeking. These initiatives should be delivered in locally understood languages and through trusted community settings, such as religious gatherings, community meetings, schools, and other spaces where residents regularly interact, and should reach both community members and gatekeepers. Education should integrate culturally familiar explanations of distress with evidence-informed suicide-prevention knowledge so that new understanding complements rather than displaces existing beliefs. Evidence indicates that targeted awareness initiatives can improve mental health knowledge, reduce stigma, and promote help-seeking, including in resource-limited settings (Hegerl et al., 2013; Ongeri et al., 2022; Plackett et al., 2025; Zalsman et al., 2016).

4. Improve and Formalize Referral Pathways

Community gatekeepers, health services, and social workers should jointly establish clear, community-embedded referral pathways, equip residents with practical guidance on where and how to refer at-risk individuals, and develop locally adapted crisis-response protocols that connect people to available care quickly.

5. Build Local Capacity for Mental Health Support

NGOs, health authorities, and community organizations should train community members, volunteers, and lay counsellors in basic suicide-prevention skills to expand the community's capacity to recognize and respond to distress. Existing task-shifted programmes can be adapted for Makoko, including WHO's mhGAP, which provides structured guidance for non-specialists on identifying and managing common mental health conditions (WHO, 2016). Training should be practical, culturally sensitive, and aligned with existing informal support systems. When delivered this way, task-shifting redistributes mental health care to trained lay providers, an approach shown to be feasible and effective in low-resource settings (Bolton et al., 2023; Patel et al., 2018). It also extends both the reach and sustainability of support where formal services are scarce.

7.7 Dissemination of the Findings

Disseminating the findings of this study is essential to ensure that knowledge generated through community engagement and scholarly inquiry translates into meaningful impact across practice, policy, education, and future research. Dissemination strategies are designed to reach multiple audiences, including academic researchers, social work practitioners, mental health professionals, policymakers, community stakeholders in Makoko, and civil society organizations, with content tailored to each audience's needs and interests.

The dissemination plan for this study comprises four major areas: academic dissemination, professional and policy dissemination, community dissemination, and collaborative knowledge mobilization. First, the findings will be shared through academic channels, including journal publications and conference presentations. The researcher intends to publish peer-reviewed articles based on key aspects of the dissertation, particularly those focusing on cultural interpretations of suicide, stigma, and community-based prevention approaches. The findings will also be presented at relevant conferences in social work, public health, and suicide prevention. In addition, the dissertation will be deposited in the University of Manitoba repository to ensure accessibility for researchers and practitioners.

Second, the findings will be shared with professional and policy stakeholders in Nigeria, including mental health organizations, NGOs working in informal settlements, and relevant government agencies in Lagos State. A brief policy-focused summary will be prepared, highlighting key findings and practical recommendations. It will be written in clear language and emphasize actionable strategies, such as gatekeeper training, culturally appropriate education, and strengthened referral systems.

Third, community dissemination is especially important for ethical reasons. Participants shared their lived experiences and contributed valuable insights, so it is important that the community receive the research report. The researcher shared a summary of the preliminary results with participants after the data analysis. The final study report will be disseminated to participants and community stakeholders. In addition, the researcher intends to explore holding a small community meeting or knowledge-sharing session with community leaders to discuss the findings and gather feedback. To improve accessibility and promote knowledge translation, the researcher will create a simple, culturally suitable infographic that summarises key findings, warning signs,

and available support options. This infographic will use locally relevant language and examples and can be shared within the community as a tangible resource to raise awareness and support ongoing conversations about suicide prevention.

Finally, dissemination will involve collaborating with community-based organizations and professional stakeholders to translate the findings into action. The proposed Makoko framework can guide the development of pilot suicide-prevention programs. The researcher hopes the findings will support partnerships to develop community education materials, training modules for gatekeepers, and advocacy strategies to address the structural challenges that contribute to distress in Makoko.

7.8 Conclusion

This dissertation explored awareness of suicide and community-based suicide prevention approaches in Makoko, an informal settlement and urban slum community in Lagos State, Nigeria. Suicide is a major global public health concern, yet research and prevention efforts in Nigeria have rarely focused on informal settlements, despite the heightened vulnerability associated with poverty, unemployment, housing insecurity, and limited access to healthcare and mental health services. This study addressed this gap by centring the voices and lived experiences of Makoko residents and key informants, providing culturally grounded qualitative evidence relevant to social work knowledge and practice.

The findings showed that awareness of suicide in Makoko is limited and shaped largely by informal sources of knowledge. Suicide was frequently interpreted through moral, cultural, and religious beliefs rather than as a mental health issue. These interpretations contribute to stigma, silence, and reluctance to openly discuss suicide or seek professional support. However, participants also demonstrated awareness of the everyday realities that contribute to distress,

including poverty, unemployment, youth vulnerability, family conflict, and limited access to services. These factors reflect the structural hardships that shape vulnerability in marginalized urban settings.

The study also revealed that formal suicide prevention programs are largely absent in Makoko and that referral pathways for mental health support are weak and inconsistent. In response, residents rely heavily on informal support systems, such as family networks, peer relationships, religious leaders, and community vigilance. While these informal supports provide important protective value, they are not always sufficient to address severe mental distress. At the same time, these informal networks represent important strengths that can be leveraged for culturally grounded prevention strategies.

This study contributes to social work knowledge by emphasizing that suicide awareness and prevention are deeply shaped by cultural meanings, social learning, and structural conditions. It challenges the tendency in dominant suicide prevention literature to focus mainly on individual-level explanations and clinical responses. By integrating Ecological Systems Theory, Social Learning Theory, and the Strengths-Based Perspective, the study provides a multi-level understanding of how suicide risk and resilience are shaped within the Makoko context.

Based on the findings, the dissertation proposed a new community-centric, culturally responsive, and structurally supported suicide prevention and mental health support framework for Makoko. This framework highlights the need for culturally relevant mental health literacy, strengthened informal support networks through gatekeeper and task-sharing programs, improved referral pathways, and addressing structural vulnerabilities through multi-sector collaboration. It reflects the understanding that suicide prevention in marginalized communities must be community-driven, culturally responsive, and supported by broader structural interventions.

References

Abamara, N. C., & Ozongwu, O. E. (2024). The rising cases of suicide among Nigerians: What are the risk factors, prevention, and remedies? *Consortium Psychiatricum*, *5*(3), 56–61. https://doi.org/10.17816/CP15497

Abbo, C., Odokonyero, R., & Ovuga, E. (2019). A narrative analysis of the link between modern medicine and traditional medicine in Africa: A case of mental health in Uganda. *Brain Research Bulletin*, *145*, 109–116. https://doi.org/10.1016/j.brainresbull.2018.07.018

Abdi, F., Rahnemaei, F. A., Shojaei, P., Afsahi, F., & Mahmoodi, Z. (2021). Social determinants of mental health of women living in slums: A systematic review. *Obstetrics & Gynecology Science*, *64*(2), 143–155. https://doi.org/10.5468/ogs.20264

Abdu-Raheem, B.O., & Alonge, R. A. (2021). Socio-cultural variables as correlates of youths' vulnerability to Suicide in Ekiti State, Nigeria. *Global Academic Journal of Humanities and Social Sciences*, *3*. https://www.gajrc.com/media/articles/GAJHSS_33_104-111.pdf

Aborisade, O. (2015). Suicide in Yoruba Ontology. *International Journal of History and Philosophical Research*, *vol. 3(1), pp.* 29–34.

Abrutyn , S., & Mueller, A. S. (2019). *Structural and cultural perspectives on suicide. In The Oxford handbook of sociology and organization studies: Classical Foundations*. Oxford University Press. https://doi-org.uml.idm.oclc.org/10.1093/oxfordhb/9780199535231.001.000

Adams Adeshola. (2024). *Knowledge conflict, indigenous language deficit, and communication gap as a bane of effective mental health awareness campaigns in Nigerian slum communities*. https://doi.org/10.13140/RG.2.2.24348.50569

Adebayo, R. A., Olagunju, A. T., Olutoki, M. O., Fadipe, B., Oduguwa, T. O., & Lawal, Rahman

Abolore. (2016). A four-year review of geriatric mhservices in a Lagos-based hospital in Nigeria, accessed on 20 April 2023. *Ethiopian Medical Journal*, *54*, 125–135. https://pubmed.ncbi.nlm.nih.gov/29115781/

Adesina-Uthman, G. A., Ohioze, W. F., Odishika, V. A., & Obaka, A. I. (2022). Survey of urban poverty and urban slum lifestyle in selected areas of Lagos State. *NIU Journal of Social Sciences*, *8*(2), 243–254.

Adeshokan, O (2020). How Makoko, Nigeria's floating slum went digital with new mapping project. *CNN*, 26 February. https://edition.cnn.com/2020/02/26/africa/nigeria-makoko-mapping-intl/index.html. Accessed 10 September 2024)

Adewuya, A. O., Adewumi, T., Ola, B., Abosede, O., Oyeneyin, A., Fasawe, A., & Idris, O. (2017). Primary health care workers' knowledge and attitudes towards depression and its management in the MeHPric-P project, Lagos, Nigeria. *General Hospital Psychiatry*, *47*, 1–6. https://doi.org/10.1016/j.genhosppsych.2017.04.002

Adewuya, A. O., Atilola, O., Ola, B. A., Coker, O. A., Zachariah, M. P., Olugbile, O., Fasawe, A., & Idris, O. (2018). Current prevalence, comorbidity and associated factors for symptoms of depression and generalized anxiety in the Lagos State Mental Health Survey (LSMHS), Nigeria. *Comprehensive Psychiatry*, *81*, 60–65. https://doi.org/10.1016/j.comppsych.2017.11.010

Adewuya, A. O., Ola, B. A., Coker, O. A., Atilola, O., Zachariah, M. P., Olugbile, O., Fasawe, A., & Idris, O. (2016). Prevalence and associated factors for suicidal ideation in the Lagos State Mental Health Survey, Nigeria. *BJPsych Open*, *2*(6), 385–389. https://doi.org/10.1192/bjpo.bp.116.004333

Adewuya, A. O., & Oladipo, E. O. (2020). Prevalence and associated factors for suicidal

behaviours (Ideation, planning, and attempt) among high school adolescents in Lagos, Nigeria. *European Child & Adolescent Psychiatry*, *29*(11), 1503–1512. https://doi.org/10.1007/s00787-019-01462-x

Ae-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., Doku, V., & The MHaPP Research Programme Consortium. (2010). 'Whether you like it or not, people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry*, *22*(6), 558–567. https://doi.org/10.3109/09540261.2010.536149

Agerbo, E. (2005). Midlife suicide risk, partner's psychiatric illness, spouse and child bereavement by suicide or other modes of death: A gender specific study. *Journal of Epidemiology and Community Health*, *59*(5), 407–412. https://doi.org/10.1136/jech.2004.024950

Ahmed, G. K., Elserogy, Y. M., Elfadl, G. M. A., Ghada Abdelsalam, K., & Ali, M. A. (2023). Antidepressant and anti-suicidal effects of ketamine in treatment-resistant depression associated with psychiatric and personality comorbidities: A double-blind randomized trial. *Journal of Affective Disorders*, *325*, 127–134. https://doi.org/10.1016/j.jad.2023.01.005

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., Lynch, F., Owen-Smith, A., Hunkeler, E. M., Whiteside, U., Operskalski, B. H., Coffey, M. J., & Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, *29*(6), 870–877. https://doi.org/10.1007/s11606-014-2767-3

Aiken, C. S., Wagner, B. M., & Benjamin Hinnant, J. (2019). Observed interactions in families

of adolescent suicide attempters. *Suicide and Life-Threatening Behaviour*, *49*(1), 104–119. https://doi.org/10.1111/sltb.12423

Aina, T. (2024). *Nigeria's unemployment rate rose to 5.3% in Q1*. https://punchng.com/nigerias-unemployment-rate-rose-to-5-3-in-q1-report/

Ajayeoba, O., Olateju, S., Aaron, O., Faponle, A., Komolafe, M., Adebowale, A., & Adesanmi, A. (2023). Intensive care management of sniper (Organophosphate) poisoning secondary to deliberate self-harm: A case report. *Journal of Clinical Sciences*, *20*(3), 104. https://doi.org/10.4103/jcls.jcls_1_23

Ajayi, O., Soyinka-Airewele, P., & Samuel, O. (2019). Gentrification and the challenge of development in Mkokoakoko, Lagos State, Nigeria: A rights-based perspective. *Environmental Justice*, *12*(2), 41–47. https://doi.org/10.1089/env.2018.0020

Ajibola, A. O., & Agunbiade, O. M. (2022). Suicide ideation and its correlates among university undergraduates in Southwestern Nigeria. *Community Health Equity Research & Policy*, *43*(1), 45–58. https://doi.org/10.1177/0272684X211004929

Akanni, O. O., & Edozien, L. C. (2023). The new Nigerian Mental Health Act: A huge leap before looking closely? *Nigerian Medical Journal*, *64*(6), 838–845.

Akimoju, O. T., & Sadri, H. (2017). Spatial Exclusion in the Slums of Ibadan. *Int J Humanit Soc Sci Invent*, *6*, 36-57.

Akindejoye, F., Ezedinma, C., & Ike, C. (2021). Urban design for wellbeing in Lagos: Examining the role of green spaces. Journal of Urban Design and Mental Health, 11(2), 1-15

Akinsete, E., Hoelzel, F., & Oshodi, L. (2014). Delivering sustainable urban regeneration in emerging nations: Introducing neighbourhood hotspots. *Journal of Architectural*

Education, *68*(2), 238–245. https://doi.org/10.1080/10464883.2014.937245

Akinsulore, A., Esimai, O. A., Mapayi, B. M., & Aloba, O. O. (2018). Public awareness and attitude towards depression: A community-based study among an adult population in Ile-Ife, South-Western Nigeria. *Community Mental Health Journal*, *54*(6), 866–874. https://doi.org/10.1007/s10597-017-0222-8

Akintayo, T. (2021). Options for Africa's child welfare systems from Nigeria's unsustainable multicultural models. *Sustainability*, *13*(3), 1118. https://doi.org/10.3390/su13031118

Akorede, S. *Employees in Lagos are stressed, burned out and exhausted because of 'hellish traffic* (2019). CNN Travel. https://edition.cnn.com/travel/article/traffic-stress-lagos-nigeria/index.html. Accessed on 5 August 2022

Akwanalo, C., Njuguna, B., Mercer, T., et al. (2019). Strategies for effective stakeholder engagement in strengthening referral networks for management of hypertension across health systems in Kenya. *Global Heart*, *14*(2), 173. https://doi.org/10.1016/j.gheart.2019.06.003

Alabi, O. O., Alabi, A. I., Ayinde, O. O., & Abdulmalik, J. O. (2014). Suicide and suicidal behaviours in Nigeria: A review. Dokita. *5*(4)

Aloba, O., Esan, O., & Alimi, T. (2018). Adaptation of the Beck Hopelessness Scale as a suicide risk screening tool among Nigerian patients with schizophrenia. *International Journal of Psychiatry in Clinical Practice*, *22*(1), 19–24 https://doi.org/10.1080/13651501.2017.1356928

Ali, A., & Chakraborty, N. (2022). Mental Health Gap Action Programme training in Nigeria: Reflections for progressive learning among primary care workers. *BJPsych International*, *19*(2), 41–44. https://doi.org/10.1192/bji.2021.32

Amato, P. R., & Bradshaw, R. (1985). An exploratory study of people's reasons for delaying or

avoiding helpseeking. *Australian Psychologist*, *20*(1), 21–31. https://doi.org/10.1080/00050068508257557

Andrews G, Titov N. (2010). Treating people you never see: internet-based treatment of the internalizing mental disorders. *Australian Health Review* 34, 144–147. https://doi.org/10.1071/AH09775

Anyama, C. S. (2022). Perceived influence of drug abuse on undergraduates' suicidal tendencies in the University of Lagos. *International Journal of Educational Research*, *10*(1), 131–138. https://www.ajol.info/index.php/ijer/article/view/220742

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. DSM-5-TR (2022). American Psychiatric Association Publishing. doi:10.1176/appi.books.9780890425787

Arensman, E. (2017). Suicide prevention in an international context: Progress and challenges. *Crisis*, *38*(1), 1–6. https://doi.org/10.1027/0227-5910/a000461

Asogwa, E. U., & John, O. O. (2018). Economic recession in Nigeria: An important risk factor for suicide. *Archives of Business Research*, *6*(11). https://doi.org/10.14738/abr.611.5544

Atilola, O. (2017). Child mental-health policy development in sub-Saharan Africa: Broadening the perspectives using Bronfenbrenner's ecological model. *Health Promotion International*, *32*(2), 380–391. https://doi.org/10.1093/heapro/dau065

Atilola, O., & Ayinde, O. (2015). A cultural look on suicide: The Yorùbá as a paradigmatic example. *Mental Health, Religion & Culture*, *18*(6), 456–469. https://doi.org/10.1080/13674676.2015.1077212

Attipoe, H. (2024). Cultural competency: A cardinal force in social work practice and service-a cultural practice guide for human services and the helping professions. *International*

Journal of Social Work, *11*(1), 28. https://doi.org/10.5296/ijsw.v11i1.21561

Audet, C. M., Salato, J., Blevins, M., Amsalem, D., Vermund, S. H., & Gaspar, F. (2013). Educational intervention increased referrals to allopathic care by traditional healers in three high-HIV-prevalence rural districts in Mozambique. *PLoS ONE*, *8*(8), e70326. https://doi.org/10.1371/journal.pone.0070326

Austin, O. O. (2017). Religious perceptions of suicide and implications for Suicidology Advocacy in Nigeria. *International Journal of History and Philosophical Research*, 5, 34–56. Available online: www.eajournals.org. Accessed on 25 April 2024.

Bachmann, S. (2018). Epidemiology of suicide and the psychiatric perspective. *International Journal of Environmental Research and Public Health*, *15*(7), 1425. https://doi.org/10.3390/ijerph15071425

Bamidele, O. T., Agada, D., Afolayan, E., Ogunleye, A., Ogah, C., Amaike, C., & Abiodun, O. (2024). Pattern and risk factors for suicidal behaviours of people accessing HIV care in Ogun State, Nigeria: A cross-sectional survey. *HIV & AIDS Review*. https://doi.org/10.5114/hivar/171613

Bandura, A. (1977). Social learning theory. Prentice Hall.

Bantjes, J., & Swartz, L. (2020). The benefits of robust debate about the place of qualitative research in suicide prevention. *Qualitative Health Research*, *30*(6), 944–946. https://doi.org/10.1177/1049732320909104

Barak, Y., Cheung, G., Fortune, S., & Glue, P. (2020). No country for older men: Ageing male suicide in New Zealand. *Australasian Psychiatry*, *28*(4), 383–385. https://doi.org/10.1177/1039856220905304

Baril, A. (2020). Suicidism: A new theoretical framework to conceptualize suicide from an anti-

oppressive perspective. *Disability Studies Quarterly*, *40*(3). https://doi.org/10.18061/dsq.v40i3.7053

Barlow, A, Haroz, E. E., O'Keefe, V. M., et al. (2023). New collaborative research on suicide prevention, practice, and policy with American Indian and Alaska native communities holds promise for all peoples. *Health Promotion Practice*, 24(5):841–851. doi:10.1177/15248399221116630

Barredo, J. I., & Demicheli, L. (2003). Urban sustainability in developing countries' megacities: Modelling and predicting future urban growth in Lagos. *Cities*, *20*(5), 297–310. https://doi.org/10.1016/S0264-2751(03)00047-7

Bauer, G. R., Churchill, S. M., Mahendran, M., Walwyn, C., Lizotte, D., & Villa-Rueda, A. A. (2021). Intersectionality in quantitative research: A systematic review of its emergence and applications of theory and methods. *SSM - Population Health*, *14*, 100798. https://doi.org/10.1016/j.ssmph.2021.100798

Bauer, J. (2023). Roots of Hope: A uniquely Canadian approach to suicide prevention. *Journal of Community Safety and Well-Being*, *8*(2), 107–109. https://doi.org/10.35502/jcswb.335

Beyer, S. (2023, July 31). *Makoko: The city on stilts*. Independent Institute. https://www.independent.org/article/2023/07/31/makoko-city-on-stilts/. Accessed on 19 December 2024.

British Association of Social Work (BASW) (2023). Social workers in England – who they are and where they work. Available from: https://www.basw. co.uk/resources/psw-magazine/psw-online/so. Accessed on December 20, 2025.

Bazley, R., Pakenham, K., & Watson, B. (2019). Perspectives on suicide prevention amongst members of Christian faith-based organizations. *Community Mental Health Journal*,

55(5), 831–839. https://doi.org/10.1007/s10597-018-0355-4

Bailey, C. A. (2018). A guide to qualitative field research. Sage.

Beattie, D., & Devitt, P. (2015). *Suicide: A modern obsession*. Liberties Press.

Bécares, L., Dewey, M. E., & Das-Munshi, J. (2018). Ethnic density effects for adult mental health: Systematic review and meta-analysis of international studies. *Psychological Medicine*, *48*(12), 2054–2072. https://doi.org/10.1017/S0033291717003580

Benard, O., Orjiakor, C. T., Nwokolo, C., Ajaero, C., Das, M., & Onwujekwe, O. (2025). Community leaders' perspectives on linking formal and informal health providers in Nigerian urban slums: A qualitative study. *Discover Social Science and Health*, *5*(1), 61. https://doi.org/10.1007/s44155-025-00205-5

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, *40*(4), 361–368. https://doi.org/10.1037/a0016401

Bennett, K., Rhodes, A. E., Duda, S., Cheung, A. H., Manassis, K., Links, P., Mushquash, C., Braunberger, P., Newton, A. S., Kutcher, S., Bridge, J. A., Santos, R. G., Manion, I. G., McLennan, J. D., Bagnell, A., Lipman, E., Rice, M., & Szatmari, P. (2015). A youth suicide prevention plan for Canada: a systematic review of reviews. *The Canadian Journal of Psychiatry*, *60*(6), 245–257. https://doi.org/10.1177/070674371506000603

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counselling Psychology*, *58*(3), 279–289. https://doi.org/10.1037/a0023626

Benute, G. R., Yamamoto Nomura, R. M., Ferreira Jorge, V. M., Nonnenmacher, D., Junior, R. F., De Lucia, M. C. S., & Zugaib, M. (2011). Risk of suicide in high-risk pregnancy: An

exploratory study. *Revista Da Associação Médica Brasileira (Edição Em Inglês)*, *57*(5), 570–574. https://doi.org/10.1016/S2255-4823(11)70115-1

Bering, J. (2018). *Suicidal: Why we kill ourselves*. University of Chicago Press.

Berrouiguet, S., Larsen, M. E., Mesmeur, C., Gravey, M., Billot, R., Walter, M., HUGOPSY Network, Lemey, C., & Lenca, P. (2018). Toward mhealth brief contact interventions in suicide prevention: Case series from the suicide intervention assisted by messages (Siam) randomized controlled trial. *JMIR mHealth and uHealth*, *6*(1), e8. https://doi.org/10.2196/mhealth.7780

Biaggi, C., & Wa-Mbaleka, S. (2018). Grounded theory: A practical overview of the Glaserian school. *JPAIR Multidisciplinary Research*, *32*(1), 1–29. https://doi.org/10.7719/jpair.v32i1.573

Biddle, L., Donovan, J., Sharp, D., & Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: A dynamic interpretive model of illness behaviour. *Sociology of Health & Illness*, *29*(7), 983–1002. https://doi.org/10.1111/j.1467-9566.2007.01030.x

Bilge, S., & Collins, P. H. (2016). Intersectionality. *Cambridge, UK: Polity*.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Bolton P, West J, Whitney C, et al. Expanding mental health services in low- and middle-income countries: A task-shifting framework for delivery of comprehensive, collaborative, and community-based care. *Cambridge Prisms: Global Mental Health*. 2023;10:e16. doi:10.1017/gmh.2023.5

Bolton P, West J, Whitney C, et al (2023). Expanding mental health services in low- and middle-income countries: A task-shifting framework for delivery of comprehensive, collaborative, and community-based care. *Camb Prism Glob Ment Health,* 10:e16. doi:10.1017/gmh.2023.5

Bolton, J. M., Gunnell, D., & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *BMJ*, *351*(nov09 1), h4978–h4978. https://doi.org/10.1136/bmj.h4978

Bourke, C., Douglas, K., & Porter, R. (2010). Processing of facial emotion expression in major depression: A review. *Australian & New Zealand Journal of Psychiatry*, *44*(8), 681–696. https://doi.org/10.3109/00048674.2010.496359

Burns, J. K., & Tomita, A. (2015). Traditional and religious healers in the pathway to care for people with mental disorders in Africa: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*, 50(6), 867–877. https://doi.org/10.1007/s00127-014-0989-7

Bowleg, L. (2012). The problem with the phrase *women and minorities:* intersectionality—An important theoretical framework for public health. *American Journal of Public Health*, *102*(7), 1267–1273. https://doi.org/10.2105/AJPH.2012.300750

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Breet, E., Goldstone, D., & Bantjes, J. (2018). Substance use and suicidal ideation and behaviour in low- and middle-income countries: A systematic review. *BMC Public Health*, *18*(1), 549. https://doi.org/10.1186/s12889-018-5425-6

Britton, P. C., Van Orden, K. A., Hirsch, J. K., & Williams, G. C. (2014). Basic psychological needs, suicidal ideation, and risk for suicidal behaviour in young adults. *Suicide and Life-Threatening Behaviour*, *44*(4), 362–371. https://doi.org/10.1111/sltb.12074

Broome, J. (2006). *Weighing Lives*. Oxford: Oxford University Press.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513–531. https://doi.org/10.1037/0003-066X.32.7.513

Bronfenbrenner, U., & Crouter, A. C. (1983). The evolution of environmental models in developmental research. In W. Kessen (Ed.) *Handbook of child psychology: Vol. 1. History, theories, and methods* (4th ed). New York: Wiley

Bryant, J., Bolt, R., Botfield, J. R., Martin, K., Doyle, M., Murphy, D., Graham, S., Newman, C. E., Bell, S., Treloar, C., Browne, A. J., & Aggleton, P. (2021). Beyond deficit: 'Strengths-based approaches' in Indigenous health research. *Sociology of Health & Illness*, *43*(6), 1405–1421. https://doi.org/10.1111/1467-9566.13311

Buhari, O., Ogbolu, R. E., Ogunmodede, A. J., Erubu, A., & Mohammed, A. T. (2022). A 2 year (2019-2020) analysis of suicide reports in the nigerian media. *Proceedings of Global Public Health Conference*, 36–48. https://doi.org/10.17501/26138417.2022.5105

Bukuluki, P., Wandiembe, S., Kisaakye, P., Besigwa, S., & Kasirye, R. (2021). Suicidal ideations and attempts among adolescents in Kampala urban settlements in Uganda: A case study of adolescents receiving care from the Uganda Youth Development Link. *Frontiers in Sociology*, *6*, 646854. https://doi.org/10.3389/fsoc.2021.646854

Burnette, C., Ramchand, R., & Ayer, L. (2015). Gatekeeper training for suicide prevention. *Rand*

Health Quarterly, *5*(1), 16. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158249/

Busby Grant, J., Bruce, C. P., & Batterham, P. J. (2016). Predictors of personal, perceived and self-stigma towards anxiety and depression. *Epidemiology and Psychiatric Sciences*, *25*(3), 247–254. https://doi.org/10.1017/S2045796015000220

Canadian Centre on Substance Abuse (2016). Substance Use and Suicide among Youth: Prevention and Intervention Strategies. www.ccsa.ca. Accessed on August 7, 2025.

Caine, E. D., Reed, J., Hindman, J., & Quinlan, K. (2018). Comprehensive, integrated approaches to suicide prevention: Practical guidance. *Injury Prevention*, *24*(Suppl 1), i38–i45. https://doi.org/10.1136/injuryprev-2017-042366

Cajaiba-Santana, G. (2014). Social innovation: Moving the field forward. A conceptual framework. *Technological Forecasting and Social Change*, *82*, 42–51. https://doi.org/10.1016/j.techfore.2013.05.008

Calear, A. L., Christensen, H., Freeman, A., Fenton, K., Busby Grant, J., Van Spijker, B., & Donker, T. (2016). A systematic review of psychosocial suicide prevention interventions for youth. *European Child & Adolescent Psychiatry*, *25*(5), 467–482. https://doi.org/10.1007/s00787-015-0783-4

Candela, A. (2019). Exploring the function of member checking. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2019.3726

Cantor, M. H. (1979). Neighbours and friends: An overlooked resource in the informal support system. *Research on Aging*, *1*(4), 434–463. https://doi.org/10.1177/016402757914002

Caribé, A. C., Núñez, R., Montal, D., Ribeiro, L., Sarmento, S., Quarantini, L. C., & Miranda-Scippa, Â. (2012). Religiosity as a protective factor in suicidal behaviour: A case-control study. *Journal of Nervous & Mental Disease*, *200*(10), 863–867.

https://doi.org/10.1097/NMD.0b013e31826b6d05

Centers for Disease Control and Prevention [CDC] (2025). Suicide Data and Statistics. Suicide Data and Statistics. https://www.cdc.gov/suicide/facts/data.html. Accessed in August 2025

Centers for Disease Control and Prevention [CDC] (2022). *The Social-Ecological Model: A Framework for Prevention*. https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html.

Centers for Disease Control and Prevention [CDC] (2021). Suicide prevention. Centers for Disease Control and Prevention. https://www.cdc.gov/suicide/facts/index.html. Accessed in November 2022 from

Centers for Disease Control and Prevention [CDC] (2020). About Violence Prevention. https://www.cdc.gov/violence-prevention/about/index.html. Accessed on March 4, 2022.

Cero, I., Zuromski, K. L., Witte, T. K., Ribeiro, J. D., & Joiner, T. E. (2015). Perceived burdensomeness, thwarted belongingness, and suicide ideation: Re-examination of the Interpersonal-Psychological Theory in two samples. *Psychiatry Research*, *228*(3), 544–550. https://doi.org/10.1016/j.psychres.2015.05.055

Cheng, Q., Li, H., Silenzio, V., & Caine, E. D. (2014). Suicide contagion: A systematic review of definitions and research utility. *PLoS ONE*, *9*(9), e108724. https://doi.org/10.1371/journal.pone.0108724

Chike-Obuekwe, S., Gray, N. J., & Gorton, H. C. (2022). Suicide prevention in Nigeria: Can community pharmacists have a role? *Pharmacy*, *10*(5), 109. https://doi.org/10.3390/pharmacy10050109

Chu, J. P., Goldblum, P., Floyd, R., & Bongar, B. (2010). The cultural theory and model of

suicide. *Applied and Preventive Psychology*, *14*(1–4), 25–40. https://doi.org/10.1016/j.appsy.2011.11.001

Cicchetti, D., & Blender, J. A. (2004). A multiple-levels-of-analysis approach to the study of developmental processes in maltreated children. *Proceedings of the National Academy of Sciences*, *101*(50), 17325–17326. https://doi.org/10.1073/pnas.0408033101

Coker, O. O., Olibamoyo, O., Adewunmi, A. O, Osakwe, V. A., Taiwo, T., & Alonge, A. (2019). Help-seeking behaviour of individuals with mental illness before pursuing professional mental health care services in Lagos, Nigeria. *International Journal of Advanced Community Medicine*, *2*(1), 10–16. https://doi.org/10.33545/comed.2019.v2.i1a.03

Coker, A. O., Olugbile, O. B., & Oluwatayo, O. (2015). Integration of mental healthcare into primary healthcare in Lagos, Nigeria: the way forward. *Healthcare in Low-resource Settings*, *3*(2). https://distantreader.org/stacks/journals/hls/hls-3786.pdf

Collings, S., Strnadová, I., Loblinzk, J., & Danker, J. (2020). Benefits and limits of peer support for mothers with intellectual disability affected by domestic violence and child protection. *Disability & Society*, *35*(3), 413–434. https://doi.org/10.1080/09687599.2019.1647150

Collins, P.Y., Patel, V., Joestl, S.S., et al. Grand challenges in global mental health. *Nature*. 2011;475(7354):27-30. doi:10.1038/475027a

Commonwealth (2024). Global Youth Development Index Update Report 2023 commonwealth-global-youth-development-index-update-report-2023_d19495.pdf. Accessed on February 20, 2025.

Community-based suicide prevention. (2024). In the *National Strategy for Suicide Prevention [Internet]*. US Department of Health and Human Services.

https://www.ncbi.nlm.nih.gov/books/NBK604170/

Conn, M. (2021). *Mental health and suicide prevention*. https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Research/Budget_Review/2021-22/MentalHealthAndSuicidePrevention

Constitution of Nigeria (2019). Criminal Code Act, Section 327. Retrieved from: https://jurist.ng/criminal_code_act/sec-327. Accessed on December 17, 2022.

Cooper, B. (2015). Intersectionality. In L. Disch & M. Hawkesworth (Eds.), *The Oxford Handbook of Feminist Theory* (1st ed., pp. 385–406). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199328581.013.20

Corlett S, Mavin S. (2018). Reflexivity and researcher positionality. In: *The SAGE Handbook of Qualitative Business and Management Research Methods: History and Traditions*. SAGE Publications Ltd, 377–398. doi:10.4135/9781526430212.n23

Coveney, C. M., Pollock, K., Armstrong, S., & Moore, J. (2012). Callers' experiences of contacting a national suicide prevention helpline: Report of an online survey. *Crisis*, *33*(6), 313–324. https://doi.org/10.1027/0227-5910/a000151

Cover R (2016). Critical Suicidology: Transforming Suicide Research and Prevention for the 21st century. In: White J, Marsh I, Kral M.J, Morris J (Eds). Queer Youth Suicide: Discourses of difference, framing Suicidality, and Regimentation of Identity. Toronto: UBC Press, pp. 188–208.

Cramer, R. J., & Kapusta, N. D. (2017). A social-ecological framework of theory, assessment, and prevention of suicide. *Frontiers in Psychology*, *8*, 1756. https://doi.org/10.3389/fpsyg.2017.01756

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), 139–167.

Creswell, J.W., & Creswell, J. D. (2023). *Research design: Qualitative, quantitative, and mixed methods approaches* (6th ed.) SAGE Publications, Inc.

Creswell, J. W. & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Los Angeles: Sage

Creswell, J. W., & Polit, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE.

Criminal Law of Lagos, Section 235. Criminal-Law-of-Lagos-State.pdf. Retrieved from: https://s3-eu-west-1.amazonaws.com/s3.sourceafrica.net/documents/120445/Criminal-Law-of-Lagos-State.pdf. Accessed on 20 Dec. 2022

Cross, W., Matthieu, M. M., Lezine, D., & Knox, K. L. (2010). Does a brief suicide prevention gatekeeper training program enhance observed skills? *Crisis*, *31*(3), 149–159. https://doi.org/10.1027/0227-5910/a000014

Culbreth R, Swahn M, Ndetei D, Ametewee L, Kasirye R. (2018). Suicidal ideation among youth living in the slums of Kampala, Uganda. *IJERPH*,15(2):298. doi:10.3390/ijerph15020298

Curtin, S. C., Warner, M., & Hedegaard, H. (2016). Increase in Suicide in the United States, 1999-2014. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Cwik, M., Doty, S. B., Hinton, A., Goklish, N., Ivanich, J., Hill, K., Lee, A., Tingey, L., & Craig, M. (2021). Community perspectives on social influences on suicide within a native

American reservation. *Qualitative Health Research*, *32*(1), 16–30. https://doi.org/10.1177/10497323211045646

Cwik, M. F., Barlow, A., Goklish, N., Larzelere-Hinton, F., Tingey, L., Craig, M., Lupe, R., & Walkup, J. (2014). Community-based surveillance and case management for suicide prevention: An american indian tribally initiated system. *American Journal of Public Health*, *104*(S3), e18–e23. https://doi.org/10.2105/AJPH.2014.301872

Daoud, N., Haque, N., Gao, M., Nisenbaum, R., Muntaner, C., & O'Campo, P. (2016). Neighbourhood settings, types of social capital and depression among immigrants in Toronto. *Social Psychiatry and Psychiatric Epidemiology*, *51*(4), 529–538. https://doi.org/10.1007/s00127-016-1173-z

Das-Munshi, J., Becares, L., Dewey, M. E., Stansfeld, S. A., & Prince, M. J. (2010). Understanding the effect of ethnic density on mental health: Multi-level investigation of survey data from England. *BMJ*, *341*(oct21 1), c5367–c5367. https://doi.org/10.1136/bmj.c5367

De Leo, D., Goodfellow, B., Silverman, M., Berman, A., Mann, J., Arensman, E., Hawton, K., Phillips, M. R., Vijayakumar, L., Andriessen, K., Chavez-Hernandez, A.-M., Heisel, M., & Kolves, K. (2021). International study of definitions of English-language terms for suicidal behaviours: A survey exploring preferred terminology. *BMJ Open*, *11*(2), e043409. https://doi.org/10.1136/bmjopen-2020-043409

De Silva, E., Bowerman, L., & Zimitat, C. (2015). A suicide awareness and intervention program for health professional students. *Education for Health*, *28*(3), 201. https://doi.org/10.4103/1357-6283.178597

Deidda, M. (2015). Economic hardship, housing cost burden and tenure status: Evidence from

EU-SILC. *Journal of Family and Economic Issues*, *36*(4), 531–556. https://doi.org/10.1007/s10834-014-9431-2

Denneson, L. M., Kemp, K. M., & Tompkins, K. J. (2025). Veteran perspectives on priority areas for rural community-level suicide prevention. *Journal of Rural Mental Health*, *49*(3), 234–243. https://doi.org/10.1037/rmh0000298

Denzin, N. K. (2018). *The qualitative manifesto: A call to arms* (1st ed.). Routledge. https://doi.org/10.4324/9780429449987

Denzin, N. K. (1978). Triangulation: A Case for Methodological Evaluation and Combination. Sociological Methods, 339–357.

Dieserud, G., Gerhardsen, R. M., Van Den Weghe, H., & Corbett, K. (2010). Adolescent suicide attempts in bærum, Norway, 1984–2006: Trends, triggers, and underlying reasons. *Crisis*, *31*(5), 255–264. https://doi.org/10.1027/0227-5910/a000030

Dillon, C. B., Saab, M. M., Meehan, E., Goodwin, M. J., Murphy, M., Heffernan, M. S., Greaney, M. S., Kilty, C., Hartigan, I., Chambers, D., Twomey, U., & Horgan, A. (2020). Staff awareness of suicide and self-harm risk in healthcare settings: A mixed-methods systematic review. *Journal of Affective Disorders*, *276*, 898–906. https://doi.org/10.1016/j.jad.2020.07.113

Dimmrothová, R., Křivánková, M., Navrátil, P., & Hendrychová, V. (2024). Risk factors contributing to crossing professional boundaries in the context of COVID-19 in the Czech Republic. *The British Journal of Social Work*, *54*(3), 976–994. https://doi.org/10.1093/bjsw/bcad215

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), 54–63.

https://doi.org/10.1177/160940690900800105

Dyikuk, J. J. (2019). Media and ministry: Examining the role of priests in Nigeria in new evangelization. *Annals of Journalism and Mass Communication*, *1*(2), 15–22.

Ele, C. O. (2017). The perception of suicide in Igbo religion: A study in African traditional suicidology. *NG-Journal of Social Development*, *6*(3), 64–72. https://doi.org/10.12816/0038071

Eliasu, A. (2017). Addressing Gender Inequality in Enrolment and Attendance in Basic Education: The Role of Non-Governmental Organizations (NGOs) In The Northern Region of Ghana. *UDS International Journal of Development*, *4*(2), 59–74.

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *Sage Open*, *4*(1), 2158244014522633. https://doi.org/10.1177/2158244014522633

Emedo, C. C. (2021). Hermeneutics of suicide in the ethics of the Igbo traditional philosophy. *AMAMIHE Journal of Applied Philosophy*, *19*(1). https://acjol.org/index.php/ajap/article/view/1092

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health*, *16*(4), 414–433. https://doi.org/10.1057/s41285-018-0065-6

Eskin, M. (2020). Suicide and culture. *BAU Journal - Health and Wellbeing*, *1*(1). https://doi.org/10.54729/2789-8288.1014

Eze, P., Ilechukwu, S., & Lawani, L. O. (2023). Impact of community-based health insurance in low- and middle-income countries: A systematic review and meta-analysis. *PLOS*

ONE, *18*(6), e0287600. https://doi.org/10.1371/journal.pone.0287600

Fadele, K. P., Igwe, S. C., Toluwalogo, N.-O., Udokang, E. I., Ogaya, J. B., & Lucero-Prisno, D. E. (2024). Mental health challenges in Nigeria: Bridging the gap between demand and resources. *Cambridge Prisms: Global Mental Health*, *11*, e29. https://doi.org/10.1017/gmh.2024.19

Falade, K. (2013). Yoruba culture abhors suicide. *National Mirror*.

Fayehun, O., Ajisola, M., Uthman, O., Oyebode, O., Oladejo, A., Owoaje, E., Taiwo, O., Odubanjo, O., Harris, B., Lilford, R., Omigbodun, A., & On behalf of the Improving Health in Slums Collaborative. (2022). A contextual exploration of healthcare service use in urban slums in Nigeria. *PLOS ONE*, *17*(2), e0264725. https://doi.org/10.1371/journal.pone.0264725

Fayemi, A. K. (2009). Human personality and the Yoruba worldview: An ethico-sociological interpretation. *The Journal of Pan African Studies*, *2*(9), https://www.researchgate.net/profile/Fayemi-Ademola-Kazeem/publication/242365526

Fazel, S., & Runeson, B. (2020). Suicide. *New England Journal of Medicine*, *382*(3), 266–274. https://doi.org/10.1056/NEJMra1902944

Federal Ministry of Youth Development (FMYSD) (2022). Nigerian. Youth Employment Action Plan. Federal Ministry of Youth and Sports Development, Nigeria. Accessed in April 2024.

Feigelman, W., Cerel, J., Sheehan, L., & Oexle, N. (2023). Using multiple regression analyses to uncover patterns of correlates of grief problems, depression and suicidal ideation among suicide bereaved individuals. *OMEGA - Journal of Death and Dying*, *87*(2), 554–571. https://doi.org/10.1177/00302228211024812

Feldman, B. N., & Freedenthal, S. (2006). Social work education in suicide intervention and prevention: An unmet need? *Suicide and Life-Threatening Behaviour*, *36*(4), 467–480. https://doi.org/10.1521/suli.2006.36.4.467

Fernandez, L. A. B., Schoo, C., Aslam, S. P., & Rouster, A. S. (2025). Family dynamics. In *StatPearls [Internet]*. StatPearls Publishing.

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From Mastery to Accountability: Cultural Humility as an Alternative to Cultural Competence. *Social Work Education*, *34*(2), 165–181. https://doi-org.uml.idm.oclc.org/10.1080/02615479.2014.977244

Fitzgerald, M., London-Johnson, A., & Gallus, K. L. (2020). Intergenerational transmission of trauma and family systems theory: An empirical investigation. *Journal of Family Therapy*, *42*(3), 406–424. https://doi.org/10.1111/1467-6427.12303

Fleischmann, A., Arensman, E., Berman, A., Carli, V., De Leo, D., Hadlaczky, G., Howlader, S., Vijayakumar, L., Wasserman, D., & Saxena, S. (2016). Overview evidence on interventions for population suicide with an eye to identifying best-supported strategies for LMICs. *Global Mental Health*, *3*, e5. https://doi.org/10.1017/gmh.2015.27

Fong, T. C., & Yip, P. S. (2023). Prevalence of hikikomori and associations with suicidal ideation, suicide stigma, and help-seeking among 2,022 young adults in Hong Kong. *International Journal of Social Psychiatry*, *69*(7), 1768–1780. https://doi.org/10.1177/00207640231174376

Fogarty, W., Lovell, M., Langenberg, J., & Heron, M. J. (2018a). Deficit discourse and strengths-based approaches. *Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing. Melbourne:* The Lowitja Institute.

https://www.lowitja.org.au/wp-content/uploads/2023/05/deficit-discourse-strengths-based.pdf.

Fogarty, W., Bulloch, H., McDonnell, S., & Davis, M. (2018b). Deficit Discourse and Indigenous Health: How narrative framings of Aboriginal and Torres Strait Islander people are reproduced in policy. The Lowitja Institute, Melbourne.

Forster, M., Grigsby, T. J., Gower, A. L., Mehus, C. J., & McMorris, B. J. (2020). The role of social support in the association between childhood adversity and adolescent self-injury and suicide: Findings from a statewide sample of high school students. *Journal of Youth and Adolescence*, *49*(6), 1195–1208. https://doi.org/10.1007/s10964-020-01235-9

Fung, H., Stoeber, F., Yeung, D. Y. L., L. F. R. (2008). Cultural specificity of socioemotional selectivity: age differences in social network composition among Germans and Hong Kong Chinese. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 63(3): P156-P164. doi:10.1093/geronb/63.3. P156

Garnett, B. R., Masyn, K. E., Austin, S. B., Miller, M., Williams, D. R., & Viswanath, K. (2014). The intersectionality of discrimination attributes and bullying among youth: An applied latent class analysis. *Journal of Youth and Adolescence*, *43*(8), 1225–1239. https://doi.org/10.1007/s10964-013-0073-8

Gearing, R. E., & Alonzo, D. (2018). Religion and suicide: New findings. *Journal of Religion and Health*, *57*(6), 2478–2499. https://doi.org/10.1007/s10943-018-0629-8

Gelman, C. R., et al. (2021). Community engagement in social work practice: The importance of building trust. Social Work Research, 45(1), 23-34

Giebel, C., Gabbay, M., Shrestha, N., Saldarriaga, G., Reilly, S., White, R., Liu, G., Allen, D., & Zuluaga, M. I. (2024). Community-based mental health interventions in low- and middle-

income countries: A qualitative study with international experts. *International Journal for Equity in Health*, *23*(1), 19. https://doi.org/10.1186/s12939-024-02106-6

Goldney, R. D., Fisher, L. J., Wilson, D. H., & Cheok, F. (2002). Mental health literacy of those with major depression and suicidal ideation: An impediment to help-seeking. *Suicide and Life-Threatening Behaviour*, *32*(4), 394–403. https://doi.org/10.1521/suli.32.4.394.22343

Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (2002). Reducing suicide: A national imperative (Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, Board on Neuroscience and Behavioural Health, Institute of Medicine of the National Academies). Washington, DC: National Academy of Sciences.

Granek, L., Nakash, O., Ben-David, M., Shapira, S., & Ariad, S. (2018). Oncologists', nurses', and social workers' strategies and barriers to identifying suicide risk in cancer patients. *Psycho-Oncology*, *27*(1), 148–154. https://doi.org/10.1002/pon.4481

Granovetter, M. (1973). The strength of weak ties. *American Journal of Sociology*, 78(6):1360–1380. doi:10.1086/225469

Grattidge, L., Hoang, H., Mond, J., Lees, D., Visentin, D., & Auckland, S. (2023). Exploring community-based suicide prevention in the context of rural Australia: A qualitative study. *International Journal of Environmental Research and Public Health*, *20*(3), 2644. https://doi.org/10.3390/ijerph20032644

Gray, M. (2011). Back to basics: A critique of the strengths perspective in social work. *Families in Society: The Journal of Contemporary Social Services*, *92*(1), 5–11. https://doi.org/10.1606/1044-3894.4054

Gray, M., & Amadasun, S. (2023). *Social work, social welfare, and social development in Nigeria: A postcolonial perspective* (1st ed.). Routledge.

https://doi.org/10.4324/9781003382126

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Gunnell, D., & Chang, S. (2016). Economic recession, unemployment, and suicide. In R. C. O'Connor & J. Pirkis (Eds.), *The International Handbook of Suicide Prevention* (1st ed., pp. 284–300). Wiley. https://doi.org/10.1002/9781118903223.ch16

Gureje, O., Nortje, G., Makanjuola, V., Oladeji, B. D., Seedat, S., & Jenkins, R. (2015a). The role of global traditional and complementary systems of medicine in the treatment of mental health disorders. *The Lancet Psychiatry*, *2*(2), 168–177. https://doi.org/10.1016/S2215-0366(15)00013-9

Gureje, O., Abdulmalik, J., Kola, L., Musa, E., Yasamy, M. T., & Adebayo, K. (2015b). Integrating mental health into primary care in Nigeria: Report of a demonstration project using the mental health gap action programme intervention guide. *BMC Health Services Research*, *15*(1), 242. https://doi.org/10.1186/s12913-015-0911-3

Guy-Evans, O. (2020, Nov. 9). Bronfenbrenner's ecological systems theory. https://www.simplypsychology.org/bronfenbrenner.html

Hagen, M. (2022). *A critical perspective on ecological "risk" and "protective" factors for youth suicide in Canada*. http://ruor.uottawa.ca/handle/10393/43849

Hammond, W. (2010). Principles of strength-based practice. *Resiliency Initiatives*, *12*(2), 1–7.

Hanlon, C., Luitel, N. P., Kathree, T., Murhar, V., Shrivasta, S., Medhin, G., Ssebunnya, J., Fekadu, A., Shidhaye, R., Petersen, I., Jordans, M., Kigozi, F., Thornicroft, G., Patel, V., Tomlinson, M., Lund, C., Breuer, E., De Silva, M., & Prince, M. (2014). Challenges and

opportunities for implementing integrated mental health care: A district level situation analysis from five low- and middle-income countries. *PLoS ONE*, *9*(2), e88437. https://doi.org/10.1371/journal.pone.0088437

Hanschmidt, F., Lehnig, F., Riedel-Heller, S. G., & Kersting, A. (2016). The stigma of suicide survivorship and related consequences—A systematic review. *PLOS ONE*, *11*(9), e0162688. https://doi.org/10.1371/journal.pone.0162688

Harris, S. J., & McGee, J. (2022). Resilience and community engagement: A social work perspective. *Journal of Community Practice,* 30(2), 145–162.

Hasan, N., Rana, R., Chowdhury, S., Dola, A., Rony, M. (2021). Ethical considerations in research. *JNRPSP*, (11):1-4. doi:10.55529/jnrpsp11.1.4

Hatzenbuehler, M. L. (2018). Structural stigma and health. In B. Major, J. Dovidio, & B. Link (Eds.), *The Oxford Handbook of Stigma, Discrimination, and Health* (pp. 105–121). Oxford University Press.

Haw, C., Hawton, K., Gunnell, D., & Platt, S. (2015). Economic recession and suicidal behaviour: Possible mechanisms and ameliorating factors. *International Journal of Social Psychiatry*, *61*(1), 73–81. https://doi.org/10.1177/0020764014536545

Haw, C., Hawton, K., Niedzwiedz, C., & Platt, S. (2013). Suicide clusters: A review of risk factors and mechanisms. *Suicide and Life-Threatening Behaviour*, *43*(1), 97–108. https://doi.org/10.1111/j.1943-278X.2012.00130.x

Hawton, K., & Pirkis, J. (2017). Suicide is a complex problem that requires a range of prevention initiatives and methods of evaluation. *British Journal of Psychiatry*, *210*(6), 381–383. https://doi.org/10.1192/bjp.bp.116.197459

Hawton, K., Witt, K. G., Salisbury, T. L. T. et al. (2016). Psychosocial interventions following

self-harm in adults: A systematic review and meta-analysis. *The Lancet Psychiatry*, *3*(8), 740–750. https://doi.org/10.1016/S2215-0366(16)30070-0

Hazell T, Dalton H, Caton T, Perkins D. (2017). Rural Suicide and its Prevention: A CRRMH position paper. Centre for Rural and Remote Mental Health, University of Newcastle, Australia.

Heckert, C.J. (2022). Ecology of Suicide: Envisioning a Social Work Approach in Suicidology (Doctoral dissertation, University of St. Thomas, Minnesota). [online] [cit. 2024-09-07]. Available from: https://researchonline.stthomas.edu/esploro/outputs/doctoral/Ecology-of-Suicide-Envisioning-a-Social/991015131432203691

Hegerl, U., Heinz, I., O'Connor, A., & Reich, H. (2021). The 4-level approach: Prevention of suicidal behaviour through community-based intervention. *Frontiers in Psychiatry*, *12*, 760491. https://doi.org/10.3389/fpsyt.2021.760491

Hegerl, U., Maxwell, M., Harris, F., Koburger, N., Mergl, R., Székely, A., Arensman, E., Van Audenhove, C., Larkin, C., Toth, M. D., Quintão, S., Värnik, A., Genz, A., Sarchiapone, M., McDaid, D., Schmidtke, A., Purebl, G., Coyne, J. C., Gusmão, R., & The OSPI-Europe Consortium. (2019). Prevention of suicidal behaviour: Results of a controlled community-based intervention study in four European countries. *PLOS ONE*, *14*(11), e0224602. https://doi.org/10.1371/journal.pone.0224602

Hegerl, U., Rummel-Kluge, C., Värnik, A., Arensman, E., & Koburger, N. (2013). Alliances against depression – A community-based approach to target depression and to prevent suicidal behaviour. *Neuroscience & Biobehavioral Reviews*, *37*(10), 2404–2409. https://doi.org/10.1016/j.neubiorev.2013.02.009

Hesse, M., Thylstrup, B., Seid, A. K., & Skogen, J. C. (2020). Suicide among people treated for

drug use disorders: A Danish national record-linkage study. *BMC Public Health*, *20*(1), 146. https://doi.org/10.1186/s12889-020-8261-4

Hetrick, S. E., Cox, G. R., Witt, K. G., Bir, J. J., & Merry, S. N. (2016). Cognitive behavioural therapy (Cbt), third-wave CBT and interpersonal therapy (Ipt) based interventions for preventing depression in children and adolescents. *Cochrane Database of Systematic Reviews*, *2016*(8). https://doi.org/10.1002/14651858.CD003380.pub4

Hilton, S. C., Fellingham, G. W., & Lyon, J. L. (2002). Suicide rates and religious commitment in young adult males in Utah. *American Journal of Epidemiology*, *155*(5), 413–419. https://doi.org/10.1093/aje/155.5.413

Hirsch, J. K., Webb, J. R., & Kaslow, N. J. (2014). Daily hassles and suicidal ideation in African-American female suicide attempters: Moderating effect of spiritual well-being. *Mental Health, Religion & Culture*, *17*(5), 529–541. https://doi.org/10.1080/13674676.2013.858682

Hjelmeland, H., & Knizek, B. L. (2017). Suicide and mental disorders: A discourse of politics, power, and vested interests. *Death Studies*, *41*(8), 481–492. https://doi.org/10.1080/07481187.2017.1332905

Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behaviour*, *40*(1), 74–80. https://doi.org/10.1521/suli.2010.40.1.74

Hjelmeland, H., Knizek, B. L., Kinyanda, E., Musisi, S., Nordvik, H., & Svarva, K. (2008). Suicidal behaviour as communication in a cultural context: A comparative study between Uganda and Norway. *Crisis*, *29*(3), 137–144. https://doi.org/10.1027/0227-5910.29.3.137

Hoffberg, A. S., Stearns-Yoder, K. A., & Brenner, L. A. (2020). The effectiveness of crisis line

services: A systematic review. *Frontiers in Public Health*, *7*, 399. https://doi.org/10.3389/fpubh.2019.00399

Hofstra, E., Van Nieuwenhuizen, C., Bakker, M., Özgül, D., Elfeddali, I., De Jong, S. J., & Van Der Feltz-Cornelis, C. M. (2020). Effectiveness of suicide prevention interventions: A systematic review and meta-analysis. *General Hospital Psychiatry*, *63*, 127–140. https://doi.org/10.1016/j.genhosppsych.2019.04.011

Hogan, M. F., & Grumet, J. G. (2016). Suicide prevention: An emerging priority for health care. *Health Affairs*, *35*(6), 1084–1090. https://doi.org/10.1377/hlthaff.2015.1672

Hong, J. S., Espelage, D. L., & Kral, M. J. (2011). Understanding suicide among sexual minority youth in America: An ecological systems analysis. *Journal of Adolescence*, *34*(5), 885–894. https://doi.org/10.1016/j.adolescence.2011.01.002

Hooper, L. M., Epstein, S. A., Weinfurt, K. P., DeCoster, J., Qu, L., & Hannah, N. J. (2012). Predictors of primary care physicians' self-reported intention to conduct suicide risk assessments. *The Journal of Behavioural Health Services & Research*, *39*(2), 103–115. https://doi.org/10.1007/s11414-011-9268-5

Horowitz, L. M., Ryan, P. C., Wei, A. X., Boudreaux, E. D., Ackerman, J. P., & Bridge, J. A. (2023). Screening and assessing suicide risk in medical settings: Feasible strategies for early detection. *Focus*, *21*(2), 145–151. https://doi.org/10.1176/appi.focus.20220086

Hoven, C. W., Wasserman, D., Wasserman, C., & Mandell, D. J. (2009). Awareness in nine countries: A public health approach to suicide prevention. *Legal Medicine*, *11*, S13–S17. https://doi.org/10.1016/j.legalmed.2009.01.106

Iemmi, V., Bantjes, J., Coast, E., Channer, K., Leone, T., McDaid, D., Palfreyman, A., Stephens, B., & Lund, C. (2016). Suicide and poverty in low-income and middle-income countries: a systematic review. *The Lancet Psychiatry* 3(8), 774–783.

International Labour Organization. (2024). *Nigeria decent work country programme III (DWCP) 2023–2027*. https://www.ilo.org/sites/default/files/2024-05/Nigeria%20Decent%20Work%20Programme%20III.pdf. Accessed on 5 December 2024.

International Organization for Migration [IOM] Nigeria Youth Strategy 2023 – 2027. https://nigeria.iom.int/resources/iom-nigeria-youth-strategy-2023-2027. Accessed on 24 October 2025.

Isaac, M., Elias, B., Katz, L. Y., Belik, S.-L., Deane, F. P., Enns, M. W., Sareen, J., & The Swampy Cree Suicide Prevention Team (12 members)8. (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. *The Canadian Journal of Psychiatry*, *54*(4), 260–268. https://doi.org/10.1177/070674370905400407

Ishikawa, A., Rickwood, D., Bariola, E., & Bhullar, N. (2022). Autonomy versus support: Self-reliance and help-seeking for mental health problems in young people. *Social Psychiatry and Psychiatric Epidemiology*, 57(11), 2183–2193. https://doi.org/10.1007/s00127-022-02361-4

Ishimo, M.-C., Sampasa-Kanyinga, H., Olibris, B., Chawla, M., Berfeld, N., Prince, S. A., Kaplan, M. S., Orpana, H., & Lang, J. J. (2021). Universal interventions for suicide prevention in high-income Organization for Economic Co-operation and Development (OECD) member countries: A systematic review. *Injury Prevention*, *27*(2), 184–193. https://doi.org/10.1136/injuryprev-2020-043975

Ishor, G. D. & Iorkosu, T.S. (2022). Spiritual Healing as an Alternative Health Care Delivery in Benue State: Issues and Challenges. *International Journal of Trend in Scientific Research and Development* (IJTSRD), vol. 6 (2), pp. 365-375, www.ijtsrd.com/papers/ijtsrd33616.pdf.

Jacob, K. S. (2017). Suicide prevention in low- and middle-income countries: Part perceptions, partial solutions. *British Journal of Psychiatry*, *211*(5), 264–265. https://doi.org/10.1192/bjp.bp.117.198150

Jani, J. S., Pierce, D., Ortiz, L., & Sowbel, L. (2011). Access to intersectionality, content to competence: Deconstructing social work education diversity standards. *Journal of Social Work Education*, *47*(2), 283–301. https://doi.org/10.5175/JSWE.2011.200900118

Jegede, S.A. (2005). The notion of 'were' in Yoruba conception of mental illness. *Nordic Journal of African Studies*.

Jidong, D. E., Ike, T. J., Husain, N., Francis, C., Husain, M. O., Mwankon, S. B., Murshed, M., Jidong, J. E., Jack, D. B., Nyam, P. P., Bassett, P., Pwajok, J. Y., Taru, M. Y., & Nwoga, C. N. (2024). Perspectives on self-harm and suicidal ideation in Nigeria: A mixed-methods study of patients, family caregivers, clinicians, and the public. *Archives of Suicide Research*, *28*(4), 1417–1431. https://doi.org/10.1080/13811118.2024.2314520

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigour in qualitative research. *American Journal of Pharmaceutical Education*, *84*(1), 7120. https://doi.org/10.5688/ajpe7120

Joiner, T. (2005). *Why people die by suicide.* Harvard University Press.

Jolaosho, T., Elegbede, I., Akintola, S., Jimoh, A., Ndimele, Prince Emeka, & Mustapha, Adejuwon. (2024). Bioaccumulation dynamics, noncarcinogenic and carcinogenic risks

of heavy metals in commercially valuable shellfish and finfish species from the world's largest floating slum, Makoko, Nigeria. Marine Pollution Bulletin. 10. 1–20. 10.1016/j.marpolbul.2024.116807.

Jones, E., Huey, S. J., & Rubenson, M. (2018). Cultural competence in therapy with African Americans. In C. L. Frisby & W. T. O'Donohue (Eds.), *Cultural Competence in Applied Psychology* (pp. 557–573). Springer International Publishing. https://doi.org/10.1007/978-3-319-78997-2_22

Jordans, M. J. D., Luitel, N. P., Kohrt, B. A., Rathod, S. D., Garman, E. C., De Silva, M., Komproe, I. H., Patel, V., & Lund, C. (2019). Community-, facility-, and individual-level outcomes of a district mental healthcare plan in a low-resource setting in Nepal: A population-based evaluation. *PLOS Medicine*, *16*(2), e1002748. https://doi.org/10.1371/journal.pmed.1002748

Jordans, M., Rathod, S., Fekadu, A., Medhin, G., Kigozi, F., Kohrt, B., Luitel, N., Petersen, I., Shidhaye, R., Ssebunnya, J., Patel, V., & Lund, C. (2018). Suicidal ideation and behaviour among community and health care seeking populations in five low- and middle-income countries: A cross-sectional study. *Epidemiology and Psychiatric Sciences*, *27*(4), 393–402. https://doi.org/10.1017/S2045796017000038

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, *166*(4), 182–186. https://doi.org/10.5694/j.1326-5377.1997.tb140071.x

Joulaei H, Bhuiyan AR, Sayadi M, Morady F, Afsar Kazerooni P (2014). Slums' access to and coverage of primary health care services: a cross-sectional study in Shiraz, a metropolis

in southern Iran. *Iran J Med Sci., 39(2 Suppl)*:184–90.

Junus, A., & Yip, P. S. F. (2022). Suicide risk profile and the social convoy: Population-level patterns of the young generation's help-seeking behaviour and implications for suicide prevention. *Journal of Affective Disorders*, *297*, 559–569. https://doi.org/10.1016/j.jad.2021.10.106

Kabir, H., Wayland, S., & Maple, M. (2023). Qualitative research in suicidology: A systematic review of the literature of low-and middle-income countries. *BMC Public Health*, *23*(1), 918. https://doi.org/10.1186/s12889-023-15767-9

Kamau, J. W., Omigbodun, O. O., Bella-Awusah, T., & Adedokun, B. (2017). Who seeks child and adolescent mental health care in Kenya? A descriptive clinic profile at a tertiary referral facility. *Child and Adolescent Psychiatry and Mental Health*, *11*(1), 14. https://doi.org/10.1186/s13034-017-0151-x

Khandagale, A. B. (2024). Empowering marginalized communities through social work: Case studies of grassroots movements. *ShodhKosh: Journal of Visual and Performing Arts*, *5*(7). https://doi.org/10.29121/shodhkosh.v5.i7.2024.2187

Kim, H. S., Sherman, D. K., & Taylor, S. E. (2008). Culture and social support. *American Psychologist*, *63*(6), 518–526. https://doi.org/10.1037/0003-066X

Kim, J., & Park, G.-R. (2024). Poor housing conditions in adolescence and housing hardship in adulthood: A longitudinal mediation analysis. *Cities*, *155*, 105428. https://doi.org/10.1016/j.cities.2024.105428

King James Bible. (2019). Christian Art Publishers. (Original work published 1769).

King, K., Hall, T., Oostermeijer, S., & Currier, D. (2022). Community participation in Australia's national suicide prevention trial. *Australian Journal of Primary Health*, *28*(3),

255–263. https://doi.org/10.1071/PY21083

King, T., Shields, M, Shakespeare, T, Milner, A, Kavanagh, A. (2019). An intersectional approach to understandings of mental health inequalities among men with disability. *SSM - Population Health*. 2019;9:100464. doi:10.1016/j.ssmph.2019.100464

Kisthardt, W. E. (1992). A strengths model of case management: The principles and functions of a helping partnership with persons with persistent mental illness. In D. Saleebey (Ed.), The strengths perspective in social work practice: Power in the people (pp. 59–83). White Plains, NY: Longman.

Kitchen, J. A., Hallett, R. E., Perez, R. J., & Rivera, G. J. (2019). Advancing the use of ecological systems theory in college student research: The ecological systems interview tool. *Journal of College Student Development*, *60*(4), 381–400. https://doi.org/10.1353/csd.2019.0043

Kizza, D., Knizek, B. L., Kinyanda, E., & Hjelmeland, H. (2012). Men in despair: A qualitative psychological autopsy study of suicide in Northern Uganda. *Transcultural Psychiatry*, *49*(5), 696–717. https://doi.org/10.1177/1363461512459490

Klonsky, E. D., May, A. M., & Saffer, B. Y. (2016). Suicide, suicide attempts, and suicidal ideation. *Annual Review of Clinical Psychology*, *12*(1), 307–330. https://doi.org/10.1146/annurev-clinpsy-021815-093204

Klonsky, E. D., Saffer, B. Y., & Bryan, C. J. (2018). Ideation-to-action theories of suicide: A conceptual and empirical update. *Current Opinion in Psychology*, *22*, 38–43. https://doi.org/10.1016/j.copsyc.2017.07.020

Knipe, D., Padmanathan, P, Newton-Howes, G, Chan, L.F, Kapur, N. Suicide and self-harm (2022). *The Lancet*, 399(10338):1903-1916. doi:10.1016/S0140-6736(22)00173-8

Knizek, B. L., Kinyanda, E., Owens, V., & Hjelmeland, H. (2011). Ugandan men's perceptions of what causes and what prevents suicide. *Journal of Men, Masculinities and Spirituality*, *5*(1), 4-21. ISSN (electronic):1177-2484. https://search.informit.org/doi/epdf/10.3316/informit.728866917855369

Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy Research*, *19*(4–5), 566–575. https://doi.org/10.1080/10503300802702105

Kourgiantakis, T., Sewell, K. M., Lee, E., Adamson, K., McCormick, M., Kuehl, D., & Bogo, M. (2020). Teaching note—Enhancing social work education in mental health, addictions, and suicide risk assessment. *Journal of Social Work Education*, *56*(3), 587–594. https://doi.org/10.1080/10437797.2019.1656590

Kral, M. J., Morris, J., & White, J. (2017). Seeing suicidology in a new light. *Death Studies*, *41*(8), 469–471. https://doi.org/10.1080/07481187.2017.1332898

Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education & Behaviour*, *30*(2), 133–146. https://doi.org/10.1177/1090198102251021

Kreuze, L. J., Pijnenborg, G. H. M., De Jonge, Y. B., & Nauta, M. H. (2018). Cognitive-behaviour therapy for children and adolescents with anxiety disorders: A meta-analysis of secondary outcomes. *Journal of Anxiety Disorders*, *60*, 43–57. https://doi.org/10.1016/j.janxdis.2018.10.005

Krysinska, K., Batterham, P. J., Tye, M., Shand, F., Calear, A. L., Cockayne, N., & Christensen, H. (2016). Best strategies for reducing the suicide rate in Australia. *Australian & New Zealand Journal of Psychiatry*, *50*(2), 115–118.

https://doi.org/10.1177/0004867415620024

Kukoyi, O., Orok, E., Oluwafemi, F., Oni, O., Oluwadare, T., Ojo, T., Bamitale, T., Jaiyesimi, B., & Iyamu, D. (2023). Factors influencing suicidal ideation and self-harm among undergraduate students in a Nigerian private university. *Middle East Current Psychiatry*, *30*(1), 1. https://doi.org/10.1186/s43045-022-00274-1

Kumpfer, K. L., Alvarado, R., Smith, P., & Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science*, *3*(3), 241–246. https://doi.org/10.1023/A:1019902902119

Kwon, K., Park, S, Kim, J (2026). Housing hardship and suicidal ideation: The mediating role of psychological resilience. *Cities*,168:106452. doi: 10.1016/j.cities.2025.106452

Labinjo, T., Serrant, L., Ashmore, R., & Turner, J. (2020). Perceptions, attitudes and cultural understandings of mental health in Nigeria: A scoping review of published literature. *Mental Health, Religion & Culture*, *23*(7), 606–624. https://doi.org/10.1080/13674676.2020.1726883

Labouliere, C. D., Vasan, P., Kramer, A., Brown, G., Green, K., Rahman, M., ... & Stanley, B. (2018). "Zero Suicide"–A model for reducing suicide in the United States behavioural healthcare. *Suicidologi*, *23*(1), 22. https://pmc.ncbi.nlm.nih.gov/articles/PMC6022755/

Ladi-Akinyemi, T. 'Wunmi, Okpue, A. P., Onigbinde, O. A., Okafor, I. P., Akodu, B., & Odeyemi, K. (2023). Depression and suicidal ideation among undergraduates in state tertiary institutions in Lagos, Nigeria. *PLOS ONE*, *18*(4), e0284955. https://doi.org/10.1371/journal.pone.0284955

Lagos Bureau of Statistics (2022). Spotlight on Lagos Statistics, 2021 Edition. Accessed on February 20, 2024, from https://lagosmepb.org/wp-content/uploads/Hotline_Stat.pdf

Lamis, D. A. (2016). The association between physical illness/medical conditions and suicide risk. In R. C. O'Connor & J. Pirkis (Eds.), *The International Handbook of Suicide Prevention* (1st ed., pp. 133–148). Wiley. https://doi.org/10.1002/9781118903223.ch8

Lanre-Abass, B. A. (2010). Suicide and human dignity: An African perspective. *Humanity and Social Sciences Journal*, *5*(1), 50-62. https://idosi.org/hssj/hssj5(1)10/7.pdf.

Landers-Potts, M. A., Wickrama, K. A. S., Simons, L. G., Cutrona, C., Gibbons, F. X., Simons, R. L., & Conger, R. (2015). An extension and moderational analysis of the family stress model focusing on African American adolescents. *Family Relations*, *64*(2), 233–248. https://doi.org/10.1111/fare.12117

Lannin, D. G., Vogel, D. L., Brenner, R. E., Abraham, W. T., & Heath, P. J. (2016). Does self-stigma reduce the probability of seeking mental health information? *Journal of Counselling Psychology*, *63*(3), 351–358. https://doi.org/10.1037/cou0000108

Lawal, O. (2018). Attitudes towards depression and suicide: An analysis of news coverage and online comments on Nigerian news sites. *Communication Theses*. https://doi.org/https://doi.org/10.57709/12517878

Lawrence, K. (2022). Prevalence of suicidal tendencies and associated risk factors among Nigerian university students: A quantitative survey. *The Open Psychology Journal*, *15*(1), e187435012204141. https://doi.org/10.2174/18743501-v15-e2204141

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A Comparison of historical and methodological considerations. International Journal of Qualitative Methods, 2 (3). http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/laverty.pdf. Accessed on 1st August 2026

Lawanson, O. I., Proverbs, D., & Ibrahim, R. L. (2023). The impact of flooding on poor

communities in Lagos State, Nigeria: The case of the Makoko urban settlement. *Journal of Flood Risk Management*, *16*(1), e12838. https://doi.org/10.1111/jfr3.12838

Lazard, L., & McAvoy, J. (2017). *Doing reflexivity in psychological research: What's the point? What's the practice? Qual Res Psychol 17 (2): 1–19*.

Lerner, R. M., & Damon, W. (Eds.). (2006). *Handbook of child psychology: Theoretical models of human development* (6th ed.). John Wiley & Sons, Inc.

Lestari, P. A., & Fitriyah, A. (2024). Community resilience and suicide prevention: A review of policy-aligned intervention strategies. *Sinergi International Journal of Psychology*, *3*(1), 52–66. https://doi.org/10.61194/psychology.v3i1.698

Leung, C. A. W. (2020). *Suicide by Firearm Among Women: An Analysis of Ecological and Individual Correlates*. University of California, Los Angeles.

Levine, J., & Sher, L. (2020). How to increase the role of social workers in suicide preventive interventions. *Acta Neuropsychiatrica*, *32*(4), 186–195. https://doi.org/10.1017/neu.2020.11

Lewin, S., & Glenton, C. (2018). Are we entering a new era for qualitative research? Using qualitative evidence to support guidance and guideline development by the World Health Organization. *International Journal for Equity in Health*, *17*(1), 126. https://doi.org/10.1186/s12939-018-0841-x

Lichtman, M. (2006). *Qualitative research in education. A user's guide*. Thousand Oaks, CA: Sage.

Lin, V. W., Lin, J., & Zhang, X. (2016). U. S. Social worker workforce report card: Forecasting nationwide shortages. *Social Work*, *61*(1), 7–15. https://doi.org/10.1093/sw/swv047

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Liu, J., & Zhang, Y. (2024). Exploring young adults' mental health help-seeking journey: Preliminary findings on resource navigation behaviour. *Proceedings of the Association for Information Science and Technology*, *61*(1), 570–575. https://doi.org/10.1002/pra2.1060

Lund, C., Tomlinson, M., & Patel, V. (2016). Integration of mental health into primary care in low- and middle-income countries: The PRIME mental healthcare plans. *British Journal of Psychiatry*, *208*(s56), s1–s3. https://doi.org/10.1192/bjp.bp.114.153668

Luxton, D. D., June, J. D., & Comtois, K. A. (2013). Can postdischarge follow-up contacts prevent suicide and suicidal behaviour? : A review of the evidence. *Crisis*, *34*(1), 32–41. https://doi.org/10.1027/0227-5910/a000158

Maclean, B. R., Forrester, T., Hawgood, J., O'Gorman, J., & Rimkeviciene, J. (2023). The personal suicide stigma questionnaire (PSSQ): Relation to self-esteem, well-being, and help-seeking. *International Journal of Environmental Research and Public Health*, *20*(5), 3816. https://doi.org/10.3390/ijerph20053816

Maharlouei, N., Hoseinzadeh, A., Ghaedsharaf, E., Zolfi, H., Arab, P., Farahmand, Z., Hallaj, M., Fazilat, S., Heidari, S. T., Joulaei, H., Karbalaie, F., & Lankarani, K. B. (2014). The mental health status and associated factors affecting underprivileged Iranian women. *Asian Journal of Psychiatry*, *12*, 108–112. https://doi.org/10.1016/j.ajp.2014.07.005

Mäkinen, I. H., Rojas, Y., & Wasserman, D. (2021). Labour market, work environment, and suicide. In D. Wasserman (Ed.), *Oxford Textbook of Suicidology and Suicide Prevention* (2nd ed., pp. 249–258). Oxford University Press, Oxford.

https://doi.org/10.1093/med/9780198834441.003.0030

Mann, J.J., Michel, C.A., Auerbach, R.P. (2021). Improving suicide prevention through evidence-based strategies: a systematic review. *AJP*, 178(7):611–624. doi: 10.1176/appi.ajp.2020.20060864

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., Hegerl, U., Lonnqvist, J., Malone, K., Marusic, A., Mehlum, L., Patton, G., Phillips, M., Rutz, W., Rihmer, Z., Schmidtke, A., Shaffer, D., Silverman, M., Takahashi, Y., … Hendin, H. (2005). Suicide prevention strategies: A systematic review. *JAMA*, *294*(16), 2064. https://doi.org/10.1001/jama.294.16.2064

Mann, J. J., Arango, V. A., Avenevoli, S., Brent, D. A., Champagne, F. A., Clayton, P., Currier, D., Dougherty, D. M., Haghighi, F., Hodge, S. E., Kleinman, J., Lehner, T., McMahon, F., Mościcki, E. K., Oquendo, M. A., Pandey, G. N., Pearson, J., Stanley, B., Terwilliger, J., & Wenzel, A. (2009). Candidate endophenotypes for genetic studies of suicidal behaviour. *Biological Psychiatry*, *65*(7), 556–563. https://doi.org/10.1016/j.biopsych.2008.11.021

Maple, M., Pearce, T., Sanford, R. L., & Cerel, J. (2017). The role of social work in suicide prevention, intervention, and postvention: A scoping review. *Australian Social Work*, *70*(3), 289–301. https://doi.org/10.1080/0312407X.2016.1213871

Marsiglia, F. F., & Booth, J. M. (2015). Cultural adaptation of interventions in real practice settings. *Research on Social Work Practice*, *25*(4), 423–432. https://doi.org/10.1177/1049731514535989

Martin, T., Kirkcaldy, B., & Siefen, G. (2003). Antecedents of adult wellbeing: Adolescent religiosity and health. *Journal of Managerial Psychology*, *18*(5), 453–470.

https://doi.org/10.1108/02683940310484044

Martin-Carrasco, M., Evans-Lacko, S., Dom, G., Christodoulou, N. G., Samochowiec, J., González-Fraile, E., Bienkowski, P., Gómez-Beneyto, M., Dos Santos, M. J. H., & Wasserman, D. (2016). EPA guidance on mental health and economic crises in Europe. *European Archives of Psychiatry and Clinical Neuroscience*, *266*(2), 89–124. https://doi.org/10.1007/s00406-016-0681-x

Martínez-Hernáez, A., DiGiacomo, S. M., Carceller-Maicas, N., Correa-Urquiza, M., & Martorell-Poveda, M. A. (2014). Non-professional-help-seeking among young people with depression: A qualitative study. *BMC Psychiatry*, *14*(1), 124. https://doi.org/10.1186/1471-244X-14-124

Matthieu, M. M., W. Cross, A. R. Batres, C. M. Flora, & K. L. Knox (2008). "Evaluation of Gatekeeper Training for Suicide Prevention in Veterans," *Archives of Suicide Research*, Vol. 12, No. 2, pp. 148–154.

Mathew, A., Saradamma, R., Krishnapillai, V., & Muthubeevi, S. B. (2021). Exploring the family factors associated with suicide attempts among adolescents and young adults: A qualitative study. *Indian Journal of Psychological Medicine*, *43*(2), 113–118. https://doi.org/10.1177/0253717620957113

Mathieu, S., Treloar, A., Hawgood, J., Ross, V., & Kõlves, K. (2022). The role of unemployment, financial hardship, and economic recession on suicidal behaviours and interventions to mitigate their impact: A review. *Frontiers in Public Health*, *10*, 907052. https://doi.org/10.3389/fpubh.2022.907052

Matsubayashi, T., Sawada, Y., & Ueda, M. (2014). Does the installation of blue Lights on train platforms shift suicide to another station? Evidence from Japan. *Journal of Affective*

Disorders, *169*, 57–60. https://doi.org/10.1016/j.jad.2014.07.036

Mirick, R. G., Bridger, J., & McCauley, J. (2022). Trauma-informed clinical practice with clients with suicidal thoughts and behaviours. *Smith College Studies in Social Work*, *92*(3), 169–184. https://doi.org/10.1080/00377317.2022.2104778

Mba-Oduwusi, N., Ifesinachi Eze, Tochukwu Osuji, Mubarak Ahmed, Bolaji Akala et al. (2024). Evaluating the Effectiveness of Quality Improvement Strategies in Mid-Level Private Healthcare Facilities of Lagos State: A Donabedian Model-Based Approach. *Journal of Public Health International-7 (1)*, 1-25. https://doi.org/10.14302/issn.2641-4538.jphi-23-4871

Mbachu, D. (2025). Nigeria's revamp of economic indicators sparks debate. African Business. 13 February. https://african.business/2025/02/trade-investment/nigerias-revamp-of-economic-indicators-sparks-debate. Accessed 20 January 2025.

McKenzie-Mohr, S., & Lafrance, M. N. (2011). Telling stories without the words: 'Tightrope talk' in women's accounts of coming to live well after rape or depression. *Feminism & Psychology*, *21*(1), 49–73. https://doi.org/10.1177/0959353510371367

McPhillips, R., Allen, R., Ramesh, P., Barnett, K., Chadwick, H., Batool, S., Elahi, A., Hawton, K., Huxley, P., Krayer, A., Krishna, M., Nafees, S. B., & Robinson, C. (2025). Knowledge, attitudes, and experiences of self-harm and suicide in low- and middle-income countries: Quantitative systematic review. *Crisis*, *46*(4), 232–242. https://doi.org/10.1027/0227-5910/a001004

Meltzer, H., Brugha, T., Dennis, M. S., Hassiotis, A., Jenkins, R., McManus, S., Rai, D., & Bebbington, P. (2012). The influence of disability on suicidal behaviour. *Alter*, *6*(1), 1–12. https://doi.org/10.1016/j.alter.2011.11.004

Merriam, S. B. (2009). Qualitative research: A guide to design and implementation. Revised and expanded from Qualitative Research and Case Study Applications in Education. San Francisco, CA: Jossey-Bass.

Methu, S. (2014). "Postcards from home: documenting Nigeria's floating community". CNN. https://edition.cnn.com/2014/12/24/world/africa/nigeria-makoko-photograph-sulayman-afose/. Accessed on 1st of August 2025.

Merriam, S. B., & Tisdell, E. (2016). Qualitative research: A guide to design and implementation. San Francisco, CA: Jossey-Bass.

Meyer, I. H., Teylan, M., & Schwartz, S. (2015). The role of help-seeking in preventing suicide attempts among lesbians, gay men, and bisexuals. *Suicide and Life-Threatening Behaviour*, *45*(1), 25–36. https://doi.org/10.1111/sltb.12104

Miley, K. K., O'Melia, M., & DuBois, B. (2001). *Generalist social work practice: An empowering approach*. Allyn & Bacon.

Mirick, R. G. (2024). Social work practice instructors' preparedness and readiness to teach suicide content. *Social Work Education*, *43*(1), 224–240. https://doi.org/10.1080/02615479.2022.2102162

Mishara, B. L., & Weisstub, D. N. (2016). The legal status of suicide: A global review. *International Journal of Law and Psychiatry*, *44*, 54–74. https://doi.org/10.1016/j.ijlp.2015.08.032

Mohr, D. C., Ho, J., Duffecy, J., Reifler, D., Sokol, L., Burns, M. N., Jin, L., & Siddique, J. (2012). Effect of telephone-administered vs face-to-face cognitive behavioural therapy on adherence to therapy and depression outcomes among primary care patients: A randomized trial. *JAMA*, *307*(21). https://doi.org/10.1001/jama.2012.5588

Mojaverian, T., Hashimoto, T., & Kim, H. S. (2013). Cultural differences in professional help-seeking: A comparison of Japan and the U.S. *Frontiers in Psychology,* 3, Article 615. https://doi.org/10.3389/fpsyg.2012.00615

Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus*, *18*(1), 16–24. https://doi.org/10.1176/appi.focus.20190028

Morris, M., & Crooks, C. (2015). Structural and cultural factors in suicide prevention: The contrast between mainstream and Inuit approaches to understanding and preventing suicide. *Journal of Social Work Practice*, *29*(3), 321–338. https://doi.org/10.1080/02650533.2015.1050655

Morris, T. (2006). *Social work research methods: Four alternative paradigms*. Sage.

Morgan, H. (2024). Using triangulation and crystallization to make qualitative studies trustworthy and rigorous. *The Qualitative Report*, *29*(7), 1844–1856. https://doi.org/10.46743/2160-3715/2024.6071

Moser, A., & Korstjens, I. (2018). Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice*, *24*(1), 9–18. https://doi.org/10.1080/13814788.2017.1375091

Moreton, J., Kelly, C. S., & Sandstrom, G. M. (2023). Social support from weak ties: Insight from the literature on minimal social interactions. *Social and Personality Psychology Compass*, 17(3), e12729. https://doi.org/10.1111/spc3.12729

Mottelson, J. (2020). A new hypothesis on informal land supply, livelihood, and urban form in sub-Saharan African cities. *Land*, *9*(11), 435. https://doi.org/10.3390/land9110435

Mueller, A. S., James, W., Abrutyn, S., & Levin, M. L. (2015). Suicide ideation and bullying

among us adolescents: Examining the intersections of sexual orientation, gender, and race/ethnicity. *American Journal of Public Health*, *105*(5), 980–985. https://doi.org/10.2105/AJPH.2014.302391

National Bureau of Statistics (2022). Nigeria launches its most extensive national measure of multidimensional poverty. Retrieved from: https://nigerianstat.gov.ng/news/78#:~:text=In%20Nigeria%2C%2040.1%25%20of%20people,of%20people%20in%20urban%20areas. Accessed on August 5, 2024.

National Bureau of Statistics. (2021). Labour force statistics: Unemployment and underemployment report (Q4 2020).

National Strategy for Suicide Prevention. Washington (DC): US Department of Health and Human Services; 2024. STRATEGIC DIRECTION 1, Community-Based Suicide Prevention. Available from: https://www.ncbi.nlm.nih.gov/books/NBK604170/. Accessed on 19 August 2024.

Necho, M., Tsehay, M., Birkie, M., Biset, G., & Tadesse, E. (2021). Prevalence of anxiety, depression, and psychological distress among the general population during the COVID-19 pandemic: A systematic review and meta-analysis. *International Journal of Social Psychiatry*, *67*(7), 892–906. https://doi.org/10.1177/00207640211003121

Neto, D. D., & Maugi, P. L. (2022). Mental health literacy regarding depression and suicide. *European Journal of Mental Health*, *17*(3), 96–103. https://doi.org/10.5708/EJMH.17.2022.3.7

Newland, R. P., Crnic, K. A., Cox, M. J., Mills-Koonce, W. R., & Family Life Project Key Investigators. (2013). The family model stress and maternal psychological symptoms: Mediated pathways from economic hardship to parenting. *Journal of Family Psychology*,

27(1), 96–105. https://doi.org/10.1037/a0031112

Niederkrotenthaler, T., Reidenberg, D. J., Till, B., & Gould, M. S. (2014). Increasing help-seeking and referrals for individuals at risk for suicide by decreasing stigma. *American Journal of Preventive Medicine*, *47*(3), S235–S243. https://doi.org/10.1016/j.amepre.2014.06.010

Nikolopoulou, K. (2023). *What Is Purposive Sampling? | Definition & Examples.* Scribbr. Retrieved August 15, 2023, from https://www.scribbr.com/methodology/purposive-sampling/.

Nwafor, C. I. (2024). Suicide prevention strategies in Nigeria: Exploring religious roles, insights, and challenges. *Religions*, *15*(1), 64. https://doi.org/10.3390/rel15010064

Nyimbili, F., & Nyimbili, L. (2024). Types of purposive sampling techniques with their examples and applications in qualitative research studies. *British Journal of Multidisciplinary and Advanced Studies*, *5*(1), 90–99. https://doi.org/10.37745/bjmas.2022.0419

Obarisiagbon, O. E., & Abu, I. E. (2021). Assessment of knowledge and attitude towards suicidal ideation and suicidal risk of adults in Benin City, Edo State, Nigeria. *International Journal Of Community Medicine And Public Health*, *8*(12), 5751. https://doi.org/10.18203/2394-6040.ijcmph20214562

O'Connor, R. C., Ferguson, E., Scott, F., Smyth, R., McDaid, D., Park, A.-L., Beautrais, A., & Armitage, C. J. (2017). A brief psychological intervention to reduce repetition of self-harm in patients admitted to hospital following a suicide attempt: A randomized controlled trial. *The Lancet Psychiatry*, *4*(6), 451–460. https://doi.org/10.1016/S2215-0366(17)30129-3

O'Connor, R. C., & Nock, M. K. (2014). The psychology of suicidal behaviour. *The Lancet Psychiatry*, *1*(1), 73–85. https://doi.org/10.1016/S2215-0366(14)70222-6

O'Connor, R. C., & Portzky, G. (2018). Looking to the future: A synthesis of new developments and challenges in suicide research and prevention. *Frontiers in Psychology*, *9*, 2139. https://doi.org/10.3389/fpsyg.2018.02139

O'Connor, R., Kirtley, O. J (2018). The integrated motivational-volitional model of suicidal behaviour. Philos Trans R Soc Lond B Biol Sci. 2018 Sep 5;373(1754):20170268. doi: 10.1098/rstb.2017.0268.

O'Connor, R. (2011). The integrated motivational-volitional model of suicidal behaviour. *Crisis*, 232(6):295–298. doi:10.1027/0227-5910/a000120

Oderinde, S. L., & Oderinde, T. A. (2023). Understanding the determinants of suicidal behaviours among people in southwest Nigeria. *Baltic Journal of Sport and Health Sciences*, *3*(130), 25–31. https://doi.org/10.33607/bjshs.v3i130.1417

O'Donnell, S., & Richardson, N. (2020). No country for middle-aged men? : An intersectional approach to explore sources of psychological distress and patterns of seeking support among middle-aged men considered at risk' of suicide in Ireland. *International Journal of Men's Social and Community Health*, *3*(2), e32–e45. https://doi.org/10.22374/ijmsch.v3i2.32

Oduwaye, L., Ilechukwu, V., & Yadua, O. (2011). *Socio-economic determinants of urban poor housing types in Makoko area, Lagos*. Retrieved from: https://corp.at/archive/CORP2011_152.pdf. Accessed on 10 September 2024

Oexle, N., Feigelman, W., & Sheehan, L. (2020). Perceived suicide stigma, secrecy about suicide loss and mental health outcomes. *Death Studies*, *44*(4), 248–255.

https://doi.org/10.1080/07481187.2018.1539052

Oexle, N., Herrmann, K., Staiger, T., Sheehan, L., Rüsch, N., & Krumm, S. (2019). Stigma and suicidality among suicide attempt survivors: A qualitative study. *Death Studies*, *43*(6), 381–388. https://doi.org/10.1080/07481187.2018.1474286

Office of the High Commissioner for Human Rights. (2026, February 19). *Nigeria: UN experts condemn continued demolitions of informal settlements in Lagos* [Press release]. United Nations. https://www.ohchr.org/en/press-releases/2026/02/nigeria-un-experts-condemn-continued-demolitions-informal-settlements-lagos. Accessed 15 August 2026

Office of the United Nations High Commissioner for Human Rights. (2024, November 28). *Communication to the Government of Nigeria concerning forced evictions and demolitions in the waterfront settlements of Oko Baba and Ayetoro, Lagos* (Reference No. AL NGA 2/2024). United Nations Special Procedures. https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=29518. Accessed 15 August 2026

Ogbolu, R. E., Adepoju, O. A., Ola, B., & Tade, T. (2018). Suicide prevention in Nigeria: A medicoreligious approach. *Nigerian Quarterly Journal of Hospital Medicine*, *28*(3). https://www.ajol.info/index.php/nqjhm/article/view/207271.

Ogbolu, R., Oyatokun, B., Ogunsola, K., Adegbite, T., Tade, T., Olafisoye, O., & Aina, O. (2020a). The pattern of crisis calls to a suicide telephone helpline service in Nigeria. *Annals of Health Research*, *6*(3), 246–257. https://doi.org/10.30442/ahr.0603-01-87

Ogbolu, R. E., Ijadunola, M. Y., Adepoju, O. A., Ola, B. A., Quadri-Asorona, B., Ogundiran, A., Akinyemi, P. A., & Alaba, O. A. (2020b). *Channelling the right path to care: Improving religious leaders' knowledge and beliefs about suicide prevention in South West Nigeria*.

https://doi.org/10.21203/rs.2.22502/v1

Ogundipe, S. (2019). Suicide: Nigeria lacks a national prevention strategy. *Vanguard Newspaper.* Retrieved on August 20, 2022, from www.vanguardngr.com/2019/12/suicide-nigeria-lacks-national-prevention-strategy/

Ogunleye, A. J., Azikiwe, J. C., Aroso, S. O., Tenibiaje, M. O., & Solomon, D. I. (2019). A measure of Aggression and Anxiety as factors of Suicide among undergraduates in a Nigerian university. *IOSR Journal of Humanities and Social Science (IOSR-JHSS)*, *24*(2), 81–87.

Ogunwale, A., Smith, A, Fakorede, O, Ogunlesi, A. (2024). Artificial intelligence and forensic mental health in Africa: a narrative review. Int Rev Psychiatry, 37(1):3–13

Ohayi, S. R. (2019). "Doctor, please don't say he died by suicide": Exploring the burden of suicide survivorship in a developing country. *Egyptian Journal of Forensic Sciences*, *9*(1), 48. https://doi.org/10.1186/s41935-019-0153-3

Ojagbemi, A., Oladeji, B., Abiona, T., & Gureje, O. (2013). Suicidal behaviour in old age—Results from the Ibadan study of ageing. *BMC Psychiatry*, *13*(1), 80. https://doi.org/10.1186/1471-244X-13-80

Okafor, O. S. (2023). Awareness of causes and strategies for prevention of suicide among tertiary school students in Anambra State, Nigeria. *Sapientia Foundation Journal of Education, Sciences and Gender Studies*, *5*(4), 281 – 288. ISSN: 2734 -2514.

O'Keefe, V. M., Tucker, R. P., Cole, A. B., Hollingsworth, D. W., & Wingate, L. R. (2018). Understanding indigenous suicide through a theoretical lens: A review of general, culturally-based, and indigenous frameworks. *Transcultural Psychiatry*, *55*(6), 775–799. https://doi.org/10.1177/1363461518778937

Okeke, A. O., Ezeokana, J. O., & Abamara, N. C. (2020). Age, gender, stress and self-blame as predictors of suicidal ideation among prison inmates in South-East Nigeria. *Social Science Research*, *6*(1). https://journals.aphriapub.com/index.php/SSR/article/view/1429

Okoro, D., Okhakhume, S. (2017). Role of depression and impulsivity as determinants of suicidal ideation among students in Ibadan, Nigeria. *IJSS*, 15(1). doi:10.36108/ijss/7102.51.0190

Okudo, O. C., Obumse, N. A., & Okafor, O. S. (2023). Awareness of causes and strategies for prevention of suicide among tertiary school students in Anambra State, Nigeria. *Sapientia Foundation Journal of Education, Sciences and Gender Studies, 5*(4), 281–288.

Olafimihan, K. O. (2009). *Improvisation in architecture: a critical study of the Makoko fishing community of Lagos, Nigeria* (Doctoral dissertation, Carleton University).

Olajide, O., & Lawanson, T. (2014). Climate change and livelihood vulnerabilities of low-income coastal communities in Lagos, Nigeria. *International Journal of Urban Sustainable Development*, *6*(1), 42–51. https://doi.org/10.1080/19463138.2013.878348

Olalekan, A. A., & Jimoh, R. A. (2021). Barriers in accessing healthcare services by patients with disabilities in Nigerian hospitals. *Gusau International Journal of Management and Social Sciences*, *4*(1), 17–17. https://www.gijmss.com.ng/index.php/gijmss/article/view/27

Olaoye, A. (2013). The role of indigenous languages in national development: A case study of the Nigerian linguistic situation. *International Journal of Applied Linguistics & English Literature*, *2*(3), 29–34. https://doi.org/10.7575/aiac.ijalel.v.2n.3p.29

Olibamoyo, O., Lebimoyo, A., & Adegbite, T. (2023). Evaluation of a Brief Training of Police Constables in Recognizing Suicidal Behaviour in Lagos, Nigeria. *Journal of Behavioural Health,* vol. 12(3), 1–6.

Olibamoyo, O., Ola, B., Coker, O., Adewuya, A., & Onabola, A. (2021). Trends and patterns of suicidal behaviour in Nigeria: Mixed-methods analysis of media reports from 2016 to 2019. *South African journal of psychiatry*, *27*(1), 1-9.

Oliffe, J. L., Hannan-Leith, M. N., Ogrodniczuk, J. S., Black, N., Mackenzie, C. S., Lohan, M. & Creighton, G. (2016). Men's depression and suicide literacy: A nationally representative Canadian survey. *Journal of Mental Health*, *25*(6), 520–526. https://doi.org/10.1080/09638237.2016.1177770

Oloko, A., Fakoya, K., Ferse, S., Breckwoldt, A., & Harper, S. (2022). The challenges and prospects of women fisherfolk in Makoko, Lagos State, Nigeria. *Coastal Management*, *50*(2), 124–141. https://doi.org/10.1080/08920753.2022.2022969

Omeje, A., Ebimgbo, S., Abalogu, D., & Okafor, A. (2022). Perceived reasons for suicidal behaviour among undergraduates in Nigerian Universities: Implications for social work practice. *Journal of Social Work in Developing Societies, 4*(1), 1-17.

Omokhabi, U. S., & Omokhabi, A. A. (2023). Role of social workers and community engagement in suicide prevention in Nigeria. *Rivers State University Journal of Education*, *26*(2), 124–138. https://rsujoe.com.ng/index.php/joe/article/view/187

Omomia, O. A. (2017). Religious Perceptions of Suicide and Implications for Suicidiology Advocacy in Nigeria. *International Journal of History and Philosophical Research*, *5*(2), 34-56. Available online: www.eajournals.org. Accessed on 30 December 2022.

Ongeri, L., Nyawira, M., Kariuki, S. M., Theuri, C., Bitta, M., Penninx, B., Newton, C. R., &

Tijdink, J. (2022). Sociocultural perspectives on suicidal behaviour at the Coast Region of Kenya: An exploratory qualitative study. *BMJ Open*, *12*(4), e056640. https://doi.org/10.1136/bmjopen-2021-056640

Onokerhoraye, A. et al. (2014). *Primary Health Care in Nigeria: Past, Present, and Future Perspectives*, Centre for Population and Environmental Development (CPED). Nigeria. from https://coilink.org/20.500.12592/3vd29w/. Accessed on 3 July 2025.

Onu, S., et al. (2020). Suicide ideation among undergraduates in Nigeria: The predictive role of personality traits and academic stress. International Journal of Innovation Research and Development, 9(2), 17–22.

Onuu, M. and O. Oluwasegun (2015). *Study of road traffic noise pollution and impacts on residents of Ikeja Local Government Area of Lagos State*. https://www.ijser.org/researchpaper/STUDY-OF-ROAD-TRAFFIC-NOISE-POLLUTION-AND-IMPACTS-ON-RESIDENTS-OF-IKEJA.pdf

Onuh, P., Agwu, P., Mbachu, C., Onwujekwe, O., Ensor, T., Elsey, H., & Das, M. (2024). Informal–formal healthcare services delivery nexus in Nigeria's urban slums: A reconnaissance study. *Journal of Social Service Research*, *50*(4), 711–724. https://doi.org/10.1080/01488376.2024.2371859

Onwujekwe, O., Mbachu, C., Onyebueke, V., Ogbozor, P., Arize, I., Okeke, C., Ezenwaka, U., & Ensor, T. (2022). Stakeholders' perspectives and willingness to institutionalize linkages between the formal health system and informal healthcare providers in urban slums in Southeast Nigeria. *BMC Health Services Research*, *22*(1), 583. https://doi.org/10.1186/s12913-022-08005-2

Onyemelukwe, C. (2020). Long overdue: Decriminalization of attempted suicide in Nigeria. *Criminal Law Forum*, *31*(2), 225–249. https://doi.org/10.1007/s10609-020-09392-z

Oquendo, M. A., & Porras-Segovia, A. (2020). Barriers for the research, prevention, and treatment of suicidal behaviour. In E. Baca-Garcia (Ed.), *Behavioural Neurobiology of Suicide and Self-Harm* (Vol. 46, pp. 25–40). Springer International Publishing. https://doi.org/10.1007/7854_2020_159

Oquendo, M. A., Sullivan, G. M., Sudol, K., Baca-Garcia, E., Stanley, B. H., Sublette, M. E., & Mann, J. J. (2014). Toward a biosignature for suicide. *American Journal of Psychiatry*, *171*(12), 1259–1277. https://doi.org/10.1176/appi.ajp.2014.14020194

Ormston, Rachel, et al (2014). "The Foundations of Qualitative Research." Qualitative Research Practice: A guide for Social Science Students and Researchers, edited by Ritchie, Jane, et al., Sage.

Osafo, J., Akotia, C. S., Quarshie, E. N.-B., Andoh-Arthur, J., & Boakye, K. E. (2019). Community leaders' attitudes towards and perceptions of suicide and suicide prevention in Ghana. *Transcultural Psychiatry*, *56*(3), 529–551. https://doi.org/10.1177/1363461518824434

Osafo, J., Asante, K. O., & Akotia, C. S. (2020). Suicide prevention in the African region. *Crisis*, *41*(Supplement 1), S53–S71. https://doi.org/10.1027/0227-5910/a000668

Osafo, J., Knizek, B. L., Akotia, C. S., & Hjelmeland, H. (2013). Influence of religious factors on attitudes toward suicidal behaviour in Ghana. Journal of Religion and Health, 52(2), 488–504.

Osafo, J., Hjelmeland, H., Akotia, C. S., & Knizek, B. L. (2011). Social injury: An interpretative phenomenological analysis of the attitudes towards suicide of lay persons in Ghana.

International Journal of Qualitative Studies on Health and Well-being, 6(4), 8708. https://doi.org/10.3402/qhw.v6i4.8708

Oshodi, Y. O., Aina, O. F., & Onajole, A. T. (2020). Substance use among secondary school students in Lagos, Nigeria: Prevalence and associated factors. *Journal of Addiction*, 15(3), 234–245

Oweibia, M., Egberipou, T., Timighe, G. C., Ogbe, P. D., Elemuwa, U. G., & Wilson, T. R. (2025). *Drug abuse in Nigeria: the public health impact of collective actions and inactions: A systematic review*. https://doi.org/10.1101/2025.05.13.25327537

Owolabi, T. O. S., & Nurudeen, N. A. (2020). Indigenous language media and communication for health purposes in the digital age: In K. O. Oyesomi & A. Salawu (Eds.), *Advances in Human Services and Public Health* (pp. 123–145). IGI Global. https://doi.org/10.4018/978-1-7998-2091-8.ch007

Oyafunke-Omoniyi, C. O., Aborisade, R. A., Adeleke, O. A., Bawalla, O. G., Akindele-Oscar, Y., Olayinka-Aliu, D., Adeyemo, O., & Adenuga, A. O. (2022). Exploring the psychosocial causes of suicide in southwest Nigeria. *Covenant Journal of Business and Social Sciences*. https://doi.org/10.20370/cjbss.v13i1.2992

Oyetunji, T. P., Arafat, S. M. Y., Famori, S. O., Akinboyewa, T. B., Afolami, M., Ajayi, M. F., & Kar, S. K. (2021). Suicide in Nigeria: Observations from the content analysis of newspapers. *General Psychiatry*, *34*(1), e100347. https://doi.org/10.1136/gpsych-2020-100347

Oyinlola, R. (2025). Protecting Patients' Rights Under the National Mental Health Act 2021: Challenges in Implementation and Enforcement. *Available at SSRN 5724962*.

Padmanathan, P., Biddle, L., Hall, K., Scowcroft, E., Nielsen, E., & Knipe, D. (2019). Language

use and suicide: An online cross-sectional survey. *PLOS ONE*, *14*(6), e0217473. https://doi.org/10.1371/journal.pone.0217473

Park, G.-R., & Kim, J. (2023). Cumulative exposure to poor housing conditions and psychological well-being: Does the relationship differ for young and middle-aged adults and older adults? *Aging & Mental Health*, *27*(8), 1584–1591. https://doi.org/10.1080/13607863.2022.2102145

Parkar, S. R., Nagarsekar, B., & Weiss, M. G. (2009). Explaining suicide in an urban slum of Mumbai, India: A sociocultural autopsy. *Crisis*, *30*(4), 192–201. https://doi.org/10.1027/0227-5910.30.4.192

Participedia. (2019). The Makoko Sustainable Regeneration Plan. https://participedia.net/case/the-Makoko-sustainable-regeneration-plan. Accessed on 6 July 2025.

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., … UnÜtzer, Jü. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet*, *392*(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative Social Work*, *1*(3), 261–283. https://doi.org/10.1177/1473325002001003636

Payne, M. W. (1992). Akiwowo, orature and divination: Approaches to the construction of an emic sociological paradigm of society. *Sociological Analysis*, *53*(2), 175.

https://doi.org/10.2307/3711122

Peltzer, K., Mngqundaniso, N., & Petros, G. (2006). A controlled study of an hiv/aids/STI/TB intervention with traditional healers in KwaZulu-Natal, South Africa. *AIDS and Behaviour*, *10*(6), 683–690. https://doi.org/10.1007/s10461-006-9110-x

Peterson, T. J. (2023). *Strength-based approach to therapy: how it works, examples and what to expect*. https://www.choosingtherapy.com/strength-based-approach/. Accessed in July 2025

Phillippi, J., & Lauderdale, J. (2018). A guide to field notes for qualitative research: Context and conversation. *Qualitative Health Research*, *28*(3), 381–388. https://doi.org/10.1177/1049732317697102

Pinto, A., Whisman, M. A., & Conwell, Y. (1998). Reasons for living in a clinical sample of adolescents. *Journal of Adolescence*, *21*(4), 397–405. https://doi.org/10.1006/jado.1998.0173

Pirani, S., Qureshi, A., Khan, M. Z., Aslam, M., & Khan, M. M. (2023). Assessing knowledge, attitudes, and practices of emergency department staff towards patients with suicidal behaviours in Pakistan. *Asian Journal of Psychiatry*, *80*, 103420. https://doi.org/10.1016/j.ajp.2022.103420

Pirkis, J., Rossetto, A., Nicholas, A., Ftanou, M., Robinson, J., & Reavley, N. (2019). Suicide prevention media campaigns: A systematic literature review. *Health Communication*, *34*(4), 402–414. https://doi.org/10.1080/10410236.2017.1405484

Pirkis, J., Too, L. S., Spittal, M. J., Krysinska, K., Robinson, J., & Cheung, Y. T. D. (2015). Interventions to reduce suicides at suicide hotspots: A systematic review and meta-analysis. *The Lancet Psychiatry*, *2*(11), 994–1001. https://doi.org/10.1016/S2215-

0366(15)00266-7

Pisani, A. R., Cross, W. F., & Gould, M. S. (2011). The assessment and management of suicide risk: State of workshop education. *Suicide and Life-Threatening Behavior*, *41*(3), 255–276. https://doi.org/10.1111/j.1943-278X.2011.00026.x

Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *The Lancet Psychiatry*, *1*(1), 86–94. https://doi.org/10.1016/S2215-0366(14)70224-X

Plackett, R., Steward, J.-M., Kassianos, A. P., Duenger, M., Schartau, P., Sheringham, J., Cooper, S., Biddle, L., Kidger, J., & Walters, K. (2025). The effectiveness of social media campaigns in improving knowledge and attitudes toward mental health and help-seeking in high-income countries: Scoping review. *Journal of Medical Internet Research*, *27*, e68124. https://doi.org/10.2196/68124

Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (10th ed.). Philadelphia, PA: Wolters Kluwer.

Pompili, M., Lester, D., Forte, A., Seretti, M. E., Erbuto, D., Lamis, D. A., Amore, M., & Girardi, P. (2014). Bisexuality and suicide: A systematic review of the current literature. *The Journal of Sexual Medicine*, *11*(8), 1903–1913. https://doi.org/10.1111/jsm.12581

Prayson, R. A., Bierer, S. B., & Dannefer, E. F. (2016). Medical student resilience strategies: A content analysis of medical students' portfolios. *Perspectives on Medical Education*, *6*(1), 29–35. https://doi.org/10.1007/S40037-016-0313-1

Price, S.D, Callahan, J.L (2017). Religious attendance serves as a protective variable against suicidal ideation during treatment. *Pastoral Psychol*., 66(1):103-115. doi:10.1007/s11089-016-0725-1

Pridmore, S., Varbanov, S., Aleksandrov, I., & Shahtahmasebi, S. (2016). Social attitudes to suicide and suicide rates. *Open Journal of Social Sciences*, *04*(10), 39–58. https://doi.org/10.4236/jss.2016.410004

Pryor, R., Wayland, S., & Maple, M. (2024). Suicide prevention and intervention education in Australian social work qualifying courses: Are students adequately prepared for the workforce? *Social Work Education*, *43*(9), 2405–2418. https://doi.org/10.1080/02615479.2023.2258140

Public Health Agency of Canada. (2024). The National Suicide Prevention Action Plan 2024-2027. https://www.canada.ca/en/public-health/services/publications/diseases-conditions/national-suicide-prevention-action-plan-2024-2027.html. Accessed on March 22, 2026

Ramchand, R., Ahluwalia, S. C., Xenakis, L., Apaydin, E., Raaen, L., & Grimm, G. (2017). A systematic review of peer-supported interventions for health promotion and disease prevention. *Preventive Medicine*, *101*, 156–170. https://doi.org/10.1016/j.ypmed.2017.06.008

Raschke, N., Mohsenpour, A., Aschentrup, L., Fischer, F., & Wrona, K. J. (2022). Socioeconomic factors associated with suicidal behaviours in South Korea: systematic review on the current state of evidence. *BMC Public Health*, *22*(1), 129. https://doi.org/10.1186/s12889-022-12498-1

Rasool A. (2022). The Role of Family in Fostering Mental Health: Nurturing Practices and Their Long-Term Effects. *Journal of Business, IT, and Social Science.* DOI: https://doi.org/10.51470/BITS.2022.01.01.01

Rasnayake, S., Navrátil, P., Orock, A. N., Chandrasekara, D., Wanniarachchi, I., & Gamage, T.

(2024). A systematic review of the role of social work in dealing with suicide. *Kontakt*, *26*(4), 383–391. https://doi.org/10.32725/kont.2024.053

Reccord, C., Power, N., Hatfield, K., et al. (2021). Rural–urban differences in suicide mortality: an observational study in Newfoundland and Labrador, Canada: différences de la mortalité par suicide en milieu rural-urbain: une étude observationnelle à Terre-Neuve-et-Labrador, Canada. *Can J Psychiatry*, 66(10):918–928. doi:10.1177/0706743721990315

Renaud, J., MacNeil, S. L., Vijayakumar, L., Spodenkiewicz, M., Daniels, S., Brent, D. A., & Turecki, G. (2022). Suicidal ideation and behaviour in youth in low- and middle-income countries: A brief review of risk factors and implications for prevention. *Frontiers in Psychiatry*, *13*, 1044354. https://doi.org/10.3389/fpsyt.2022.1044354

Resnicow, K., & Ross-Gaddy, D. (1997). Development of a racial identity scale for low-income African Americans. *Journal of Black Studies*, *28*(2), 239–254. https://doi.org/10.1177/002193479702800206

Richardson, T., Elliott, P., & Roberts, R. (2013). The relationship between personal unsecured debt and mental and physical health: A systematic review and meta-analysis. *Clinical Psychology Review*, *33*(8), 1148–1162. https://doi.org/10.1016/j.cpr.2013.08.009

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian E-Journal for the Advancement of Mental Health*, *4*(3), 218–251. https://doi.org/10.5172/jamh.4.3.218

Rickwood, D., & Thomas, (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behaviour Management*, 173. https://doi.org/10.2147/PRBM.S38707

Riise, J., & Adeyemi, K. (2015). Case study: Makoko floating school. *Current Opinion in*

Environmental Sustainability, *13*, 58–60. https://doi.org/10.1016/j.cosust.2015.02.002

Rimkeviciene, J., Hawgood, J., O'Gorman, J., & De Leo, D. (2015). Personal stigma in suicide attempters. *Death Studies*, *39*(10), 592–599. https://doi.org/10.1080/07481187.2015.1037972

Ritchie, H. (2025). Bans on highly toxic pesticides could be an effective way to save lives from suicide. Published online at OurWorldInData.org. https://ourworldindata.org/pesticide-bans-suicide-prevention. Accessed on 5 August 2025.

Robinson J, Bailey E, Witt K, et al. (2018). What works in youth suicide prevention? A systematic review and meta-analysis. *EClinicalMedicine*,4-5:52-91. doi: 10.1016/j.eclinm.2018.10.004

Robinson, J., Cox, G., Bailey, E., Hetrick, S., Rodrigues, M., Fisher, S., & Herrman, H. (2016). Social media and suicide prevention: A systematic review. *Early Intervention in Psychiatry*, *10*(2), 103–121. https://doi.org/10.1111/eip.12229

Robinson, J., Cox, G., Malone, A., Williamson, M., Baldwin, G., Fletcher, K., & O'Brien, M. (2013). A systematic review of school-based interventions aimed at preventing, treating, and responding to suicide- related behaviour in young people. *Crisis*, *34*(3), 164–182. https://doi.org/10.1027/0227-5910/a000168

Roger, K., Bone, T., Heinonen, T., Schwartz, K., Slater, J., & Thakrar, S. (2018). Exploring identity: What we do as qualitative researchers. *The Qualitative Report*, *23*(3), 532–546. https://doi.org/10.46743/2160-3715/2018.2923

Rojas, Y. (2021). Financial indebtedness and suicide: A 1-year follow-up study of a population registered at the Swedish Enforcement Authority. *International Journal of Social Psychiatry*, *68*(7), 1445–1453. https://doi.org/10.1177/00207640211036166

Rubin, H. J., & Rubin, I. S. (2005). Qualitative interviewing: The art of hearing data (2nd ed.). Thousand Oaks, CA: Sage. Rudd, M. D. (2008). Suicide warning signs in clinical practice. *Current Psychiatry Reports*, *10*(1), 87–90. https://doi.org/10.1007/s11920-008-0015-4

Rudd, M. (2008). Suicide warning signs in clinical practice. *Curr Psychiatry Rep* 10, 87–90. https://doi.org/10.1007/s11920-008-0015-4

Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behaviour*, *36*(3), 255–262. https://doi.org/10.1521/suli.2006.36.3.255

Russell-Bennett R., Kelly N., Letheren K., Chell K. (2023). The 5R Guidelines for a strengths-based approach to co-design with customers experiencing vulnerability. *International Journal of Market Research*, 65(2-3):167–182. doi:10.1177/14707853231151605

Ruzhenkov, V. A., Ruzhenkova, V. V., Boeva, A. V., & Moskvitina, U. S. (2015). Stigmatization and self-stigmatization by persons with mental disorders and suicidal behaviour. *Research Journal of Medical Sciences*, *9*(4), 168–170.

Rytilä-Manninen, M., Haravuori, H., Fröjd, S., Marttunen, M., & Lindberg, N. (2018). Mediators between adverse childhood experiences and suicidality. *Child Abuse & Neglect*, *77*, 99–109. https://doi.org/10.1016/j.chiabu.2017.12.007

Sakashita, T., & Oyama, H. (2019). Developing a hypothetical model for suicide progression in older adults with universal, selective, and indicated prevention strategies. *Frontiers in Psychiatry*, *10*, 161. https://doi.org/10.3389/fpsyt.2019.00161

Salami, K. K., & Onuegbu, C. M. (2019). Religion, Health and Turbulence of Healing Craft in the Nigerian Context. *Ibadan Journal of Sociology*, *9*, 94–124.

https://www.researchgate.net/profile/Kabiru-Salami/publication/335175573_Religion_Health_and_Turbulence_of_Healing_Craft_in_the_Nigerian_Context/links/5d5524c292851cb74c6cce9e/Religion-Health-and-Turbulence-of-Healing-Craft-

Salawu, A. (2006). Indigenous language media: A veritable tool for African language learning. *Journal of Multicultural Discourses*, *1*(1), 86–95. https://doi.org/10.1080/10382040608668533

Saleebey, D. (2006). The strengths perspective: Possibilities and problems. *The strengths perspective in social work practice*, 279–303.

Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work*, *41*(3), 296–305.

Saleebey, D. (1992). 'Introduction: Power in the People', in *The strengths perspective in social work practice,* (ed.) D. Saleebey, New York: Longman.

Sameroff, A. J. (1989). Commentary: General systems and the regulation of development. In M. R. Gunnar & E. Thelen (Eds.), *Systems and development* (pp. 219–235). Lawrence Erlbaum Associates, Inc. Sampson, D. L., Cootes, H., Paton, E., Peprah, J., Simmonette, D., Heinsch, M., Kay-Lambkin, F., & Skehan, J. (2024). Words and images matter: Perspectives on suicide, mental health concerns and alcohol and other drug use depiction. *Healthcare*, *12*(21), 2120. https://doi.org/10.3390/healthcare12212120

Sampson, D.L, Cootes, H, Paton, E, et al. Words and images matter: perspectives on suicide, mental health concerns and alcohol and other drug use depiction. *Healthcare*, 12(21):2120. doi:10.3390/healthcare12212120

Sanders, S., Jacobson, J., Ting, L. (2008). Preparing for the inevitable: training social workers to

cope with client suicide. *Journal of Teaching in Social Work*, 28(1-2):1–18. doi:10.1080/08841230802178821

Santamaría-García, H., Báez, S., Gómez, C., Rodríguez-Villagra, O., Huepe, D., Portela, M., Reyes, P., Klahr, J., Matallana, D., & Ibáñez, A. (2020). The role of social cognition skills and social determinants of health in predicting symptoms of mental illness. *Translational Psychiatry*, *10*(1), 165. https://doi.org/10.1038/s41398-020-0852-4

Sarason, S. B. (1974). *The psychological sense of community: Prospects for a community psychology.* Brookline Books.

Savin-Baden, M., & Howell Major, C. (2023). *Qualitative research: The essential guide to theory and practice* (1st ed.). Routledge. https://doi.org/10.4324/9781003377986

Saxe, A. (2017). The theory of intersectionality: A new lens for understanding the barriers faced by autistic women. *Canadian Journal of Disability Studies*, *6*(4), 153–178. https://doi.org/10.15353/cjds.v6i4.386

Scott, E. (2023, June 5). *Types of social support*. Verywell Mind. https://www.verywellmind.com/types-of-social-support-3144960

Scheyett, A. (2020). Suicide prevention: Clinic, community, classroom. *Social Work*, *65*(2), 101–103. https://doi.org/10.1093/sw/swaa003

Seale, H., Harris-Roxas, B., Mustafa, K., & McDermid, P. (2023). Communication and engagement of community members from ethnic minorities during COVID-19: A scoping review. *BMJ Open*, *13*(6), e069552. https://doi.org/10.1136/bmjopen-2022-069552

Sekoni, O., Mall, S., & Christofides, N. (2022). The relationship between protective factors and common mental disorders among female urban slum dwellers in Ibadan, Nigeria. *PLOS*

ONE, *17*(2), e0263703. https://doi.org/10.1371/journal.pone.0263703

Shaw, R. J., Atkin, K., Bécares, L., Albor, C. B., Stafford, M., Kiernan, K. E., Nazroo, J. Y., Wilkinson, R. G., & Pickett, K. E. (2012). Impact of ethnic density on adult mental disorders: Narrative review. *British Journal of Psychiatry*, *201*(1), 11–19. https://doi.org/10.1192/bjp.bp.110.083675

Sheehan, L. L., Corrigan, P. W., Al-Khouja, M. A., & the Stigma of Suicide Research Team. (2017). Stakeholder perspectives on the stigma of suicide attempt survivors. *Crisis*, *38*(2), 73–81. https://doi.org/10.1027/0227-5910/a000413

Sheftall, A. H., Mathias, C. W., Furr, R. M., & Dougherty, D. M. (2013). Adolescent attachment security, family functioning, and suicide attempts. *Attachment & Human Development*, *15*(4), 368–383. https://doi.org/10.1080/14616734.2013.782649

Sher, L. (2020). The impact of the COVID-19 pandemic on suicide rates. *QJM: An International Journal of Medicine*, *113*(10), 707–712. https://doi.org/10.1093/qjmed/hcaa202

Sidana, A., Gupta, S., & Saroye, R. (2020). Knowledge and understanding of suicide in rural and suburban community of Chandigarh. *Indian Journal of Social Psychiatry*, *36*(4), 351. https://doi.org/10.4103/ijsp.ijsp_46_20

Simon, G. E., Rutter, C. M., Peterson, D., Oliver, M., Whiteside, U., Operskalski, B., & Ludman, E. J. (2013). Does response on the PHQ-9 depression questionnaire predict subsequent suicide attempt or suicide death? *Psychiatric Services*, *64*(12), 1195–1202. https://doi.org/10.1176/appi.ps.201200587

Singer, J. B., Erbacher, T. A., & Rosen, P. (2019). School-based suicide prevention: A framework for evidence-based practice. *School Mental Health*, *11*(1), 54–71. https://doi.org/10.1007/s12310-018-9245-8

Sisask, M., & Värnik, A. (2012). Media roles in suicide prevention: A systematic review. *International Journal of Environmental Research and Public Health*, *9*(1), 123–138. https://doi.org/10.3390/ijerph9010123

Smith, J., & Noble, H. (2025). Understanding sources of bias in research. *Evidence-Based Nursing*, *28*(3), 137–139. https://doi.org/10.1136/ebnurs-2024-104231

Smith, T. B., & Griner, D. (2006). Culturally Adapted Mental Health Interventions: A Meta-Analytic Review. *Faculty Publications*. 279. https://scholarsarchive.byu.edu/facpub/279

Spilsbury, J. C., & Korbin, J. E. (2013). Social networks and informal social support in protecting children from abuse and neglect. *Child Abuse & Neglect*, *37*, 8–16. https://doi.org/10.1016/j.chiabu.2013.10.027

Standley, C. J. (2019). *Social support as a protective factor for youth suicide: An intersectional and socioecological approach - ProQuest*. https://www.proquest.com/docview/2246478843/abstract/B80E02505EAD4415PQ/1

Standley, C. J. (2022). Expanding our paradigms: Intersectional and socioecological approaches to suicide prevention. *Death Studies*, *46*(1), 224–232. https://doi.org/10.1080/07481187.2020.1725934

Stone, D., Holland, K., Holland, B., Crosby, A., Davis, S., & Wilkins, N. (2017). *Preventing suicide: A technical package of policies, programs, and practice*. National Center for Injury Prevention and Control (U.S.). Division of Violence Prevention. https://doi.org/10.15620/cdc.44275

Stuart, H. (2016). Reducing the stigma of mental illness. *Global Mental Health*, *3*, e17. https://doi.org/10.1017/gmh.2016.11

Subbaraman, R., Nolan, L., Shitole, T., Sawant, K., Shitole, S., Sood, K., Nanarkar, M., Ghannam, J., Betancourt, T. S., Bloom, D. E., & Patil-Deshmukh, A. (2014). The psychological toll of slum living in Mumbai, India: A mixed methods study. *Social Science & Medicine*, *119,* 155–169. https://doi.org/10.1016/j.socscimed.2014.08.021

Sudhinaraset, M., Ingram, M., Lofthouse, H. K., & Montagu, D. (2013). What is the role of informal healthcare providers in developing countries? A systematic review. *PLoS ONE*, *8*(2), e54978. https://doi.org/10.1371/journal.pone.0054978

Suicide Prevention Australia. (2014). Communities matter: A toolkit for community-driven suicide prevention (a resource for small towns), consultation version 1.0. 2014. Suicide Prevention Australia; Sydney. https://www.wairarapa.dhb.org.nz/news-and-publications/reports-and-publications/publications/communities-matter-suicide-prevention-toolkit.pdf

Sullivan, W. P., & Rapp, C. (2002). Environmental context, opportunity, and the process of recovery: The role of strengths-based practice and policy. In D. Saleebey (Ed.), *The strengths perspective in social work practice* (3rd ed.; pp. 247–263). New York: Longman.

Sullivan, W. P., & Fisher, B. J. (1994). Intervening for success: Strengths-based case management and successful aging. *Journal of Gerontological Social Work*, *22*(1–2), 61–74. https://doi.org/10.1300/J083V22N01_05

Swahn, M. H., Palmier, J. B., Kasirye, R., & Yao, H. (2012). Correlates of suicide ideation and attempt among youth living in the slums of Kampala. *International Journal of Environmental Research and Public Health*, *9*(2), 596–609. https://doi.org/10.3390/ijerph9020596

Swope, C. B., & Hernández, D. (2019). Housing as a determinant of health equity: A conceptual model. *Social Science & Medicine*, *243*, 112571. https://doi.org/10.1016/j.socscimed.2019.112571

Tan, N. Q. P., & Cho, H. (2019). Cultural appropriateness in health communication: A review and A revised framework. *Journal of Health Communication*, *24*(5), 492–502. https://doi.org/10.1080/10810730.2019.1620382

Teherani, A., Martimianakis, T., Stenfors-Hayes, T., Wadhwa, A., & Varpio, L. (2015). Choosing a qualitative research approach. *Journal of Graduate Medical Education*, *7*(4), 669–670. https://doi.org/10.4300/JGME-D-15-00414.1

The Clear Quran: A thematic English translation (2nd ed., M. Khattab, Trans.). (2016). Book of Signs Foundation.

Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness*. Oxford University Press.

Thomas, D. R. (2017). Feedback from research participants: Are member checks useful in qualitative research? *Qualitative Research in Psychology*, *14*(1), 23–41. https://doi.org/10.1080/14780887.2016.1219435

Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry*, *15*(3), 276–286. https://doi.org/10.1002/wps.20349

Threlfall, J., Jobling, H., & Graham, K. (2025). The role of informal social networks in supporting parents with learning disabilities: A systematic review. *British Journal of Learning Disabilities*, *53*(2), 230–247. https://doi.org/10.1111/bld.12628

Till, B., Sonneck, G., Baldauf, G., Steiner, E., & Niederkrotenthaler, T. (2013). Reasons to love

life: Effects of a suicide-awareness campaign on the utilization of a telephone emergency line in Austria. *Crisis*, *34*(6), 382–389. https://doi.org/10.1027/0227-5910/a000212

Tolulope, O., Olubukola, O., & Olutayo, A. (2021). Prevalence and factors associated with suicidal behaviours in a cross-sectional sample of Nigerian young adults. *Taiwanese Journal of Psychiatry*, *35*(3), 117–123. https://doi.org/10.4103/TPSY.TPSY_24_21

Tondo, L., Albert, M. J., & Baldessarini, R. J. (2006). Suicide rates in relation to health care access in the United States: An ecological study. *The Journal of Clinical Psychiatry, 67(4),* 517–523. https://www.psychiatrist.com/wp-content/uploads/2021/02/18010_suicide-rates-relation-health-care-access-united-states.pdf

Triandis, H. C. (1995). *Individualism & Collectivism: New Directions in Social Psychology.* Boulder, CO: Westview Press Inc.

Tsai, J., Snitkin, M., Trevisan, L., Kraus, S. W., Pietrzak, R. H. (2020). Awareness of suicide prevention programs among u. S. Military veterans. *Adm Policy Ment Health*, 47(1):115-125. doi:10.1007/s10488-019-00975-6

Tsai, W., Lin L., Chang H., Yu L., Chou, M. (2011). The effects of the gatekeeper suicide-awareness program for nursing personnel: the effects of the gatekeeper suicide-awareness program for nursing personnel. *Perspectives in Psychiatric Care*, 47(3):117-125. doi:10.1111/j.1744-6163.2010.00278.x

Turecki, G. (2016). Preventing suicide: Where are we? *The Lancet Psychiatry*, *3*(7), 597–598. https://doi.org/10.1016/S2215-0366(16)30068-2

Tyson, P., Law, C., Reed, S., Johnsey, E., Aruna, O., & Hall, S. (2016). Preventing suicide and self-harm: Evaluating the efficacy of a helpline from a service user and helpline worker

perspective. *Crisis*, *37*(5), 353–360. https://doi.org/10.1027/0227-5910/a000390

Udengwu, N., Ukonu, M. O., & Department of Mass Communication, University of Nigeria, Nsukka. (2022). Influences of social integrative factors on perception of suicide among university students in Southeast Nigeria. *Rupkatha Journal on Interdisciplinary Studies in Humanities*, *14*(4). https://doi.org/10.21659/rupkatha.v14n4.07

Ugochukwu, O., Mbaezue, N., Lawal, S. A., Azubogu, C., Sheikh, T. L., & Vallières, F. (2020). The time is now: Reforming Nigeria's outdated mental health laws. *The Lancet Global Health*, *8*(8), e989–e990. https://doi.org/10.1016/S2214-109X(20)30302-8

UN-Habitat (2019). Annual Progress Report. https://unhabitat.org/sites/default/files/2020/03/annual_report_2019.pdf/. Accessed on 5 January 2025.

United Nations Human Settlements Programme (UN-Habitat), (2003). The Challenge of Slums: Global Report on Human Settlements. London: Earthscan Publications. https://unhabitat.org/sites/default/files/download-manager-files/The%20Challenge%20of%20Slums%20-%20Global%20Report%20on%20Human%20Settlements%202003.pdf

Urigwe, S. E. (2010). Understanding mental illness in Nigeria: Bringing culture and traditional medicine into mental health policy. *Texas Medical Center Dissertations (via ProQuest)*, 1–66. https://digitalcommons.library.tmc.edu/dissertations/AAI1495488

Uriri & Makanju (2019). A Socio-Economic Profiling of Households Livelihood and Vulnerability at Urban Slum/Blighted Communities in Lagos: A Case Study of Makoko. *International Journal of Research and Innovation in Social Science (IJRISS)*, vol. 3 (8). ISSN 2454-6186.

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012, September). *2012 National Strategy for Suicide Prevention: Goals and objectives for action.* Washington, DC: HHS. http://www. surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf. Accessed on 8 August 2025.

U.S. Department of Veterans Affairs. (2018). VA national suicide data report 2005–2015. Washington, DC. https://www.mentalhealth.va.gov/docs/data-sheet. s/OMHSP_National_Suicide_Data_Report_2005-2015_06-14- 18_508-compliant.pdf. Accessed on 6 September 2024.

Uwakwe, R., Oladeji, B. D., & Gureje, O. (2012). Traumatic events and suicidal behaviour in the Nigerian survey of mental health and well-being. *Acta Psychiatrica Scandinavica*, *126*(6), 458–466. https://doi.org/10.1111/j.1600-0447.2012.01852.x

Van Der Watt, A. S. J., Nortje, G., Kola, L., Appiah-Poku, J., Othieno, C., Harris, B., Oladeji, B. D., Esan, O., Makanjuola, V., Price, L. N., Seedat, S., & Gureje, O. (2017). Collaboration between biomedical and complementary and alternative care providers: Barriers and pathways. *Qualitative Health Research*, *27*(14), 2177–2188. https://doi.org/10.1177/1049732317729342

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, 117(2), 575.https://doi.org/10.1037/a0018697

Vannoy, S. D., Mauer, B., Kern, J., Girn, K., Ingoglia, C., Campbell, J., Galbreath, L., & Unützer, J. (2011). A learning collaborative of CMHCS and CHCS to support integration of behavioural health and general medical care. *Psychiatric Services*, *62*(7), 753–758.

https://doi.org/10.1176/ps.62.7.pss6207_0753

Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C., & Rees, C. E. (2017). Shedding the cobra effect: Problematizing thematic emergence, triangulation, saturation and member checking. *Medical Education*, *51*(1), 40–50. https://doi.org/10.1111/medu.13124

Venerandi, A., Mottelson, J., & Porta, S. (2025). Urban form of settlements on water: A morphometric comparison between Makoko and Venice. In M. Hanzl, A. A. Kantarek, A. Zaguła, Ł. Musiaka, & T. Figlus (Eds.), *Urban Morphology versus Urban Redevelopment and Revitalization* (pp. 589–609). Springer Nature Switzerland. https://doi.org/10.1007/978-3-031-77752-3_29

Vijayakumar, L., Pathare, S., Jain, N., Nardodkar, R., Pandit, D., Krishnamoorthy, S., ... & Shields-Zeeman, L. (2020). Implementation of a comprehensive surveillance system for recording suicides and attempted suicides in rural India. *BMJ open*, *10*(11), e038636.

Vijayakumar L, Kumar M.S., Vijayakumar V. (2011). Substance use and suicide. *Curr Opin Psychiatry*, 24:197–202.

Virk, A., Nelson, E.U., & Dele-Adedeji, I. (2023). The challenge of youth unemployment in Nigeria. *Journal of International and Comparative Social Policy*, *39*(3), 319–329. https://doi.org/10.1017/ics.2024.4

Virupaksha, H. G., Muralidhar, D., & Ramakrishna, J. (2016). Suicide and suicidal behaviour among transgender persons. *Indian Journal of Psychological Medicine*, *38*(6), 505–509. https://doi.org/10.4103/0253-7176.194908

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, J.-M. E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and opportunities in global mental health: A research-to-practice perspective. *Current*

Psychiatry Reports, *19*(5), 28. https://doi.org/10.1007/s11920-017-0780-z

Wallace, M., Miller, V. J., Fields, N. L., Xu, L., & Mercado-Sierra, M. A. (2021). Empirically evaluated suicide prevention program approaches for older adults: A review of the literature from 2009-2021. *Journal of Gerontological Social Work*, *64*(5), 480–498. https://doi.org/10.1080/01634372.2021.1907495

Wasserman, D., Iosue, M., Wuestefeld, A., & Carli, V. (2020). Adaptation of evidence-based suicide prevention strategies during and after the COVID-19 pandemic. *World Psychiatry*, *19*(3), 294–306. https://doi.org/10.1002/wps.20801

Waszak, P. M., Opalko, J., Olszańska, N., & Zagożdżon, P. (2025). Anti-suicidal effects of Lithium, ketamine, and clozapine—A 10-Year Systematic Review. *Pharmaceuticals*, *18*(5), 742. https://doi.org/10.3390/ph18050742

Weissinger, G., Myhre, K., Ruan-Iu, L., Van Fossen, C., & Diamond, G. (2023). Adolescent suicide risk, firearm access, and family functioning: Screening in primary care. *Families, Systems, & Health*, *41*(1), 16–25. https://doi.org/10.1037/fsh0000680

Wetzstein, S. (2017). The global urban housing affordability crisis. *Urban Studies*, *54*(14), 3159–3177. https://doi.org/10.1177/0042098017711649

Wilde, E. J. D. (2002). Qualitative research in suicidology: Still a well-disguised blessing? *Archives of Suicide Research*, *6*(1), 55–59. https://doi.org/10.1080/13811110213126

Willging, C. E., Green, A. E., & Ramos, M. M. (2016). Implementing school nursing strategies to reduce LGBTQ adolescent suicide: A randomized cluster trial study protocol. *Implementation Science*, *11*(1), 145. https://doi.org/10.1186/s13012-016-0507-2

Williams S.A., Baldeh M., Bah A.J., Dennis F., Robinson D.R, Adeniyi Y.C (2025). Pathways to mental health services across local health systems in sub-Saharan Africa: Findings from a

systematic review. Wagner RG, ed. *PLoS One*, 20(6):e0324064. doi: 10.1371/journal.pone.0324064

Williams, A. J., Maguire, K., Morrissey, K., Taylor, T., & Wyatt, K. (2020). Social cohesion, mental well-being and health-related quality of life among a cohort of social housing residents in Cornwall: A cross-sectional study. *BMC Public Health*, *20*(1), 985. https://doi.org/10.1186/s12889-020-09078-6

Wilkinson, S. T., Trujillo Díaz, D., Rupp, Z. W., et al. (2023). Pharmacological and somatic treatment effects on suicide in adults: A systematic review and meta-analysis. *Focus*, *21*(2), 197–208. https://doi.org/10.1176/appi.focus.23021006

Wilson, C., Janes, G., & Williams, J. (2022). Identity, positionality and reflexivity: Relevance and application to research paramedics. *British Paramedic Journal*, *7*(2), 43–49. https://doi.org/10.29045/14784726.2022.09.7.2.43

Wilson, H., & Hutchinson, S. (1991). Triangulation of Qualitative Methods: Heideggerian Hermeneutics and Grounded Theory. Qualitative Health Research, 1(2), 263-276. doi:10.1177/104973239100100206

Wong, M. L. L., & Liu, S. (2024). The role of online social networking sites in facilitating friendships and adaptation among international students in Malaysia. *International Journal of Intercultural Relations*, *99*, 101942. https://doi.org/10.1016/j.ijintrel.2024.101942

Woodward, W. R. (1982). The “discovery” of social behaviourism and social learning theory, 1870–1980. *American Psychologist*, *37*(4), 396–410. https://doi.org/10.1037/0003-066X.37.4.396

World Bank. (2023). Nigeria Data. https://data.worldbank.org/country/nigeria. Accessed on 5 January 2025.

World Bank. (n.d.-a). *Unemployment, youth total (% of total labour force ages 15–24) (modelled ILO estimate) – Nigeria* [Data set]. https://data.worldbank.org/indicator/SL.UEM.1524.ZS?locations=NG. Accessed August 23, 2025

World Bank. (n.d.-b). *Poverty* [Data set]. https://data.worldbank.org/topic/11. Accessed on August 23, 2025

World Health Organization. (2023). *Suicide*. Accessed in December 2023 from https://www.who.int/news-room/fact-sheets/detail/suicide

World Health Organization. (2022). Training manual for surveillance of suicide and self-harm in communities via key informants. Geneva: World Health Organization.

World Health Organization. (2021). Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization. https://www.who.int/ publications/i/item/9789240031029. Accessed in March 2021.

World Health Organization. (2020). *Mental disorders*. https://www.who.int/news-room/fact-sheets/detail/mental-disorders. Accessed in March 2021

World Health Organization. (2019). *Suicide: Key facts*. https://www.who.int/news-.room/factsheets/detail/suicide. Accessed in March 2021.

World Health Organization. (2018). *National suicide prevention strategies: progress, examples and indicators*. World Health Organization. https://iris.who.int/handle/10665/279765

World Health Organization. (2016). mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings (Version 2.0). World Health Organization.

World Health Organization. (2014). *Preventing suicide: A global imperative.* https://apps.who.int/iris/handle/10665/131056. Accessed in March 2021

Worldometer. (2025). Nigeria Population (LIVE). https://www.worldometers.info/world-population/nigeria-population/. Accessed on 3 August 2025.

Wright, K. (2021). *Community resilience: A critical approach* (1st ed.). Routledge. https://doi.org/10.4324/9780429448188

Wu, A., Wang, J.-Y., & Jia, C.-X. (2015). Religion and completed suicide: A meta-analysis. *PLOS ONE*, *10*(6), e0131715. https://doi.org/10.1371/journal.pone.0131715

Wuestenfeld, I. (2024). Suicide and Family Dynamics. State University of New York, The College at Brockport. Department of Counsellor Education.

Wyllie, J. M., Robb, K. A., Sandford, D., Etherson, M. E., Belkadi, N., & O'Connor, R. C. (2025). Suicide-related stigma and its relationship with help-seeking, mental health, suicidality and grief: Scoping review. *BJPsych Open*, *11*(2), e60. https://doi.org/10.1192/bjo.2024.857

Wyman, P. A., Brown, C. H., Inman, J., Cross, W., Schmeelk-Cone, K., Guo, J., & Pena, J. B. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of consulting and clinical psychology*, *76*(1), 104.

Yasgur, M. (2017). *Suicide prevention and intervention: Cross-cultural perspectives*.

Psychiatry Advisor. https://www.psychiatryadvisor.com/features/suicide-prevention-and-intervention-cross-cultural-perspectives/

Yip, P. S., Caine, E., Yousuf, S., Chang, S.-S., Wu, K. C.-C., & Chen, Y.-Y. (2012). Means restriction for suicide prevention. *The Lancet*, *379*(9834), 2393–2399. https://doi.org/10.1016/S0140-6736(12)60521-2

Zalsman, G., Hawton, K., Wasserman, D., Van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V., Höschl, C., Barzilay, R., Balazs, J., Purebl, G., Kahn, J. P., Sáiz, P. A., Lipsicas, C. B., Bobes, J., Cozman, D., Hegerl, U., & Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. *The Lancet Psychiatry*, *3*(7), 646–659. https://doi.org/10.1016/S2215-0366(16)30030-X

Zippia. (2023). *How to become a clinical social worker: What it is and career path*. https://www.zippia.com/clinical-social-worker-jobs/. Accessed on 5 August 2025

Appendix A-Recruitment Poster (Resident)

RESEARCH PARTICIPANTS NEEDED

I WANT TO HEAR FROM YOU!

This is a doctoral research at the University of Manitoba exploring the awareness of suicide and prevention approaches in Makoko, Lagos State.

What's Involved:

- One-on-one interview.
- Sharing your thoughts and knowledge about suicide and how it can be prevented.
- Completing the demographic questionnaire.

Total Estimated Time: approximately 2-2.5 hours.

Eligibility :

I am seeking residents who:

- Are 18 years and older.
- Have resided in Makoko for at least 1 year.
- Can communicate in English, Pidgin English, or Yoruba.
- Willing to provide informed consent.

Your Privacy Matters:

Your identity will remain confidential!

How to Participate:

If you are interested in participating or have any questions, contact Karamat Kelani (Principal Investigator) through:

Email: kelanik@myumanitoba.ca

Your participation is voluntary, and you can withdraw at any time.

Advisor:

Dr. Tracey Bone
Email: Tracey.Bone@umanitoba.ca

University of Manitoba

This study has been reviewed and approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus (HE2024-0357)

Appendix B-Recruitment Poster (Key Informant)

RESEARCH PARTICIPANTS NEEDED

I WANT TO HEAR FROM YOU!

This is a doctoral research at the University of Manitoba exploring the awareness of suicide and prevention approaches in Makoko, Lagos State.

What's Involved:

- One-on-one interview.
- Sharing your thoughts and knowledge about suicide and how it can be prevented.
- completing the demographic questionnaire.

Total Estimated Time: approximately 2- 2.5 hours.

Eligibility :

I am seeking key informants who:

- Are doctors, nurses, religious leaders, or traditional healers.
- Experience working on mental health, suicide prevention, or community well-being with the Makoko community members.
- Can communicate in English, Pidgin English, or Yoruba.
- Willing to share professional insights in an interview.
- Willing to provide informed consent.

Your Privacy Matters:

Your identity will remain confidential!

How to Participate:

If you are interested in participating or have any questions, contact Karamat Kelani (Principal Investigator) through:

Email: Kelanik@myumanitoba.ca

Your participation is voluntary, and you can withdraw at any time.

Advisor:

Dr. Tracey Bone
Email: Tracey.Bone@umanitoba.ca

University of Manitoba

This study has been reviewed and approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus (HE2024-0357)

Appendix C-Informed Consent (Resident)

University of Manitoba | Faculty of Social Work

173 Dafoe Road,
Winnipeg,
Manitoba, Canada
R3T 2N2
T: 204 474 7050
F: 204 474 7594
Social_Work@umanitoba.ca

Informed Consent Form (Resident)

Research Title: Exploring Awareness of Suicide and Suicide Prevention in an Urban Slum in Nigeria: A Qualitative Study

Student Principal Investigator: Karamat Kelani Ayotola

PhD Candidate, Faculty of Social Work

University of Manitoba, Winnipeg, Canada.

Email: kelanik@myumanitoba.ca

Research Advisor: Dr. Tracey Bone, MSW, Ph.D., RSW

Associate Professor,

Faculty of Social Work,

University of Manitoba.

Email: tracey.bone@umanitoba.ca

Conflicts of Interest and Undue Influence

Karamat Kelani does not have any conflicts of interest in this study. Dr Tracey Bone does not have any conflicts of interest in this study.	

You are invited to participate in a research study. This informed consent form, a copy of which has been given to you, is only part of the informed consent process. If you want more details about something mentioned here or information not included here, please ask any of the people named

above. Please take the time to read this document and any accompanying information carefully. It is very important that you understand:

- what is being asked of you?
- what the risks and benefits of participation are, and
- how the information you provide will be used and stored.

Study Purpose:
I am doing this research under the supervision of Dr. Tracey Bone. This study aims to understand what the Makoko community members in Lagos State, Nigeria, know about suicide and ways to prevent it. This study is important because the results may help to inform culturally relevant community-based suicide prevention strategies to prevent suicide in the Makoko community.

Study Procedures:
If you decide to participate in the study, you will engage with the researcher from the Faculty of Social Work at the University of Manitoba, Canada, for a total of approximately 2–2.5 hours over a span of 2 weeks. This includes completing the informed consent process (10-15 minutes) for reviewing, discussing, and providing consent.

If you can communicate in English, you will be asked to read and sign the document if you wish to participate. If you cannot communicate in English, I will read the contents of the informed consent aloud in either Pidgin English or Yoruba. If you cannot sign, I will provide a stamp pad for thumbprinting the form.

After this, you will complete a demographic information questionnaire (5-10 minutes). Then, the interview process will commence. This involves an in-depth, one-on-one, in-person interview (45-60 minutes). With your consent, I will audio-record our meeting using an encrypted voice recorder.

I will answer any questions.

In addition, you will participate in member checking (30-45 minutes) to review and validate the findings, which will take place within 2 weeks of the initial interviews. For this process, if you have access to email, I will email a copy of your transcript to review for accuracy, and you will have two weeks to respond. You can add, change, or delete information from the transcripts as you see fit. If I do not hear from you after two weeks, I will assume you are okay with the transcript.

If you do not have access to email, I will arrange an in-person or phone meeting to read the transcripts aloud to you. You can request changes, additions, or deletions during this review to ensure the transcript accurately reflects their views.

Study Risk:
A potential risk is that you may feel distressed, sad, or emotionally disturbed, as people sometimes do when they talk about suicide or as with those who have had suicidal ideation, experienced suicide loss, or family-related trauma. If you feel distressed, sad or depressed, you can call any of the numbers in the list attached to this form to speak to a counsellor for a free counselling service.

Study Benefits:
The direct benefits for participants participating in the research include:
• Participants will receive information about available mental health services around their community.

The indirect benefits for participants participating in the research include:
• It may help participants to feel relieved psychologically when they share their thoughts, feelings, and experiences regarding suicide and mental health.
• It may help participants gain a deeper understanding of mental health and suicide prevention.
• It may help to foster a sense of belonging and collaboration for the participants.
• It could lead to improved mental health services, promoting the well-being of residents of Lagos State.

Compensation:
You will be given 15,000 naira to compensate you for your time and expenses incurred in participating in this study. The cash will be given once you consent to participate. The compensation is not contingent on completing the entire study. You retain the right to withdraw from the study at any point without penalty.

Use and Storage of Information:
All the information you provide as a participant in this study is confidential, which means we must keep it safe as the research team. We will do our best. However, it is not possible to guarantee absolute confidentiality. We will only share your personal information if required (court order or law). In compliance with current laws, any allegations or suspicions of certain offences, particularly those involving children or persons in care, must be reported to the legal authorities. This study aligns with two laws in this regard: the Lagos State Safeguarding and Child Protection Policy (this is a provision that protects the rights of children in Lagos State, Nigeria) and the Lagos State Mental Health Law (a law that seeks to protect Lagosians against stigmatization and discrimination with increased access to mental health services).

PI will comply with these laws through the following provisions:
• Any allegations or suspicions of abuse, neglect, or harm involving children or persons in care that arise during the research process will be reported promptly to the Lagos State Ministry of Youth and Social Development in accordance with the policy requirements.
• You will be informed during the consent process that confidentiality will be maintained unless disclosures involve harm to children or persons in care, in which case reporting obligations will apply.
• All disclosures and actions will be documented meticulously, ensuring accuracy and adherence to legal requirements while respecting those involved.
• If you are identified as being at risk of self-harm or suicide, immediate steps will be taken to connect you to relevant mental health services, as required under the Lagos State Mental Health Law. This includes notifying designated mental health professionals or authorities to ensure the individual receives appropriate care.

Your information will be stored in my University of Manitoba OneDrive folder created for this study. The account will be password-protected. I will have a file that links your name and contact information to your research information using a code. The file will be kept separate from the research information you share in this study and will include your name, contact information, and code. When the study results are shared, I will combine everybody's responses. This means no one will see your answers, name, or contact information. The demographic data, such as age, gender, occupation and so on, will be summarized. Summary statistics will be presented in aggregate form to protect your identities.

Verbatim or direct quotes from the interviews will be used to present the findings, but your real names or identifiers will not be used. Direct quotes will be used in the final report. In future publications, I will use pseudonyms to refer to you.

Dissemination:
The research results will be disseminated through the publication of the doctoral thesis, journal publications, and presentations in relevant academic fields. Through these ways, those in academia will be reached, and the findings will serve as knowledge contributions to the field of social work. Also, mental health professionals can be reached, and they can use the findings to improve mental health services. In addition, policymakers can be reached, and the findings can be used to develop appropriate policies.

To contribute to the community, the PI will meet with a few community members (residents, healthcare professionals, religious leaders, and community leaders) involved in the study to share final reports, including recommendations provided by participants during the study.

Withdrawing:
Your participation in this research study is voluntary. You can choose to do only the activities and/or answer only the questions you are comfortable with. You may withdraw from the study for any reason. You do not have to explain why. You will not be penalized in any way. You will keep your honorarium. Should you withdraw partway through the study, all of your information will be destroyed. You will not be able to withdraw from the study after 16 May 2025. To withdraw, please contact Karamat Kelani at the phone or email above.

Question or Concern:
Designated University of Manitoba personnel may review the research records to ensure this study is conducted safely and properly.

This study has been reviewed and approved by a Research Ethics Board at the University of Manitoba (HE2024-0357). However, this does not mean that participation is risk-free. If you have questions about your rights as a research participant, contact the Office of Human Research Ethics at humanethics@umanitoba.ca.

If you have any questions, concerns, or complaints about this study, you may contact any research team members listed on the first page or the Office of Human Research Ethics.

Consent:
By signing this document, I agree that:

- I have read the above information or had it read to me.
- I have had the opportunity to ask and have all my questions answered.
- I understand what is being asked of me.
- I will be taking part in a research study.
- I may freely stop or leave the research study activities at any time.
- My information may be shared outside the University of Manitoba.
- I do not waive my legal rights by participating in the study.

Notice Regarding Collection, Use, and Disclosure of Personal Information
Your personal information is being collected under the authority of The University of Manitoba Act. The University of Manitoba is committed to preserving your right to privacy. The information you provide will be used by the University to support our research. Your personal information will not be used or disclosed for other purposes unless permitted by The Freedom of

Information and Protection of Privacy Act or The Personal Health Information Act. If you have any questions about the collection of personal information, contact fippa@umanitoba.ca

I agree to participate in this study.	☐YES ☐ NO

_____	_____	_____
Name of Participant	Participant's Signature	Date

Summary of Results

Within two months of completing the data analysis (by 05/25), a 1–2-page summary of the research results will be prepared and sent to you through your preferred delivery method as indicated on this form. The PI will be responsible for compiling and distributing the research summary results. This ensures that findings are accurately communicated while maintaining participant confidentiality. Interested participants who indicate email as their preferred method will be emailed a digital copy of the summary of findings. On the other hand, a printed summary of the results will be sent to the mailing address of participants who indicate mailing as their preferred method of receiving it. Please provide your email or mailing address below if you would like to be sent a summary of the study results. Email/Mailing address_____	☐YES ☐ NO

I agree to have (please check):
☐ A pseudonym (fake name) used when the results are shared for this study.

Appendix C-1-List of Mental Health Services (Resident)

6

List of Free Mental Health Services in Lagos State

Name of Service	Address
Lagos MIND	Secretariat, Alausa- Ikeja, Lagos State, Nigeria
Lagos Lifeline	Emergency Number: 767/112
Lagos State University Teaching Hospital, Ikeja	1, Oba Akinjobi Way GRA, Ikeja, Lagos State, Nigeria
Suicide Research Prevention Initiative (SUPRIN)	University of Lagos Teaching Hospital, Idi Araba, Lagos State, Nigeria

Appendix D-Informed Consent (Key Informant)

University of Manitoba | Faculty of Social Work

173 Dafoe Road,
Winnipeg,
Manitoba, Canada
R3T 2N2
T: 204 474 7050
F: 204 474 7594
Social_Work@umanitoba.ca

Informed Consent Form (Key Informant)

Research Title: Exploring Awareness of Suicide and Suicide Prevention in an Urban Slum in Nigeria: A Qualitative Study

Student Principal Investigator: Karamat Kelani Ayotola

PhD Candidate, Faculty of Social Work

University of Manitoba, Winnipeg, Canada.

Email: kelanik@myumanitoba.ca

Research Advisor: Dr. Tracey Bone, MSW, Ph.D., RSW

Associate Professor,

Faculty of Social Work,

University of Manitoba

Email: Tracey.Bone@umanitoba.ca

Conflicts of Interest and Undue Influence

Karamat Kelani does not have any conflicts of interest in this study. Dr Tracey Bone does not have any conflicts of interest in this study.	

You are invited to participate in a research study. This informed consent form, a copy of which has been given to you, is only part of the informed consent process. If you want more details about something mentioned here or information not included here, please ask any of the people named

above. Please take the time to read this document and any accompanying information carefully. It is very important that you understand:

- what is being asked of you?
- what the risks and benefits of participation are, and
- how the information you provide will be used and stored.

Study Purpose:
I am doing this research under the supervision of Dr. Tracey Bone. This study aims to understand what the Makoko community members in Lagos State, Nigeria, know about suicide and ways to prevent it. This study is important because the results may help to inform culturally relevant community-based suicide prevention strategies to prevent suicide in the Makoko community.

Study Procedures:
If you decide to participate in the study, you will engage with the researcher from the Faculty of Social Work at the University of Manitoba, Canada, for a total of approximately 2–2.5 hours over a span of 2 weeks. This includes completing the informed consent process (10-15 minutes) for reviewing, discussing, and providing consent.

If you can communicate in English, you will be asked to read and sign the document if you wish to participate. If you cannot communicate in English, I will read the contents of the informed consent aloud in either Pidgin English or Yoruba. If you cannot sign, I will provide a stamp pad for thumbprinting the form.

After this, you will complete a demographic information questionnaire (5-10 minutes). Then, the interview process will commence. This involves an in-depth, one-on-one, in-person interview (45-60 minutes). With your consent, I will audio-record our meeting using an encrypted voice recorder.

I will answer any questions.

In addition, you will participate in member checking (30-45 minutes) to review and validate the findings, which will take place within 2 weeks of the initial interviews. For this process, if you have access to email, I will email a copy of your transcript to review for accuracy, and you will have two weeks to respond. You can add, change, or delete information from the transcripts as you see fit. If I do not hear from you after two weeks, I will assume you are okay with the transcript.

If you do not have access to email, I will arrange an in-person or phone meeting to read the transcripts aloud to you. You can request changes, additions, or deletions during this review to ensure the transcript accurately reflects their views.

Study Risk:
A potential risk is that you may feel distressed, sad, or emotionally disturbed, as people sometimes do when they talk about suicide or as with those who have had suicidal ideation, experienced suicide loss, or family-related trauma. If you feel distressed, sad or depressed, you can call any of the numbers in the list attached to this form to speak to a counsellor for a free counselling service.

Study Benefits:
The direct benefits for participants participating in the research include:
• Participants will receive information about available mental health services around their community.

The indirect benefits for participants participating in the research include:
• Participants may feel accomplished as they co-create knowledge.
• Participants' contributions could help shape interventions that improve the overall well-being of Lagos State residents.
• It may foster partnerships among key informants, researchers, and stakeholders, enhancing collective efforts to address mental health challenges.
• The findings from the participants could influence Nigeria and low- and middle-income countries (LMICs) facing similar challenges, potentially influencing policies.

Compensation:
You will be given 20,000 naira to compensate you for your time and expenses incurred in participating in this study. The cash will be given once you consent to participate. The compensation is not contingent on completing the entire study. You retain the right to withdraw from the study at any point without penalty.

Use and Storage of Information:
All the information you provide as a participant in this study is confidential, which means we must keep it safe as the research team. We will do our best. However, it is not possible to guarantee absolute confidentiality. We will only share your personal information if required (court order or law). In compliance with current laws, any allegations or suspicions of certain offences, particularly against children or persons in care, must be reported to legal authorities. This study aligns with two laws in this regard: the Lagos State Safeguarding and Child Protection Policy (this is a provision that protects the rights of children in Lagos State, Nigeria) and the Lagos State Mental Health Law (a law that seeks to protect Lagosians against stigmatization and discrimination with increased access to mental health services).

PI will comply with these laws through the following provisions:
• Any allegations or suspicions of abuse, neglect, or harm involving children or persons in care that arise during the research process will be reported promptly to the Lagos State Ministry of Youth and Social Development in accordance with the policy requirements.
• You will be informed during the consent process that confidentiality will be maintained unless disclosures involve harm to children or persons in care, in which case reporting obligations will apply.
• All disclosures and actions will be documented meticulously, ensuring accuracy and adherence to legal requirements while respecting those involved.
• If you are identified as being at risk of self-harm or suicide, immediate steps will be taken to connect you to relevant mental health services, as required under the Lagos State Mental Health Law. This includes notifying designated mental health professionals or authorities to ensure the individual receives appropriate care.

Your information will be stored in my University of Manitoba OneDrive folder created for this study. The account will be password-protected. I will have a file that links your name and contact information to your research information using a code. The file will be kept separate from the research information you share in this study and will include your name, contact information, and code. When the study results are shared, I will combine everybody's responses. This means no one will see your answers, name, or contact information. The demographic data, such as age, gender, occupation and so on, will be summarized. Summary statistics will be presented in aggregate form to protect your identities.

Verbatim or direct quotes from the interviews will be used to present the findings, but your real names or identifiers will not be used. Direct quotes will be used in the final report. In future publications, I will use pseudonyms to refer to you.

Dissemination:
The research results will be disseminated through the publication of the doctoral thesis, journal publications, and presentations in relevant academic fields. Through these ways, those in academia will be reached, and the findings will serve as knowledge contributions to the field of social work. Also, mental health professionals can be reached, and they can use the findings to improve mental health services. In addition, policymakers can be reached, and the findings can be used to develop appropriate policies.

To contribute to the community, the PI will meet with a few community members (residents, healthcare professionals, religious leaders, and community leaders) involved in the study to share final reports, including recommendations provided by participants during the study.

Withdrawing:
Your participation in this research study is voluntary. You can choose to do only the activities and/or answer only the questions you are comfortable with. You may withdraw from the study for any reason. You do not have to explain why. You will not be penalized in any way. You will keep your honorarium. Should you withdraw partway through the study, all of your information will be destroyed. You will not be able to withdraw from the study after 16 May 2025. To withdraw, please contact Karamat Kelani at the email above.

Question or Concern:
Designated University of Manitoba personnel may review the research records to ensure this study is conducted safely and properly.

This study has been reviewed and approved by a Research Ethics Board at the University of Manitoba (HE2024-0357). However, this does not mean that participation is risk-free. If you have questions about your rights as a research participant, contact the Office of Human Research Ethics at humanethics@umanitoba.ca.

If you have any questions, concerns, or complaints about this study, you may contact any research team members listed on the first page or the Office of Human Research Ethics.

Consent:
By signing this document, I agree that:

- I have read the above information or had it read to me.
- I have had the opportunity to ask and have all my questions answered.
- I understand what is being asked of me.
- I will be taking part in a research study.
- I may freely stop or leave the research study activities at any time.
- My information may be shared outside the University of Manitoba.
- I do not waive my legal rights by participating in the study.

Notice Regarding Collection, Use, and Disclosure of Personal Information
Your personal information is being collected under the authority of The University of Manitoba Act. The University of Manitoba is committed to preserving your right to privacy. The information you provide will be used by the University to support our research. Your personal information will not be used or disclosed for other purposes unless permitted by The Freedom of Information and Protection of Privacy Act or The Personal Health Information Act. If you have

any questions about the collection of personal information, contact:fippa@umanitoba.ca

I agree to participate in this study.	☐YES ☐ NO

Name of Participant	Participant's Signature	Date

Summary of Results

Within two months of completing the data analysis (by 05/25), a 1–2-page summary of the research results will be prepared and sent to you through your preferred delivery method as indicated on this form. The PI will be responsible for compiling and distributing the research summary results. This ensures that findings are accurately communicated while maintaining participant confidentiality. Interested participants who indicate email as their preferred method will be emailed a digital copy of the summary of findings. On the other hand, a printed summary of the results will be sent to the mailing address of participants who indicate mailing as their preferred method of receiving it. Please provide your email or mailing address below if you would like to be sent a summary of the study results. Email/Mailing address_____	☐YES ☐ NO

I agree to have (please check):
☐ A pseudonym (fake name) used when the results are shared for this study.

Appendix D-1-List of Free Mental Health Services in Lagos State (Key Informant)

6

List of Free Mental Health Services in Lagos State

Name of Service	Address
Lagos MIND	Secretariat, Alausa- Ikeja, Lagos State, Nigeria
Lagos Lifeline	Emergency Number: 767 / 112
Lagos State University Teaching Hospital, Ikeja	1, Oba Akinjobi Way GRA, Ikeja, Lagos State, Nigeria
Suicide Research Prevention Initiative (SUPRIN)	University of Lagos Teaching Hospital, Idi Araba, Lagos State, Nigeria

Appendix E-Honorarium Receipt

University of Manitoba | Faculty of Social Work

173 Dafoe Road
Winnipeg, Manitoba
Canada R3T 2N2
T: 204 474 7050
F: 204 474 7594
Social_Work@umanitoba.ca

Honorarium Receipt Form

Date: _____

Address: _____

City: _____ Location: _____

Date	Description	Amount
Total Honorarium		**NGN**

I, _____ (Print Name), hereby declare that I have received an honorarium of NGN_____ towards the participation of the research study **(Exploring Awareness of Suicide and Suicide Prevention Approaches in an Urban Slum in Nigeria)** on _____ (Date).

Recipient Signature: _____

Appendix F-Demographic Information Form (Resident)

Demographic Information Form (Resident)

Researcher: Karamat Ayotola Kelani, PhD Candidate, University of Manitoba

Date: _____

Pseudonym: _____

Demographic Information

1. Age:18-24 [ ] 25-34 [ ] 35-44 [ ] 45-54 [ ] 55-64 [ ] 65 and above [ ]
2. Gender: Male [ ] Female [ ] Other [ ] _____ Prefer not to answer [ ]
3. Marital Status: Never married [ ] Married [ ] Separated [ ] Cohabiting [ ] Widowed [ ] Prefer not to answer [ ]
4. Religious Affiliation: Christianity [ ] Islam [ ] Traditional [ ] Other [ ] _____ Prefer not to answer [ ]
5. Educational Level: No formal education [ ] Primary [ ] Junior High School/Middle [ ] Secondary [ ] Tertiary [ ] Other [ ] _____ Prefer not to answer [ ]
6. Current Occupation: Unemployed [ ] Self-employed [ ] Formal employment [ ] Casual labourer [ ] Vocational Training [ ] Other [ ] Prefer not to answer [ ]
7. Do you have access to healthcare services in the community? Yes [ ] No [ ] Prefer not to answer [ ]
8. Have you or someone close to you ever experienced a mental health issue? _____ Prefer not to answer [ ]
9. How long have you lived in Makoko? _____ Prefer not to answer [ ]

Appendix G-Demographic Information Form (Key Informant)

Demographic Information Form (Key Informant)

Researcher: Karamat Ayotola Kelani, PhD Candidate, University of Manitoba

Date: _____

Pseudonym: _____

Demographic Information

1. Age:18-24 [ ] 25-34 [ ] 35-44 [ ] 45-54 [ ] 55-64 [ ] 65 and above [ ]
2. Gender: Male [ ] Female [ ] Other [ ] _____ Prefer not to answer [ ]
3. What type of organization do you represent? Government [ ] NGO [ ] Faith-based organization [ ] Community-based organization [ ] Healthcare institution [ ]
4. What is the primary focus of your work? Mental health services [ ] General healthcare [ ] Education/awareness [ ] Social services [ ] Religious/cultural services [ ]
5. How long have you been at your current place of employment?
6. Have you received any formal training in suicide prevention or mental health? Yes [ ] No [ ] Prefer not to answer [ ]
7. How often do you engage with the community on mental health or suicide-related issues? Very frequently [ ] Sometimes [ ] Rarely [ ] Never [ ]

Appendix H-Interview Guide (Resident)

Interview Guide (Resident)

Researcher: Karamat Ayotola Kelani, PhD Candidate, University of Manitoba

Date of Interview _____ Location of Interview _____

Pseudonym _____ Code Number _____

(1) Can you tell me a little about what it is like living in this community?
Probe: What do you enjoy most about being part of it?

(2) In your experience, do people in this community talk about mental health or well-being?
Probes: What kinds of support do they seek when facing difficulties?

(3) What do you know about suicide? How would you describe it?
Probe: Can you give an example of what you mean by that? Where did you learn about suicide? From the community, media, or elsewhere?

(4) In your opinion, why might some people in the community consider suicide? Probe: What situations or problems make people feel this way? Do you think poverty or lack of resources contributes to these feelings?

(5) Are there any specific groups in Makoko that you think are more at risk of suicide? Why?
Probe: Do you think age, gender, or social status affects who might be at risk? Can you think of any recent cases in the community that illustrate this?

(6) Have you heard of any programs or efforts in the community to prevent suicide?
Probe: Can you tell me more about those efforts or programs? Who is involved in these programs? Are they run by the community, the government, or NGOs?

(7) If someone is feeling suicidal, do you know where they could go for help in Makoko?
Probe: Have you or someone you know ever sought help for a mental health issue? What kinds of help are available, and how easy is it to access them?

(8) What do you think would help prevent suicide in Makoko?
Probe: Are there specific resources or types of support you think the community needs? How could religious or cultural leaders play a role in this?

(9) How comfortable do you think people are in Makoko talking about suicide or mental health?
Probe: Do you think people are willing to seek help for mental health issues?
What prevents people from talking openly about mental health

Conclusion:

Is there anything else you want to share about this topic that we have not discussed?

Appendix I-Interview Guide (Key Informant)

Interview Guide (Key Informant)

Researcher: Karamat Ayotola Kelani, PhD Candidate, University of Manitoba

Date of Interview _____ Location of Interview _____

Pseudonym _____ Code Number _____

1. Can you tell me about your role in the community or organization and how long you have been involved in this work?
Probe: What are some of your challenges or rewarding experiences in your role?

2. Can you describe any suicide prevention programs or resources currently available in the community?
Probe: How well do you think these programs are working? Are there any groups that are not being reached by these efforts?

3. In your role, how do you support individuals at risk of suicide?
Probe: Can you share a specific example of how you have helped someone at risk?

4. What roles do cultural or religious beliefs in Makoko play in shaping suicide prevention strategies?
Probe: Are there any cultural beliefs that might prevent people from seeking help? How can religious or traditional leaders help in suicide prevention efforts?

5. What challenges or barriers exist that prevent effective suicide prevention in Makoko?
Probe: Are resources available (e.g., mental health professionals, community support)?

6. In your opinion, what areas of suicide prevention need more attention in the community?
Probe: What specific interventions do you think would be most effective?

7. Do you think more education or awareness is needed on suicide prevention in Makoko? If so, how should it be delivered?
Probe: What type of education do you think would be most impactful—community meetings, workshops, media campaigns?

8. Do you collaborate with other organizations or institutions in suicide prevention efforts?
Probe: How successful has collaboration been in addressing the issue?

Conclusion:

Is there anything else you want to share about this topic that we have not discussed?

Appendix J-Ethics Approval Letter

University of Manitoba | Research Ethics and Compliance

Human Research Ethics - Fort Garry
66 Chancellors Circle
Winnipeg, MB R3T 2N2
humanethics@umanitoba.ca

PROTOCOL APPROVAL

Effective: February 18, 2025 Expiry: February 17, 2026

Principal Investigator:	Karamat Kelani
Advisor(s):	Tracey Bone
Protocol Number:	HE2024-0357
Protocol Title:	*Exploring Suicide and Suicide Prevention Awareness in an Urban Slum in Nigeria: A Qualitative Study.*

Liz Millward, Chair, REB2

Research Ethics Board 2 has reviewed and approved the above research. The Office of Human Research Ethics (OHRE) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans- TCPS 2 (2022).*

Please note the following important information about your protocol approval:

i. Approval is granted for the research and purposes described in the protocol only.

ii. Any changes to the protocol or research materials must be approved by the OHRE **before implementation**.

iii. Any **deviations** to the research or **adverse events** must be reported to the OHRE immediately through an **REB Event**.

iv. This approval is valid **for one year only.** A Renewal Request must be submitted and approved prior to the above expiry date.

v. A **Protocol Closure** must be submitted to the OHRE when the research is complete or if the research is terminated.

vi. The University of Manitoba may request to audit your research documentation to confirm compliance with this approved protocol, and with the UM *Ethics of Research Involving Humans* policies and procedures.