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A Meta Analysis of Stigma and Help-Seeking Behaviour among Persons Living with Mental Illness in Nigeria

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Abstract

Mental illness remains a major public health concern in Nigeria, yet stigma continues to impede access to professional mental healthcare and delay treatment among affected individuals. This paper therefore examined stigma and help-seeking behaviour among persons living with mental illness in Nigeria through a meta-analysis with the aim of synthesising existing empirical evidence on the prevalence and patterns of stigma, examining the relationship between stigma and help-seeking behaviour, and determining the effect of stigma on the utilisation of professional mental health services. The paper was anchored on Modified Labeling Theory which explains how anticipated and internalised stigma influence behavioural responses to mental illness. A meta-analysis approach was adopted. Relevant peer-reviewed empirical studies were systematically identified from recognised academic databases using predefined inclusion and exclusion criteria. Eligible studies were critically appraised, relevant data were extracted and findings were synthesised to establish recurring patterns and areas of convergence. The findings revealed that public stigma, self-stigma and perceived discrimination remain widespread among persons living with mental illness in Nigeria, with internalised stigma constituting a significant challenge. The synthesis further established a consistent inverse relationship between stigma and help-seeking behaviour, showing that fear of labelling and discrimination contributes to delayed treatment, preference for informal sources of care, poor treatment adherence and reduced utilisation of professional mental health services. The paper concludes that stigma remains a major social barrier to effective mental healthcare in Nigeria and continues to widen the treatment gap despite ongoing mental health reforms. It recommended sustained nationwide anti-stigma campaigns, effective integration of mental health services into primary healthcare and strengthened implementation of the Nigerian Mental Health Act to promote early help-seeking, improve treatment utilisation and enhance the wellbeing of persons living with mental illness.

Keywords: Stigma, Help-seeking Behaviour, Mental Illness, Mental Health Services, Meta-Analysis, Nigeria.

Introduction

Mental illness remains a major public health concern because of its effect on individuals, families and national development. Mental disorders account for a considerable proportion of disability worldwide, with depressive disorders, anxiety disorders, schizophrenia, bipolar disorder and substance use disorders contributing substantially to years lived with disability. Although effective pharmacological and psychosocial interventions are available for many mental disorders, a large proportion of affected persons do not receive appropriate treatment, particularly in low- and middle-income countries where mental health services remain inadequate (World Health Organization [WHO], 2022). The treatment gap in these settings is influenced by shortages of mental health professionals, inadequate funding, poor integration of mental health into primary healthcare and persistent social stigma attached to mental illness (WHO, 2022).

In Nigeria, the burden of mental illness has continued to increase alongside demographic growth, urbanisation, economic hardship and exposure to insecurity and displacement. Despite the enactment of the Mental Health Act in 2023, access to quality mental healthcare remains limited for many citizens because specialised psychiatric services are concentrated in urban areas while primary mental healthcare is still developing across many states. Available evidence indicates that Nigeria continues to have one of the lowest psychiatrist-to-population ratios globally, resulting in substantial unmet mental health needs and delayed access to evidence-based care. These structural challenges are compounded by deeply rooted cultural beliefs that frequently associate mental illness with witchcraft, spiritual attacks, punishment from supernatural forces or moral failure, thereby encouraging reliance on traditional and faith-based healing before professional treatment is sought (WHO, 2022; Abdulmalik et al., 2023).

Stigma has consistently been identified as one of the strongest barriers preventing persons living with mental illness from seeking professional help. Mental illness stigma refers to negative stereotypes, prejudice and discriminatory attitudes directed towards individuals because of their mental health condition. Public stigma often leads to rejection, social isolation, discrimination in employment and education, and reduced social participation. Repeated exposure to these attitudes may result in self-stigma, whereby affected individuals internalise negative societal beliefs, develop feelings of shame and lose confidence in their ability to recover. Internalised stigma has been associated with poor treatment adherence, diminished self-esteem, reduced quality of life and reluctance to seek psychiatric care (Alemu et al., 2023).

The relationship between stigma and help-seeking behaviour has attracted increasing research attention because early diagnosis and treatment improve clinical outcomes for most mental disorders. Help-seeking behaviour refers to the actions individuals take to obtain assistance for psychological or psychiatric problems from formal sources such as psychiatrists, psychologists, psychiatric nurses and general medical practitioners, as well as informal sources including family members, religious leaders and traditional healers. Studies conducted across low- and middle-income countries show that stigma discourages disclosure of symptoms, delays first contact with mental health professionals and increases dependence on informal sources of care, thereby prolonging untreated illness and worsening prognosis (van den Broek et al., 2023).

Evidence from Nigeria demonstrates that misconceptions surrounding mental illness continue to influence patterns of help-seeking. Many families initially attribute symptoms of schizophrenia, depression or bipolar disorder to spiritual causes and therefore seek intervention from prayer houses

or traditional healers before presenting at psychiatric facilities. Such delays often result in longer duration of untreated illness, increased symptom severity and poorer recovery outcomes. Recent reviews of Nigerian mental health services further indicate that stigma, limited mental health literacy, financial constraints, inadequate service availability and fear of discrimination continue to discourage utilisation of formal mental healthcare services (Chijioke et al., 2024).

Recent African evidence also suggests that internalised stigma remains widespread among persons living with mental illness. A systematic review and meta-analysis by Alemu et al. (2023), involving studies conducted across several African countries, reported a pooled prevalence of internalised stigma of approximately 29%, with Nigerian studies contributing evidence of substantial levels of self-stigma among service users. The review further identified poor social support, unemployment, suicidal ideation and psychotic symptoms as factors associated with increased internalised stigma. These findings suggest that stigma remains an important obstacle to treatment engagement and recovery across African settings.

Although many primary studies have examined stigma and help-seeking behaviour in different parts of Nigeria, their findings differ because of variations in study populations, mental health conditions, research methods and geographical settings. A meta-analysis provides an opportunity to synthesise available empirical evidence, estimate the strength of the association between stigma and help-seeking behaviour, identify consistent patterns across studies and highlight areas requiring further investigation. Such evidence is valuable for informing mental health policy, public education programmes and interventions aimed at reducing stigma and improving access to professional mental healthcare among persons living with mental illness in Nigeria.

Statement of the Problem

Mental illness has become an important public health concern in Nigeria because of its increasing contribution to disability, reduced productivity and poor quality of life. Despite advances in psychiatric treatment and the introduction of the Nigerian Mental Health Act, 2023, a large proportion of persons living with mental illness still do not receive timely and appropriate care. The World Health Organization (2022) estimates that in low- and middle-income countries, between 76% and 85% of people with severe mental disorders receive no treatment. Nigeria reflects this treatment gap, where shortages of mental health professionals, poor distribution of services and inadequate financing continue to limit access to care. However, beyond these structural deficiencies, stigma remains one of the most persistent barriers preventing individuals from recognising symptoms, disclosing mental health problems and seeking professional assistance (WHO, 2022).

Mental illness continues to attract negative stereotypes and discriminatory attitudes in many Nigerian communities. Individuals diagnosed with schizophrenia, depression, bipolar disorder and other psychiatric conditions are frequently labelled as dangerous, spiritually afflicted or incapable of making rational decisions. Such beliefs often expose affected persons to rejection by family members, loss of employment opportunities, social isolation and denial of educational and economic opportunities. Repeated exposure to these attitudes may also lead to self-stigma, in which individuals internalise negative societal beliefs, experience shame and perceive themselves as unworthy of recovery or social acceptance. Internalised stigma has consistently been associated with delayed treatment, poor adherence to prescribed medication, diminished self-esteem and poorer clinical outcomes (Alemu et al., 2023).

Evidence from Nigerian studies suggests that stigma significantly influences help-seeking behaviour among persons living with mental illness. Rather than presenting early at psychiatric hospitals or primary healthcare facilities, many individuals first seek assistance from traditional healers, prayer houses or other informal sources because mental illness is commonly interpreted as the result of spiritual attack, witchcraft or supernatural punishment. Consequently, many patients present for psychiatric treatment only after symptoms have become severe or chronic, thereby reducing the likelihood of early intervention and increasing the social and economic burden on affected families (Abdulmalik et al., 2023). Delayed access to evidence-based treatment also contributes to prolonged disability, repeated hospital admissions and reduced chances of social reintegration.

Although several empirical studies have examined stigma and help-seeking behaviour among persons living with mental illness in different parts of Nigeria, the available evidence remains fragmented. Existing studies have been conducted in different geopolitical zones, using varying research designs, measurement instruments, study populations and sample sizes. While some studies report stigma as the strongest predictor of poor help-seeking behaviour, others identify factors such as mental health literacy, educational attainment, socioeconomic status, availability of services and family support as having greater influence. These inconsistencies make it difficult to determine the magnitude of the relationship between stigma and help-seeking behaviour within the Nigerian context and to identify factors that consistently influence treatment-seeking across different settings.

Furthermore, most existing studies are hospital-based and limited to single States or individual healthcare facilities, thereby restricting the generalisability of their findings. Few studies have attempted to synthesise available evidence at the national level, and there is limited quantitative evidence estimating the pooled effect of stigma on help-seeking behaviour among persons living with mental illness in Nigeria. Without such synthesis, policymakers, mental health practitioners and programme planners may continue to rely on isolated findings that do not adequately reflect the national pattern of evidence.

A meta-analysis is therefore necessary to integrate findings from existing empirical studies, estimate the pooled relationship between stigma and help-seeking behaviour, examine variations across study characteristics and identify gaps requiring further investigation. By providing statistically synthesised evidence, the study will contribute to a clearer understanding of how stigma influences access to professional mental healthcare in Nigeria. The findings are expected to support the development of evidence-based anti-stigma interventions, strengthen mental health policies and improve strategies aimed at encouraging early help-seeking among persons living with mental illness.

Aim and Objectives of the Paper

The aim of this paper was to systematically synthesise and critically evaluate existing empirical evidence on stigma and help-seeking behaviour among persons living with mental illness in Nigeria through a meta-analysis in order to determine the extent to which stigma influences the utilisation of professional mental health services.

The specific objectives of this paper are to:

i. Examine the prevalence and patterns of stigma experienced by persons living with mental illness in Nigeria based on existing empirical studies.

ii. Assess the relationship between stigma and help-seeking behaviour among persons living with mental illness in Nigeria.

iii. Synthesize available empirical evidence to determine the pooled effect of stigma on help-seeking behaviour among persons living with mental illness in Nigeria.

Literature Review

Conceptual Review

Stigma

Stigma is one of the most widely examined concepts in mental health research because of its influence on treatment utilisation, recovery and social inclusion among persons living with mental illness. Recent scholarship has continued to build on earlier theoretical formulations while refining the processes through which stigma operates. Dharmi (2023) argues that stigma should not be viewed solely as an individual attitude or cultural belief but also as a social process sustained by institutional and structural conditions that reinforce unequal treatment of people with mental illness. This perspective broadens the understanding of stigma beyond interpersonal discrimination by recognising the influence of wider social systems.

Similarly, Dany et al. (2023) distinguish between self-stigma and internalised stigma, noting that although the concepts are often used interchangeably, self-stigma refers to the process through which individuals accept negative public stereotypes, whereas internalised stigma reflects the psychological consequences of that acceptance, including shame, reduced self-worth and hopelessness. Their distinction improves conceptual clarity for empirical research, particularly when synthesising findings across studies.

However, both perspectives retain the central proposition advanced in stigma research that negative labelling, stereotyping and discrimination reduce access to health services and social participation. Although these recent contributions provide important refinements, they do not depart substantially from the conceptual foundation that stigma involves socially constructed negative judgements directed at individuals because of a discrediting characteristic. In the context of this meta-analysis, stigma is therefore adopted as the process through which persons living with mental illness experience or internalise negative stereotypes, prejudice and discriminatory attitudes that discourage disclosure of mental health problems and reduce their willingness to seek professional mental healthcare.

Mental Illness

Mental illness is generally understood in scholarly literature as a clinically significant disturbance in cognition, emotional regulation or behaviour that affects an individual's ability to function effectively in personal, social and occupational settings. Recent definitions have increasingly emphasised that mental illness cannot be explained solely by biological dysfunction but arises from the interaction of psychological, social and neurodevelopmental factors. Stein et al. (2022) contend that mental illness comprises diagnosable conditions characterised by disturbances in thought, mood, perception or behaviour that are associated with distress or impairment in important areas of functioning. Their definition is particularly useful because it aligns with current psychiatric diagnostic systems while recognising the clinical significance of functional impairment rather than focusing only on the presence of symptoms.

Similarly, Vigo et al. (2023) argue that mental illness should be viewed from a public health perspective as a group of disorders that contribute substantially to disability, premature mortality and reduced quality of life, thereby extending the concept beyond clinical diagnosis to include its social and economic consequences. While the position advanced by Vigo et al. is valuable for highlighting

the population-level burden of mental illness, it gives less attention to the subjective experiences of affected individuals.

Conversely, Stein et al. place greater emphasis on diagnosis and impairment but do not sufficiently acknowledge the influence of social determinants on the onset and progression of mental disorders. Taken together, these perspectives provide a balanced understanding of mental illness as both a clinical and public health concern. In the context of this meta-analysis, mental illness is adopted as any clinically recognised psychiatric disorder that produces significant disturbances in cognition, emotion or behaviour, results in distress or functional impairment, and influences an individual's decision and ability to seek appropriate professional mental healthcare.

Help-seeking Behaviour

Help-seeking behaviour is widely recognised in mental health literature as the process through which individuals identify a health problem and actively seek assistance from formal or informal sources to address it. Within mental health research, the concept extends beyond the act of contacting a healthcare provider to include the recognition of symptoms, willingness to disclose psychological distress and the decision to utilise available support.

Rickwood et al. (2020) maintain that help-seeking behaviour is a deliberate and goal-oriented action undertaken to obtain external assistance for mental health concerns from professional services, family members, friends or other trusted individuals. Their definition is important because it acknowledges both formal and informal pathways through which people seek support. However, by treating all sources of help as equivalent, it does not sufficiently distinguish between evidence-based mental healthcare and informal support that may delay appropriate treatment.

More recent work by Schnyder et al. (2022) argues that help-seeking behaviour should be understood as a dynamic process influenced by personal beliefs, perceived stigma, mental health literacy, accessibility of services and previous experiences with healthcare. This perspective offers a broader explanation of why individuals may delay or avoid professional treatment despite recognising symptoms, making it particularly relevant to studies conducted in low- and middle-income countries where cultural beliefs and stigma strongly influence care-seeking decisions. Nevertheless, Schnyder et al. place greater emphasis on determinants of help-seeking than on the behavioural act itself.

However, these perspectives suggest that help-seeking behaviour encompasses both the decision-making process and the actions taken to obtain assistance for mental health problems. In the context of this meta-analysis, help-seeking behaviour is adopted as the process through which persons living with mental illness recognise the need for care and intentionally seek assistance from formal mental health professionals or other available sources, with particular attention to how stigma influences the utilisation of professional mental healthcare in Nigeria.

The Prevalence and Patterns of Stigma Experienced by Persons Living with Mental Illness in Nigeria

Evidence from empirical studies conducted in Nigeria indicates that stigma remains one of the most persistent social challenges confronting persons living with mental illness despite increasing awareness of mental health and recent policy reforms. A synthesis of available Nigerian studies demonstrates that stigma occurs in several forms, including public stigma, self-stigma, family stigma and institutional discrimination, with varying levels across geographical locations, psychiatric diagnoses and treatment settings. Findings reported across psychiatric hospitals and community-

based investigations consistently show that individuals diagnosed with schizophrenia, bipolar disorder and other severe mental disorders experience higher levels of stigma than those diagnosed with common mental disorders such as anxiety and depression (Mpem & Mase, (2024).

Although prevalence estimates differ because of variations in study populations, measurement instruments and sampling procedures, the overall pattern across studies indicates that stigma remains widespread among persons living with mental illness in Nigeria. This conclusion is supported by the systematic review and meta-analysis conducted by Alemu et al. (2023), which synthesised evidence from twenty African studies involving 6,265 participants, including data from Nigeria. The review estimated the pooled prevalence of internalised stigma in Africa at 29.05%, while the pooled prevalence for Nigerian studies was 24.31% (95% CI: 17.94–30.67), confirming that nearly one-quarter of persons living with mental illness in Nigeria experience substantial internalised stigma. The review further demonstrated that stigma resistance, alienation, perceived discrimination and social withdrawal were the dominant dimensions reported across the included studies.

Beyond pooled prevalence estimates, Nigerian empirical studies reveal that the manifestations of stigma extend beyond internal psychological experiences to social exclusion and discrimination in everyday life. A recent investigation conducted among 468 persons living with mental illness in Benue State by Mpem and Mase (2024) reported that 67.9% of participants exhibited elevated internalised stigma. The study further observed that respondents who had previously relied on traditional healing services recorded significantly higher stigma scores than those receiving treatment in orthodox psychiatric facilities. Qualitative interviews undertaken alongside the survey illustrated that some participants intentionally consumed excessive doses of prescribed medication in an attempt to cope with the emotional consequences of public rejection and ridicule. These findings demonstrate that stigma is not merely a social attitude but a factor capable of influencing medication use, treatment experiences and psychological wellbeing among affected individuals.

The available evidence further demonstrates that stigma follows identifiable patterns across different social environments in Nigeria. Public stigma remains the most frequently reported form and is characterised by negative stereotypes portraying persons with mental illness as dangerous, violent, spiritually possessed or incapable of productive social functioning. These perceptions often result in exclusion from employment opportunities, denial of accommodation, marital rejection and diminished participation in community activities. Studies conducted among healthcare workers, university students and members of the general public have also reported varying degrees of social distancing towards persons with schizophrenia and other severe mental illnesses, suggesting that stigmatising attitudes are not restricted to the general population but may also exist within healthcare settings. Such attitudes discourage open disclosure of psychiatric symptoms and reinforce social isolation among affected individuals. Abdulmalik et al. (2023) have similarly argued that negative public perceptions continue to undermine mental healthcare utilisation and social reintegration in Nigeria despite increasing recognition of mental illness as a public health concern.

Another consistent pattern emerging from Nigerian studies is the influence of cultural and religious interpretations of mental illness on stigma. Across many communities, psychiatric disorders continue to be attributed to witchcraft, ancestral punishment, demonic possession or spiritual attacks. Consequently, families frequently seek intervention from traditional healers and faith-based centres before consulting psychiatrists or psychologists. Although traditional and religious institutions provide emotional support for many families, delayed presentation at psychiatric facilities has been

associated with prolonged untreated illness and increased severity of symptoms. This pattern contributes to a cycle in which visible manifestations of untreated psychosis reinforce public stereotypes that persons living with mental illness are unpredictable or dangerous, thereby sustaining stigma within communities. Recent reviews of Nigerian mental health services similarly conclude that misconceptions regarding the causes of mental illness remain one of the principal barriers to effective mental healthcare utilisation (Mpem & Mase, 2024).

Meta-analytic evidence also demonstrates that stigma is not uniformly distributed across all individuals living with mental illness. Alemu et al. (2023) identified poor social support, unemployment, low educational attainment, suicidal ideation, psychotic symptoms and being unmarried as significant predictors of elevated internalised stigma. These findings correspond with Nigerian hospital-based studies in which unemployed individuals and patients with chronic psychotic disorders consistently reported higher stigma scores than those with stronger family support and stable employment. The observed pattern suggests that stigma is reinforced by existing social disadvantage, making economically vulnerable individuals particularly susceptible to discrimination and self-stigmatisation. Furthermore, the review found considerable heterogeneity among studies, reflecting differences in psychiatric diagnoses, study settings and measurement scales. Such heterogeneity supports the need for country-specific meta-analyses capable of generating pooled national estimates and identifying contextual factors unique to Nigeria.

In sum, the available empirical evidence demonstrates that stigma remains highly prevalent among persons living with mental illness in Nigeria and manifests through public discrimination, internalised shame, social withdrawal and institutional exclusion. Although prevalence estimates differ across studies because of methodological variation, the consistency of findings indicates that stigma continues to undermine recovery, reduce social participation and adversely affect treatment experiences. The recurring association between stigma, unemployment, limited social support and delayed access to psychiatric care further suggests that interventions should extend beyond clinical treatment to include sustained public education, community engagement and policies aimed at reducing discrimination. For a meta-analysis such as the present study, synthesising these findings provides an opportunity to establish a more precise estimate of stigma prevalence and identify patterns that remain consistent across different Nigerian populations.

The Relationship between Stigma and Help-Seeking Behaviour among Persons Living with Mental Illness in Nigeria

Evidence synthesised from empirical studies conducted in Nigeria consistently demonstrates that stigma is inversely related to help-seeking behaviour among persons living with mental illness. Across hospital-based, community-based and systematic review studies, individuals who experience higher levels of public or internalised stigma are less likely to disclose symptoms, utilise formal psychiatric services or adhere to recommended treatment. Although the magnitude of this relationship varies according to study design, psychiatric diagnosis and measurement instruments, the direction of the association remains remarkably consistent. Available evidence indicates that stigma influences help-seeking at every stage of the care pathway, beginning with symptom recognition, extending to disclosure of mental health problems and ultimately affecting the decision to access professional mental healthcare. This pattern has been consistently reported in Nigeria and other African settings, making stigma one of the most important determinants of delayed treatment among persons living with mental illness.

A major pathway through which stigma influences help-seeking in Nigeria is fear of negative social judgement. Empirical studies show that many individuals deliberately conceal symptoms of depression, psychosis or bipolar disorder because of anticipated rejection by family members, employers, religious communities and neighbours. Rather than seeking psychiatric assessment immediately after symptom onset, affected individuals frequently delay treatment until symptoms become severe enough to interfere with daily functioning. Chijioke et al. (2024), in their systematic review of barriers to mental health service utilisation in Nigeria, identified stigma, shame, ignorance, poor mental health literacy, financial constraints, inadequate service availability and fear of discrimination as the most frequently reported barriers preventing utilisation of formal mental health services. Their review synthesised findings from numerous Nigerian studies and concluded that stigma remains one of the strongest predictors of poor engagement with psychiatric care irrespective of geographical location or healthcare setting.

The relationship between stigma and help-seeking is also reflected in the continued reliance on informal sources of care before presentation at psychiatric facilities. Nigerian studies repeatedly show that families commonly interpret hallucinations, delusions, severe mood disturbances and behavioural changes as evidence of spiritual attacks, witchcraft or ancestral punishment (van den Broek et al. 2023). Consequently, many patients initially seek assistance from prayer houses, traditional healers and spiritual centres before consulting psychiatrists or psychologists. Although these institutions remain important sources of emotional and spiritual support, prolonged dependence on non-specialist care frequently delays diagnosis and evidence-based treatment. Clinical reports from psychiatric hospitals in Nigeria have documented numerous cases in which patients present after months or years of untreated psychosis following unsuccessful traditional or faith-based interventions. Such delayed presentation contributes to greater symptom severity, poorer treatment outcomes and prolonged recovery. Abdulmalik et al. (2023) similarly observed that stigma and culturally rooted misconceptions continue to discourage timely utilisation of formal mental healthcare despite increasing policy attention to mental health in Nigeria.

Meta-analytic evidence provides further support for the relationship between stigma and help-seeking behaviour. Alemu et al. (2023), in a systematic review and meta-analysis involving 6,265 participants from twenty African studies, found that approximately 29% of persons living with mental illness experienced elevated internalised stigma, with Nigeria recording a pooled prevalence of 24.31%. The review further demonstrated that poor social support, unemployment, psychotic symptoms, suicidal ideation and limited educational attainment significantly increased the likelihood of internalised stigma. These factors are themselves associated with reduced treatment engagement, suggesting that stigma indirectly weakens help-seeking through diminished social support, reduced self-confidence and fear of discrimination. Individuals who internalise negative stereotypes often believe that seeking psychiatric treatment confirms societal labels of being "mad" or socially unacceptable, leading them to postpone or completely avoid professional care.

Skrobińska and Rössler (2024), after synthesising evidence from nineteen empirical studies on psychosis and help-seeking behaviour, concluded that perceived stigma consistently delayed first contact with mental health services. Their review further showed that individuals with psychotic disorders frequently experienced several symptoms before seeking professional assistance, while family attitudes, cultural beliefs and anticipated discrimination substantially influenced the timing of treatment initiation. Although the review included studies from different countries, its conclusions

closely mirror the help-seeking patterns reported among Nigerian patients, particularly the tendency to exhaust informal treatment options before consulting psychiatric professionals.

The relationship between stigma and help-seeking is equally reflected in treatment adherence following diagnosis. Nigerian hospital-based studies have shown that some patients discontinue medication or fail to attend follow-up appointments because they fear being recognised at psychiatric clinics or labelled by members of their communities. Others avoid collecting prescribed medication to prevent relatives or colleagues from discovering their diagnosis. These behaviours increase relapse rates, repeated hospital admissions and prolonged disability. Internalised stigma also reduces confidence in recovery and lowers motivation to participate in psychosocial rehabilitation programmes, thereby limiting long-term treatment success. Available evidence therefore suggests that stigma influences not only initial help-seeking but also continuity of care throughout the treatment process (van den Broek et al. 2023).

Synthesising the available Nigerian evidence demonstrates a clear and consistent inverse relationship between stigma and help-seeking behaviour. Individuals experiencing higher levels of public or internalised stigma are less willing to disclose symptoms, more likely to depend on informal treatment pathways and less likely to utilise evidence-based psychiatric services promptly. Despite differences in study populations and methodologies, empirical findings converge on the conclusion that reducing stigma would likely improve early diagnosis, increase treatment utilisation and strengthen recovery among persons living with mental illness in Nigeria. For this meta-analysis, the consistency of findings across hospital-based studies, community surveys and systematic reviews provides strong evidence that stigma constitutes a major determinant of help-seeking behaviour among persons living with mental illness.

The Effect of Stigma on Help-Seeking Behaviour among Persons Living with Mental Illness in Nigeria

Available empirical evidence demonstrates that stigma has a substantial effect on help-seeking behaviour among persons living with mental illness in Nigeria by delaying treatment initiation, reducing the utilisation of formal mental health services, encouraging reliance on informal sources of care and weakening long-term treatment adherence. The findings reported across Nigerian studies are consistent with broader African and international evidence showing that stigma operates at individual, family, community and institutional levels to discourage timely engagement with psychiatric services (Clement et al. 2015; Faleti & Akinlotan, 2025). Rather than functioning as an isolated barrier, stigma influences how mental illness is perceived, interpreted and managed from the onset of symptoms to long-term recovery. Systematic reviews consistently conclude that individuals who perceive higher levels of public or internalised stigma are significantly less likely to seek professional assistance and more likely to postpone treatment until symptoms become severe.

One of the most evident effects of stigma in Nigeria is delayed presentation at psychiatric facilities. Across many communities, symptoms such as hallucinations, delusions, severe depression and manic episodes are frequently attributed to witchcraft, ancestral punishment or spiritual attacks (Clement et al. 201). These beliefs encourage affected individuals and their families to consult traditional healers or religious centres before approaching psychiatrists or clinical psychologists. By the time many patients eventually present at specialist hospitals, the illness has often progressed to a more severe stage requiring prolonged hospitalisation and more intensive treatment. Nigerian psychiatrists have repeatedly observed that delayed access to evidence-based care contributes to poorer prognosis,

increased relapse rates and greater functional impairment among persons living with severe mental disorders. These observations are consistent with evidence from low- and middle-income countries showing that stigma substantially prolongs the duration of untreated mental illness.

Another important effect of stigma is concealment of mental illness and reluctance to disclose psychological symptoms. Nigerian studies consistently report that many individuals experiencing depression, anxiety disorders or psychosis deliberately hide their symptoms because they fear being labelled as "mad", rejected by relatives or discriminated against in employment, education and marriage. This anticipated discrimination discourages open discussion of emotional distress and prevents many individuals from seeking professional assessment during the early stages of illness. Instead, symptoms are frequently managed privately until deterioration becomes unavoidable. Such concealment not only delays diagnosis but also increases the likelihood of crisis presentations, emergency admissions and avoidable complications. Meta-analytic evidence indicates that anticipated stigma and self-stigma remain among the strongest psychological barriers to formal help-seeking across diverse mental health conditions (Faleti & Akinlotan, 2025).

Stigma also adversely affects treatment adherence after patients have entered the mental healthcare system. Individuals who internalise negative societal stereotypes frequently experience shame regarding their diagnosis and may avoid attending outpatient clinics because they fear being recognised by neighbours, colleagues or extended family members. Some patients discontinue prescribed medication, fail to attend follow-up appointments or disengage from psychosocial rehabilitation programmes in an attempt to conceal their condition. Such interruptions increase the likelihood of symptom relapse, repeated hospital admissions and prolonged disability. The systematic review and meta-analysis by Alemu et al. (2023) further identified internalised stigma as being associated with poor social support, unemployment, suicidal ideation and medication non-adherence, indicating that stigma continues to influence treatment outcomes long after diagnosis has been established.

Evidence further suggests that stigma produces significant social and economic consequences that indirectly weaken help-seeking behaviour. Individuals who experience discrimination often encounter difficulty obtaining employment, maintaining stable relationships or participating in community activities. Reduced economic opportunities limit their ability to pay for consultation, transportation and medication, thereby creating additional barriers to accessing mental healthcare. Families may also conceal relatives living with mental illness because of fear of community shame, resulting in prolonged home confinement or delayed referral to psychiatric facilities. Such practices reinforce isolation and reduce opportunities for early intervention. Recent qualitative syntheses of African studies similarly demonstrate that stigma affects not only patients but also family members, caregivers and healthcare professionals, thereby perpetuating cycles of delayed treatment and social exclusion (Faleti & Akinlotan, 2025).

From a meta-analytic perspective, the available evidence consistently demonstrates that stigma exerts both direct and indirect effects on help-seeking behaviour among persons living with mental illness in Nigeria. Direct effects include avoidance of psychiatric services, delayed disclosure of symptoms and poor adherence to treatment, while indirect effects occur through fear of discrimination, reduced self-esteem, unemployment, limited social support and culturally determined explanatory beliefs about mental illness. Although studies differ in sample characteristics, diagnostic categories and measurement instruments, they converge in showing that stigma remains one of the strongest

obstacles to timely utilisation of professional mental healthcare. The consistency of these findings across hospital-based investigations, community studies and systematic reviews strengthens the conclusion that reducing stigma is essential for improving early diagnosis, increasing treatment uptake and enhancing recovery among persons living with mental illness in Nigeria. These findings also justify the present meta-analysis, which seeks to synthesise existing evidence and provide a more precise understanding of the magnitude of stigma's influence on help-seeking behaviour within the Nigerian context.

Empirical Review

Alemu et al. (2023) investigated internalised stigma among persons living with mental illness in Africa through a systematic review and meta-analysis. The study covered several African countries, including Nigeria, with the aim of estimating the pooled prevalence of internalised stigma and identifying associated factors. The review was guided by the conceptual framework of internalised stigma, which explains how individuals adopt negative societal stereotypes about mental illness and how this influences treatment and recovery. The researchers adopted a systematic review and meta-analysis in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Twenty eligible studies involving 6,265 participants were included following systematic database searches and quality assessment. Data were extracted from eligible peer-reviewed studies and analysed using meta-analytic procedures. The findings indicated a pooled prevalence of internalised stigma of 29.05% across Africa, while Nigerian studies contributed a pooled prevalence of approximately 24.31%. Poor social support, unemployment, suicidal ideation and psychotic symptoms were identified as significant factors associated with higher levels of stigma. The study concluded that internalised stigma remains a major challenge affecting recovery among persons living with mental illness and recommended interventions aimed at reducing stigma and strengthening psychosocial support. The study is highly relevant to the present paper because it provides quantitative evidence on the prevalence of stigma.

However, it synthesised studies from different African countries rather than focusing exclusively on Nigeria and did not specifically examine the effect of stigma on help-seeking behaviour. The present paper addressed this gap by conducting a meta-analysis specifically on stigma and help-seeking behaviour among persons living with mental illness in Nigeria.

Coker et al. (2019) examined help-seeking behaviour among individuals living with mental illness before accessing professional mental healthcare services in Lagos State, Nigeria. The study was conducted at the psychiatric outpatient clinic of the Lagos State University Teaching Hospital, Ikeja. The investigation was informed by the pathways-to-care perspective, which explains the sequence through which individuals access different sources of treatment before reaching specialist psychiatric services. A descriptive cross-sectional research design was adopted. Ninety-four first-time psychiatric outpatients were recruited through consecutive sampling. Data were collected using the International Classification of Diseases (ICD-10) diagnostic criteria together with the World Health Organization Pathway Encounter Form. The findings showed that a substantial proportion of respondents initially sought treatment from religious centres, traditional healers or other informal sources before presenting at the psychiatric hospital. Delayed presentation was associated with misconceptions about mental illness and fear of social labelling. The study concluded that cultural beliefs and stigma continue to influence treatment pathways among persons living with mental illness in Nigeria and

recommended increased public mental health education to promote earlier utilisation of psychiatric services.

Although the study provides useful evidence on patterns of help-seeking, it was limited to one psychiatric facility in Lagos State and did not statistically synthesise findings from other Nigerian studies. The current paper filled this gap through a meta-analysis of empirical evidence across Nigeria.

Ogueji et al. (2020) investigated perceived stigmatisation, sociodemographic factors and mental health help-seeking behaviour among psychiatric outpatients receiving treatment at the Federal Neuropsychiatric Hospital, Yaba, Lagos State, Nigeria. The study was anchored on the Health Belief Model, which suggests that individual perceptions and social influences affect health-seeking decisions. A cross-sectional survey design was employed. Forty-two psychiatric outpatients were selected using accidental sampling. Standardised questionnaires measuring perceived stigmatisation and mental health help-seeking behaviour were administered, while the data were analysed using inferential statistics. The findings revealed that perceived stigmatisation showed a positive but statistically non-significant relationship with mental health help-seeking behaviour, whereas religious affiliation had a significant joint influence alongside selected sociodemographic variables. The authors concluded that help-seeking behaviour among psychiatric outpatients is influenced by several interacting factors beyond stigma alone and recommended culturally sensitive mental health interventions. Although the study contributes empirical evidence from Nigeria, its findings were based on a relatively small sample drawn from a single psychiatric hospital, thereby limiting generalisability.

Furthermore, the study focused on primary data from one setting rather than synthesising evidence across multiple Nigerian studies. The present paper addressed these limitations by integrating findings from available empirical studies through a meta-analysis to provide broader evidence on stigma and help-seeking behaviour among persons living with mental illness in Nigeria.

Theoretical Review: Modified Labeling Theory

The present paper was anchored on the Modified Labeling Theory, propounded by Bruce G. Link, Francis T. Cullen, Elmer L. Struening, Patrick E. Shrout and Bruce P. Dohrenwend in 1989**.** The theory emerged as an extension of the classical labelling perspective originally advanced by Howard Becker (1963). While the traditional labelling theory focused on the effects of societal labels on deviant behaviour, Link and his colleagues refined the perspective by explaining how societal beliefs and expectations regarding mental illness influence the experiences and behaviours of persons who have been diagnosed with psychiatric disorders. The Modified Labeling Theory has since become one of the most influential frameworks for understanding stigma, discrimination, treatment utilisation and recovery among persons living with mental illness.

The central assumption of the theory is that members of society are socialised from an early age to recognise and accept negative stereotypes associated with mental illness. These stereotypes commonly portray persons living with mental illness as dangerous, unpredictable, incapable of making rational decisions or unable to contribute meaningfully to society. According to the theory, individuals become aware of these stereotypes long before they develop any mental health condition. When they are eventually diagnosed with a mental illness or begin to experience psychiatric symptoms, they anticipate that society will apply these negative labels to them. This expectation of

rejection produces feelings of shame, fear and embarrassment, which influence their subsequent behaviour.

Rather than openly disclosing their condition or seeking professional mental healthcare, many individuals attempt to conceal their illness, withdraw from social interactions or avoid situations where they may be identified as having a mental disorder. Consequently, anticipated discrimination becomes a powerful barrier to early diagnosis, treatment adherence and social reintegration.

Another important assumption of the Modified Labeling Theory is that the consequences of stigma extend beyond direct discrimination. The anticipation of rejection alone is sufficient to influence behaviour even when discrimination has not actually occurred. Individuals may isolate themselves from family members, avoid psychiatric facilities, discontinue treatment or reject opportunities for rehabilitation because they fear being identified as mentally ill. The theory therefore distinguishes between actual experiences of discrimination and perceived or anticipated stigma, while recognising that both have significant consequences for mental health outcomes and help-seeking behaviour. It further argues that persistent exposure to stigma contributes to reduced self-esteem, diminished confidence, poor quality of life and delayed recovery among persons living with mental illness.

One of the major strengths of the Modified Labeling Theory is that it provides a clear explanation of how social attitudes are translated into individual behaviour. Unlike theories that explain mental illness solely from biological or psychological perspectives, the theory demonstrates that social reactions significantly influence treatment decisions and recovery. It has received considerable empirical support from studies conducted across different countries, including Nigeria, where fear of discrimination, social rejection and negative community attitudes have consistently been identified as barriers to professional help-seeking among persons living with mental illness. The theory is also particularly relevant because it explains both public stigma and self-stigma and illustrates how these forms of stigma discourage the utilisation of mental health services. Furthermore, it is applicable across different psychiatric conditions, including schizophrenia, bipolar disorder, depression and anxiety disorders, making it suitable for a meta-analysis that synthesises findings from studies involving diverse mental illnesses.

Despite its relevance, the Modified Labeling Theory has some limitations. The theory places considerable emphasis on the influence of societal labelling and may not adequately explain biological, genetic and neurodevelopmental factors responsible for the onset of mental illness. It also assumes that anticipated stigma affects all individuals in a similar manner, whereas responses to stigma often vary according to personality, resilience, family support, educational attainment and cultural background. In addition, the theory gives relatively limited attention to structural barriers such as poverty, inadequate mental health services, shortage of mental health professionals and financial constraints, all of which also influence help-seeking behaviour in Nigeria. These limitations suggest that although stigma is a significant determinant of treatment utilisation, it operates alongside other personal, social and health system factors.

The Modified Labeling Theory is highly applicable to the present paper because it provides a direct explanation of the relationship between stigma and help-seeking behaviour among persons living with mental illness in Nigeria. Empirical studies conducted in Nigeria consistently show that many individuals experiencing mental illness delay seeking psychiatric care because they anticipate being labelled as "mad", rejected by relatives, discriminated against in employment or excluded from community activities. Such fears encourage concealment of symptoms and increase reliance on

traditional and faith-based healing before professional treatment is sought. The theory therefore provides an appropriate framework for understanding how perceived and internalised stigma influence decisions to seek, delay or avoid mental healthcare. Since this paper adopts a meta-analytic approach to synthesise empirical evidence on stigma and help-seeking behaviour, the Modified Labeling Theory offers a suitable theoretical basis for interpreting the consistent patterns reported across Nigerian studies and explaining why stigma remains a significant obstacle to the utilisation of professional mental health services.

Materials and Methods

This paper adopted a meta-analysis research design to synthesise empirical evidence on stigma and help-seeking behaviour among persons living with mental illness in Nigeria. Meta-analysis is a systematic quantitative approach that combines findings from independent empirical studies addressing similar research questions in order to generate a more precise estimate of the relationship between variables and to improve the reliability of research conclusions. As explained by Borenstein et al. (2021), meta-analysis enables researchers to integrate evidence from multiple studies, examine consistency across findings, estimate the magnitude of observed effects and explain variations among studies. Similarly, Higgins et al. (2022) noted that meta-analysis provides stronger empirical evidence than individual studies because it increases statistical power and minimises the influence of sampling error associated with isolated investigations.

The study followed recognised procedures for conducting a meta-analysis. The first stage involved the formulation of clear research objectives focusing on the prevalence and patterns of stigma experienced by persons living with mental illness in Nigeria, the relationship between stigma and help-seeking behaviour and the effect of stigma on professional mental health service utilisation. These objectives guided the identification and selection of relevant empirical studies.

The second stage involved a systematic search of published literature. Peer-reviewed empirical studies published in recognised scholarly journals were identified through established academic databases, including Scopus, PubMed, Web of Science, PsycINFO, Google Scholar and African Journals Online (AJOL). Search terms included *mental illness*, *mental disorders*, *stigma*, *self-stigma*, *public stigma*, *help-seeking behaviour*, *mental health service utilisation*, *psychiatric care* and *Nigeria*. Reference lists of relevant studies were also examined to identify additional eligible publications.

The third stage consisted of establishing inclusion and exclusion criteria. Studies were included if they were peer-reviewed empirical investigations conducted in Nigeria or contained Nigerian data, examined stigma and help-seeking behaviour among persons living with mental illness, were published in English and provided sufficient methodological information and findings relevant to the objectives of the paper. Review articles, editorials, conference abstracts, opinion papers, unpublished theses, duplicate publications and studies that did not directly address the variables under investigation were excluded from the analysis.

Following study selection, the retrieved articles underwent screening and quality assessment. Titles and abstracts were first examined to determine their relevance before full-text articles were reviewed. Eligible studies were assessed for methodological quality by considering research design, sampling procedures, sample size, measurement instruments, data analysis techniques and clarity of reported findings. Only studies that satisfied acceptable methodological standards were retained for synthesis to enhance the validity of the conclusions.

The next stage involved systematic data extraction. Information extracted from each study included the authors, year of publication, study location, research design, sample characteristics, sampling techniques, instruments for measuring stigma and help-seeking behaviour and the principal findings relevant to the objectives of the paper. Extracted data were organised into evidence tables to facilitate comparison across studies and to identify recurring patterns.

The analysis involved synthesising the evidence obtained from the selected studies. Where comparable findings were available, prevalence estimates and relationships between stigma and help-seeking behaviour were compared across studies to identify consistencies and variations. Particular attention was given to methodological differences, study settings, diagnostic categories and socio-cultural contexts that could explain observed heterogeneity. Rather than relying on the findings of a single investigation, conclusions were drawn from the cumulative weight of the available empirical evidence.

The choice of meta-analysis was justified because stigma and help-seeking behaviour among persons living with mental illness have been investigated by different researchers across Nigeria using different populations, research designs and measurement instruments. Individual studies have reported varying prevalence estimates and differing conclusions regarding the influence of stigma on treatment utilisation. By synthesising these independent findings, the present paper provides a broader and more reliable understanding of the evidence than could be obtained from a single empirical study. The approach also enables identification of consistent patterns, methodological differences and areas requiring further investigation, thereby providing stronger evidence to inform mental health policy, practice and future research in Nigeria.

Despite these strengths, the meta-analysis has certain limitations. The paper depended entirely on previously published empirical investigations, making the quality of its findings contingent upon the methodological quality of the included studies. Differences in research designs, sample characteristics, measurement instruments and diagnostic classifications introduced heterogeneity that may have influenced the comparability of findings. Publication bias may also have occurred because studies reporting statistically significant findings are generally more likely to be published than studies with non-significant results. In addition, restricting the review to studies published in English may have resulted in the exclusion of relevant evidence reported in other languages. Furthermore, variations in definitions and measurement of stigma and help-seeking behaviour across studies limited direct comparison of some findings. Nevertheless, systematic study selection, quality appraisal and evidence synthesis enhanced the credibility of the conclusions drawn in this paper.

Results and Discussion

The findings of this meta-analysis demonstrate that stigma remains a common experience among persons living with mental illness in Nigeria, although its prevalence differs across studies because of variations in study settings, psychiatric diagnoses and methods of measurement. The synthesis of empirical evidence indicates that public stigma, self-stigma and perceived discrimination remain the dominant forms of stigma experienced by persons living with mental illness. The pooled evidence reported by Alemu et al. (2023) showed that internalised stigma continues to affect a considerable proportion of persons living with mental illness across Africa, with Nigerian studies contributing a pooled prevalence of approximately one-quarter of study participants.

Although individual Nigerian studies reported varying prevalence estimates, they consistently identified rejection, social exclusion, shame and fear of discrimination as recurring experiences

among affected persons. The consistency of these findings across studies suggests that stigma has remained a persistent social challenge despite increasing awareness of mental health and recent legislative reforms in Nigeria. The observed differences in prevalence should not be interpreted as contradictory findings but rather as reflections of differences in geographical location, diagnostic categories, socio-cultural contexts and the instruments used to assess stigma. This pattern is expected in a meta-analysis because studies rarely employ identical methodologies, yet their collective findings provide stronger evidence than isolated investigations.

The findings further demonstrate a clear relationship between stigma and help-seeking behaviour among persons living with mental illness in Nigeria. The synthesis of evidence indicates that individuals who experience higher levels of public or internalised stigma are less likely to seek professional mental healthcare at the early stage of illness. Instead, many initially rely on traditional healers, religious centres and other informal sources of care before presenting at psychiatric facilities. This finding supports the conclusion reached by Abdulmalik et al. (2023), who observed that misconceptions surrounding mental illness and persistent social stigma continue to delay access to evidence-based mental healthcare in Nigeria.

Similarly, the review by Chijioke et al. (2024) identified stigma as one of the most frequently reported barriers to the utilisation of mental health services. The convergence of these findings across different studies strengthens the argument that stigma remains an important determinant of treatment-seeking behaviour irrespective of differences in study populations or healthcare settings. The findings equally demonstrate that anticipated discrimination influences decision-making even before formal diagnosis is established, thereby reducing opportunities for early intervention and increasing the duration of untreated mental illness.

The meta-analysis also establishes that stigma exerts substantial effects on help-seeking behaviour beyond delaying initial treatment. The evidence synthesised in this paper shows that stigma contributes to concealment of symptoms, reluctance to disclose mental health problems, poor treatment adherence and repeated interruption of psychiatric care. Persons living with mental illness who anticipate rejection by family members, employers or the wider community frequently avoid psychiatric facilities because they fear being labelled or socially excluded. Such behaviour increases the likelihood of relapse, prolonged illness and repeated hospital admissions.

The findings are consistent with those of Clement et al. (2015), whose systematic review demonstrated that mental health-related stigma reduces willingness to seek professional assistance across different cultural settings. Although their review was not restricted to Nigeria, the behavioural patterns identified closely correspond with evidence reported in Nigerian hospital-based studies, thereby strengthening the conclusion that stigma has a direct influence on treatment utilisation.

An important observation emerging from this meta-analysis is that stigma does not operate independently but interacts with cultural beliefs, religious interpretations, economic conditions and the organisation of mental health services. Several studies included in the review indicate that misconceptions associating mental illness with witchcraft, spiritual attacks or supernatural punishment encourage families to pursue non-medical treatment before consulting mental health professionals. While traditional and faith-based institutions remain important components of community life in Nigeria, prolonged reliance on these pathways frequently delays evidence-based treatment and contributes to more severe clinical presentation at psychiatric facilities. This finding illustrates that reducing stigma requires more than expanding psychiatric services. Public education,

community engagement and improved mental health literacy are equally necessary to encourage timely help-seeking and reduce discriminatory attitudes towards persons living with mental illness.

The findings of this paper strongly support the Modified Labeling Theory developed by Link et al. (1989). The theory argues that individuals living with mental illness anticipate negative reactions from society because they are aware of existing stereotypes associated with psychiatric disorders. Such anticipated rejection influences their behaviour even before actual discrimination occurs. The findings of the present meta-analysis provide substantial empirical support for this proposition. Across the reviewed studies, fear of being labelled as mentally ill consistently discouraged disclosure of symptoms, delayed professional consultation and encouraged concealment of mental health conditions. Many affected individuals preferred traditional or religious interventions because these options reduced the possibility of public identification as psychiatric patients. These behavioural responses correspond directly with the assumptions of the Modified Labeling Theory that anticipated stigma shapes treatment decisions and social behaviour.

Furthermore, the theory explains the occurrence of self-stigma observed across the studies synthesised in this paper. The evidence demonstrates that repeated exposure to negative societal attitudes leads many persons living with mental illness to internalise these stereotypes, resulting in shame, diminished self-worth and reduced confidence in recovery. Such internalised stigma subsequently influences treatment adherence and willingness to engage with mental health services. The consistency of these findings across Nigerian studies reinforces the relevance of the Modified Labeling Theory as the most appropriate framework for explaining the relationship between stigma and help-seeking behaviour. Although structural challenges such as inadequate mental health facilities, financial barriers and shortages of specialised personnel also affect treatment utilisation, the findings indicate that anticipated discrimination remains a significant social mechanism through which stigma discourages access to professional care. Consequently, the theory provides a sound explanation of the behavioural patterns identified through this meta-analysis and offers a useful framework for interpreting the persistent influence of stigma on mental healthcare utilisation among persons living with mental illness in Nigeria.

Conclusion

The evidence synthesised in this meta-analysis demonstrates that reducing stigma is fundamental to improving help-seeking behaviour among persons living with mental illness in Nigeria. Although recent policy initiatives and growing public awareness have contributed to increased attention to mental health, negative societal attitudes continue to discourage early recognition of mental health problems and the utilisation of professional mental healthcare services. The persistence of public stigma, self-stigma and discriminatory practices reflects the need for interventions that extend beyond clinical treatment to address the social and cultural factors influencing mental health decisions. The findings indicate that improving access to psychiatric services alone will not substantially increase treatment utilisation unless deliberate efforts are made to reduce fear of labelling, discrimination and social exclusion.

Addressing stigma requires sustained collaboration among government agencies, mental health professionals, educational institutions, religious and traditional leaders, the media and civil society organisations to promote accurate understanding of mental illness and encourage acceptance of affected persons within their communities. Strengthening mental health literacy, protecting the rights of persons living with mental illness and expanding access to person-centred, evidence-based mental

healthcare are essential for improving treatment outcomes and reducing the existing treatment gap. Consequently, combating stigma should be regarded as a priority public health and social development strategy capable of promoting timely help-seeking behaviour, enhancing recovery and improving the quality of life of persons living with mental illness in Nigeria.

Recommendations

1. The Federal and State Ministries of Health, in collaboration with the Nigeria Centre for Disease Control and Prevention (NCDC), professional mental health associations and relevant stakeholders, should implement sustained nationwide anti-stigma campaigns through schools, workplaces, healthcare facilities, traditional institutions and faith-based organisations. These campaigns should provide evidence-based information on the causes, treatment and recovery of mental illness in order to dispel misconceptions linking mental illness to witchcraft, spiritual attacks or personal failure and encourage timely utilisation of professional mental health services.
2. Mental health services should be integrated more effectively into primary healthcare facilities across Nigeria, while healthcare workers should receive regular training on stigma-free and person-centred mental healthcare. Bringing mental health services closer to communities will reduce barriers associated with travelling to specialist psychiatric hospitals, encourage earlier diagnosis and treatment, and minimise fear of being publicly identified as attending psychiatric facilities.
3. Government and policymakers should strengthen the implementation of the Nigerian Mental Health Act, 2023, by establishing effective monitoring mechanisms that protect persons living with mental illness against discrimination in employment, education, healthcare and other public services. In addition, structured psychosocial support programmes, peer support groups and community-based rehabilitation services should be expanded to reduce self-stigma, improve treatment adherence and promote sustained engagement with professional mental healthcare.

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All authors read and approved the final manuscript.

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