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Positive Mental Health and Well-Being in Nigeria: An Ethical View

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ABSTRACT: Mental health policy in Nigeria has historically centred on the diagnosis and containment of illness. This paper argues that such a framing is ethically incomplete. Drawing on the concept of positive mental health, understood as the presence of psychological, emotional and social flourishing rather than the mere absence of disorder, it examines what Nigerian society owes its members in the domain of well-being. The paper brings three ethical traditions into conversation: principlism in biomedical ethics, African communitarian moral thought, and the capabilities approach to justice. It identifies seven areas of ethical concern: stigma and moral status, distributive justice in access to care, autonomy and coercion in traditional and faith-based settings, the vulnerability of young people and women, and the structural conditions of poverty and insecurity that erode well-being. The paper concludes that a Nigerian ethic of mental well-being should be relational, rights-based and promotive, and it proposes practical commitments for government, professionals, communities and religious institutions.

Keywords: *positive mental health; well-being; Nigeria; ethics; communitarianism; capabilities; mental health law*

1. Introduction

To ask whether a person is mentally healthy is, in most Nigerian conversations, to ask whether that person is mentally ill. The word "madness" still dominates popular speech,

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and public attention to the mind tends to arise only when someone has visibly broken down. The result is a narrow moral imagination. Mental health becomes a problem that afflicts a small and unfortunate minority, rather than a dimension of human life that every person has a stake in and that every society has a duty to cultivate.

The World Health Organization's constitution has long declared health to be a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[1] More recent WHO statements describe mental health as a state of well-being in which individuals realise their abilities, cope with normal stresses of life, work productively and contribute to their communities.[2] These formulations shift the question from "Who is sick?" to "What does it take for a person, and a people, to flourish?" That second question is at heart an ethical one, because it concerns the goods that human beings need, the obligations others bear toward them, and the fair distribution of both.

This paper takes up that question for Nigeria. It does not attempt a clinical survey. Its contribution is normative: it asks what a morally defensible approach to positive mental health and well-being would look like in a country marked by cultural plurality, severe resource constraints, widespread insecurity and a deep attachment to communal and religious life. The argument proceeds in six steps. Section 2 clarifies the concept of positive mental health. Section 3 sketches the Nigerian context. Section 4 sets out three ethical frameworks suited to the task. Section 5 applies them to seven concrete problems. Section 6 reviews the legal and policy landscape, and Section 7 offers recommendations before a brief conclusion.

2. Conceptualising Positive Mental Health and Well-Being

2.1 From absence of illness to presence of flourishing

The idea that mental health is more than freedom from symptoms has a respectable intellectual history. Marie Jahoda, writing in the late 1950s, proposed that positive mental health could be recognised through attitudes toward the self, growth and self-actualisation, integration of personality, autonomy, accurate perception of reality and environmental mastery.[3] Her criteria were contested, but they established a lasting point: the absence of disorder does not guarantee a life that is going well.

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Subsequent research has developed this insight along two main lines. The first is the hedonic tradition, which treats well-being as subjective satisfaction, the presence of positive affect and the relative absence of negative affect.[4] The second is the eudaimonic tradition, which locates well-being in the realisation of human potential. Carol Ryff's multidimensional model, for example, identifies self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth.[5] Corey Keyes later integrated these strands into a "mental health continuum" that distinguishes flourishing, moderate mental health and languishing, and showed that languishing, a condition of emptiness and stagnation, is distinct from depression yet carries real costs.[6] Martin Seligman's popular synthesis of positive psychology adds engagement, meaning and accomplishment to the list of components.[7]

2.2 Why the concept needs ethical supplementation

Most of these models were built from studies in Western, educated and relatively affluent populations. Their vocabulary of autonomy and self-actualisation presupposes a particular picture of the person, namely the individual as a self-contained chooser. Applied uncritically in Nigeria, such a picture risks misdescribing what well-being means for people whose sense of self is formed through kinship, age-grade, ethnic belonging, faith and obligation to others. A Yoruba elder, an Igbo trader, a Hausa farmer and a Niger Delta fisherwoman may each recognise "a good life," but they will not necessarily describe it as personal fulfilment alone. Respect, a good name, the capacity to support one's dependants, harmony with neighbours and standing before God or the ancestors commonly figure in how well-being is understood.

For this reason the paper adopts a working definition that is deliberately thick. *Positive mental health and well-being* is here understood as a person's capacity to live with a sense of meaning, emotional balance, healthy relationships and practical agency, within social conditions that make such a life realistically possible. The last clause matters. It makes well-being a joint product of individual capacities and social arrangements, and therefore a legitimate object of public responsibility rather than private fortune.

2.3 Measuring well-being: an ethical caution

Researchers often rely on standardised scales to measure well-being, and such tools are valuable for planning and accountability. Yet measurement carries ethical risks of its own.

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Instruments developed elsewhere may embed foreign assumptions, so that a Nigerian respondent who gives priority to family harmony or religious devotion is scored as deficient in autonomy or self-expression. Translation into Hausa, Igbo, Yoruba, Pidgin and the many other languages of the country is not a mechanical task, because words for happiness, sadness and distress carry different moral weight in different tongues. Researchers therefore have a duty to validate instruments locally, to involve community members in interpreting results, and to avoid using aggregate scores to rank or shame particular groups. Data about the mind are among the most sensitive that can be collected, and consent, confidentiality and fair use apply to them with special force.

3. The Nigerian Context

3.1 Burden and treatment gap

The best-known epidemiological study in the country, the Nigerian Survey of Mental Health and Well-Being, interviewed a nationally representative sample and reported that roughly one in eight respondents had experienced a mental disorder at some point in life, while around six percent had met criteria for a disorder in the preceding year; very few of those affected had received any treatment.[8] The survey is now several years old, and prevalence estimates have been revised in other studies, but the underlying pattern of a very large treatment gap is consistent with global findings. The *Lancet* Commission on global mental health and sustainable development has described the global neglect of mental health as a failure that imposes heavy human and economic costs, concentrated in low- and middle-income countries.[9]

Service capacity is thin. WHO's *Mental Health Atlas* documents that mental health spending in many low-income and lower-middle-income countries is a tiny share of health budgets and that specialist workforces are extremely small relative to population.[10] In Nigeria, psychiatric care has historically been concentrated in a small number of federal neuropsychiatric hospitals and teaching hospitals, largely in urban centres, leaving rural populations with few options other than family, faith and traditional healers.

3.2 Stigma, belief and help-seeking

Studies of public attitudes in south-western Nigeria have found considerable social distance toward people with mental illness, reflecting fear, beliefs about dangerousness and

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ideas about spiritual causation.[11] Research with service users in the Niger Delta has identified barriers to care that include cost, distance, stigma and preference for spiritual explanations.[12] It would be wrong to portray these beliefs as simple ignorance. Spiritual and moral explanations of distress often coexist with biomedical ones, and many families turn first to prayer houses or herbalists because those are the institutions that are accessible, affordable and culturally intelligible. The ethical task is therefore not to dismiss such practices wholesale but to separate what is supportive in them from what is abusive.

The abusive end of the spectrum is well documented. Human Rights Watch has reported the shackling and confinement of people with psychosocial disabilities in numerous countries, including Nigeria, in homes, religious centres and traditional healing sites.[13] Such practices represent the sharpest edge of a broader problem: when a society equates mental distress with spiritual defect or personal failure, it withdraws the moral regard owed to the sufferer.

3.3 Social determinants

Positive mental health cannot be separated from material conditions. Poverty, unemployment among young people, displacement caused by banditry and insurgency, communal violence, gender-based violence, inflation and the stress of unreliable infrastructure all weigh on well-being. A person who is chronically hungry, unsafe or without prospects will struggle to flourish regardless of personal resilience. This observation has direct ethical consequences, because it shows that a purely clinical response, however well-resourced, would fail to address many of the causes of poor well-being.

3.4 Religion, culture and plural healing traditions

Religion is a central fact of Nigerian public life. Christianity, Islam and indigenous traditions shape how people interpret suffering, how they seek comfort and whom they trust. For many, prayer, fasting, scripture, Qur'anic recitation and communal worship are sources of real psychological support, and religious congregations supply networks of care that formal health services seldom match. Studies of traditional and complementary systems of medicine in the treatment of mental disorders have observed both the prevalence of such systems worldwide and the need for careful evaluation of their benefits

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and harms.[26] The anthropologist and psychiatrist Arthur Kleinman has long argued that illness is shaped by cultural explanatory models, which clinicians must understand if they are to be effective and respectful.[27]

Nigeria's plurality also means that no single account of well-being can be assumed. Practices among the Yoruba, Igbo, Hausa-Fulani, Ijaw, Tiv, Efik and hundreds of other communities differ in their idioms of distress and in their rituals of healing. An ethics for the whole country must therefore be pluralistic without being relativistic: it should honour diverse conceptions of the good life while holding firm to a shared floor of protections, including freedom from cruelty, access to competent care and respect for each person's dignity.

Policy history reinforces the point. Reviews of mental health policy development in Africa have noted that colonial-era legal frameworks and underinvestment in community services left a lasting legacy, and that reform must connect to local realities rather than import models wholesale.[28]

4. Ethical Frameworks

4.1 Principlism

The most widely used framework in biomedical ethics is the four-principle approach of Tom Beauchamp and James Childress: respect for autonomy, non-maleficence, beneficence and justice.[14] Its virtues are clarity and portability. In mental health practice, respect for autonomy requires informed consent and attention to decision-making capacity; non-maleficence forbids harmful or degrading treatment, including unnecessary restraint; beneficence requires positive action for patients' good; and justice demands fair allocation of scarce resources.

Principlism has limits in the Nigerian setting. Its default image of the autonomous patient may sit uneasily with family-centred decision-making, in which relatives often participate in, or even take over, choices about care. At the same time, abandoning autonomy because decisions are communal would risk licensing precisely the coercion that harms vulnerable people. The principles are best treated as prima facie commitments to be interpreted through local moral understanding, not discarded.

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4.2 African communitarian ethics

A rich body of African moral philosophy holds that personhood is not given at birth but achieved through participation in community. John Mbiti's much-quoted summary of the outlook, "I am because we are," captures the relational ontology that many African thinkers describe.[15] Ifeanyi Menkiti argued that personhood is acquired processually, through the fulfilment of social obligations over a lifetime, so that moral status is tied to communal membership.[16] Kwame Gyekye offered a more moderate communitarianism that preserves the individual's rights and dignity while insisting that persons are by nature social and bound by duties to others.[17] Thaddeus Metz has proposed that an African moral theory can be built around the value of relationships of identity and solidarity, so that actions are right insofar as they honour communal relationship.[18]

These ideas bear on mental health in two directions. On the positive side, they supply a powerful rationale for communal responsibility: if a person's well-being is bound up with that of others, then the suffering of one member is a concern for all, and isolation is itself a harm. On the negative side, a crude version of Menkiti's view could be misused to suggest that people with severe mental illness, unable to meet social roles, are somehow lesser persons. A defensible communitarian ethic must therefore follow Gyekye in affirming an inherent dignity that illness cannot erase.

4.3 The capabilities approach

Amartya Sen and Martha Nussbaum have argued that justice should be assessed by what people are actually able to do and to be, not only by the resources they hold.[19] Nussbaum's list of central capabilities includes bodily health, emotions, practical reason, affiliation and control over one's environment, all of which map readily onto the components of positive mental health. The approach is helpful because it is neither purely individualistic nor purely collective: it asks what real opportunities for flourishing each person has, and it identifies the social conditions required to secure them. It also echoes the Aristotelian tradition, in which a flourishing life is the proper end of human activity and requires external goods and fellowship.[20]

4.4 A composite view

The three frameworks are complementary. Principlism supplies protective rules against abuse; communitarianism supplies a relational account of why well-being is a shared

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concern; the capabilities approach supplies a standard of justice that focuses on real opportunity. Together they support an *ethic of flourishing in community*: persons possess inalienable dignity, they develop through relationship, and society owes them the conditions under which they can live well. The next section tests this ethic against concrete problems.

5. Ethical Problems in the Nigerian Setting

5.1 Stigma and moral status

Stigma is the most pervasive ethical problem in this field because it attacks the very basis of moral regard. When a person with depression, psychosis or an anxiety disorder is described as bewitched, weak, cursed or dangerous, the description does more than hurt feelings. It signals that the person has forfeited the respect normally owed to a member of the community. Under principlism this is a violation of respect for persons and of non-maleficence, since stigma itself causes harm, delays help-seeking and compounds isolation. Under communitarian ethics it is a failure of solidarity, because it ruptures the very relationships through which personhood is sustained. Under the capabilities approach it constricts affiliation and the social bases of self-respect, which Nussbaum treats as central to a life worthy of human dignity.

The remedy is not only information campaigns. It requires visible examples of recovery, inclusion in schools and workplaces, responsible media representation and leadership by respected figures, including traditional rulers, pastors and imams. Such figures are credible custodians of communal values, and an ethic that draws on those values can recruit them as allies rather than treat them as obstacles.

5.2 Distributive justice and access to care

A country with a very small specialist workforce and heavily concentrated facilities faces a stark justice problem. Those who can afford private care or travel to a major city receive treatment; most others receive little or none. Out-of-pocket payment, which remains the dominant mode of health financing in Nigeria, compounds the inequity because families already strained by poverty must choose between treatment and other necessities. The treatment gap is therefore not a neutral fact but a pattern of unfairness.

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Several theories of justice converge on a response. Principlism's justice principle calls for fair distribution of benefits and burdens. Sen's and Nussbaum's approach directs priority to the removal of capability deprivation among those worst off. A communitarian reading adds that a community that leaves some members unattended while others thrive has failed in its basic duty of mutual care. Practically, the most promising strategy is task-sharing, in which trained primary care workers and community health workers deliver evidence-based interventions for common disorders under specialist supervision. The scale-up literature argues persuasively that this approach is both feasible and cost-effective in low-resource settings.[24] Integrating mental health into primary health care, funding it through public insurance and extending coverage to the poor are not optional extras; they are demands of justice.

5.3 Autonomy, coercion and traditional or faith-based care

The use of chains, confinement, forced fasting or beating to treat mental illness presents the starkest conflict between local practice and ethical norms. Those who carry out these practices are often motivated by genuine concern, fear for the person's safety, or the belief that they are expelling a spiritual affliction. Yet good intentions do not justify measures that inflict suffering, deprive liberty and often worsen the condition. Non-maleficence and respect for dignity are decisive here. International human rights law, in particular the Convention on the Rights of Persons with Disabilities, prohibits arbitrary deprivation of liberty and inhuman or degrading treatment on the basis of disability, and Nigeria has ratified the Convention.[23] The 1999 Constitution likewise guarantees dignity of the person and personal liberty.[21]

The ethically mature response is not a blanket condemnation of traditional and religious healers. Many offer companionship, ritual meaning, hope and community acceptance, goods that clinical services often lack. Kwasi Wiredu's insistence that cultural particularity must be assessed critically rather than either romanticised or rejected is instructive.[25] A collaborative model is more defensible: train willing healers and clergy to recognise serious illness, to refer, to eliminate coercive practices, and to complement rather than replace medical care. Where abuse persists, enforcement of the law must follow.

The autonomy question also arises in family decision-making. Respect for relational autonomy, the idea that choices are made in a web of relationships, allows families a

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legitimate role. But the person's own voice must still count. Supported decision-making, in which families assist rather than override, offers a way to reconcile communal and individual claims.

5.4 Young people, women and other vulnerable groups

Nigeria has one of the largest youth populations in the world, and young people face heavy pressure from unemployment, academic competition, substance use, cyberbullying and exposure to violence. Women are exposed to gender-based violence, harmful widowhood practices, early marriage and the strain of dual burdens in precarious economies. Internally displaced people and survivors of conflict carry trauma that rarely receives professional attention. Older adults, people with disabilities and persons with chronic illness are further at risk of neglect.

The ethical significance of these groups lies in their vulnerability: their limited power to protect their own interests makes the duties of others weightier. Beneficence and justice call for targeted, culturally sensitive programmes, including school-based life-skills education, counselling services in universities, trauma-informed care for displaced communities, and protection against violence. Because well-being among the young is a foundation for the future of the whole society, investment here has special moral and practical weight.

5.5 Poverty, insecurity and the structural determinants of well-being

The fifth problem is structural. It is ethically problematic to place the burden of resilience on individuals while ignoring conditions that systematically erode well-being. Counselling a person to cope with hunger or fear of kidnapping, without addressing the sources of hunger or fear, shifts responsibility from institutions to the victim. A just approach therefore treats employment policy, security, housing, education and social protection as part of mental health policy. This does not dissolve the distinct role of clinical services; it places them within a broader programme of promoting the social bases of flourishing.

5.6 Professional ethics and the mental health workforce

A sixth problem concerns the people who deliver care. Nigeria has long experienced the emigration of doctors, nurses and psychologists, leaving those who remain with heavy

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caseloads, limited supplies and little institutional support. Under such conditions, ethical practice is difficult. Overworked clinicians may find it hard to obtain meaningful consent, to protect privacy in crowded wards, or to resist the temptation to rely on sedation or restraint. Professional codes, including the Code of Medical Ethics issued by the Medical and Dental Council of Nigeria, set out duties of confidentiality, competence and respect for patients,[29] but codes cannot be fulfilled in the absence of working conditions that make compliance possible.

Task-sharing raises further questions. When lay counsellors and primary care workers deliver psychological interventions, there must be adequate training, supervision, clear referral routes and protection for the practitioner from burnout. Evidence from African settings, including the Friendship Bench programme in Zimbabwe, suggests that trained lay health workers can deliver effective problem-solving therapy for common mental disorders in primary care.[30] The WHO's mhGAP guidance provides a model for training non-specialist staff to manage priority conditions.[31] These lessons imply that Nigeria's shortage of specialists is a reason to redesign services, not to accept the absence of care. They also imply a duty on the state to look after the well-being of those who provide care, since a workforce in distress cannot sustain a flourishing public.

5.7 Media, digital technology and privacy

The seventh problem is newer. Mobile phones and social media now reach a large share of the population, and they offer helplines, peer groups, telepsychiatry and educational content that can overcome distance and stigma. They also expose users to harassment, misinformation, financial scams and social comparison, and they generate sensitive data. Responsible innovation requires that digital mental health services respect confidentiality, obtain informed consent for the use of personal data, and avoid exploiting distress for commercial gain. Nigeria's Data Protection Act of 2023 classifies health information as sensitive personal data and imposes duties on those who process it,[32] but the practical enforcement of these duties in the mental health field remains to be seen. Traditional and online media also shape public attitudes: sensational reporting of suicide or violence by people with mental illness deepens stigma, whereas accurate and compassionate storytelling can reduce it. Journalists, content creators and app developers thus share the ethical responsibilities of the health professions.

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6. Law and Policy in Nigeria

For decades the legal framework for mental health in Nigeria was the Lunacy Act of 1958, an inherited colonial statute oriented toward custody and the control of people deemed dangerous, with little attention to rights, consent or treatment in the community.[22] Its outdated language and priorities were widely criticised. A new National Mental Health Act, passed by the National Assembly and signed into law in January 2023, repealed it and replaced it with a framework that is, on paper, oriented toward rights, integration of care into the health system and the establishment of a department responsible for mental health and substance-related services.[22] Readers should consult the Act's text directly, as its implementation details are still developing.

The enactment is a significant moral and legal advance, but the ethical test of any law lies in implementation. Several questions deserve continuing scrutiny. Will funding match the ambition of the statute? Will supervisory mechanisms exist to protect the rights of persons in institutions and in informal settings? Will the Act's provisions on consent, confidentiality and non-discrimination be understood by health workers, police and the public? And will it be harmonised with other measures, including the Discrimination Against Persons with Disabilities (Prohibition) Act of 2018 and constitutional protections of dignity and liberty?[21]

The Constitution also contains Fundamental Objectives and Directive Principles of State Policy directing the state to secure the welfare, health and security of citizens. Although these provisions are not directly enforceable in the same way as the fundamental rights chapter, they articulate a moral commitment on which advocacy can build. A positive mental health agenda is consistent with, and arguably demanded by, that commitment.

7. Toward an Ethic of Flourishing in Community: Recommendations

The analysis suggests the following commitments. They are presented as ethical priorities, each of which may be translated into policy.

Treat well-being as a public good. Governments should frame mental health policy around promotion and prevention as well as treatment, and should allocate a meaningful and ring-fenced share of health budgets to it.

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Close the treatment gap fairly. Prioritise primary care integration, task-sharing, and subsidised or insured access for the poor and rural populations, so that care does not depend on wealth or geography.

Protect dignity absolutely. Prohibit and enforce against chaining, torture and degrading treatment in all settings, formal and informal, while offering alternatives and support to families.

Engage traditional and religious leaders as partners. Provide training, referral pathways and shared codes of conduct, and recognise the genuine goods that communal and spiritual care can provide.

Cultivate communal solidarity. Support family and community-based programmes that reduce isolation, including peer support, community mental health groups and inclusive employment schemes.

Invest in young people and the vulnerable. Develop school and university programmes, trauma-informed services for survivors of violence and displacement, and protection for women, older adults and people with disabilities.

Address social determinants. Coordinate mental health policy with economic, security, education and housing policy, and assess major policies for their effect on well-being.

Build culturally grounded research and ethics. Fund local research on well-being concepts and measures, train mental health professionals in African moral thought as well as biomedical ethics, and include service users in policy design.

Safeguard autonomy through supported decision-making. Develop practice guidance that respects relational decision-making while ensuring each person's voice is heard.

Monitor and report. Establish transparent indicators of access, rights protection and population well-being, with public reporting and independent oversight.

8. Conclusion

This paper has argued that the ethics of mental health in Nigeria should move beyond the management of illness toward the cultivation of flourishing. Concepts of positive mental

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health drawn from psychology offer a useful vocabulary, but they require supplementation by moral frameworks capable of expressing both individual rights and communal obligations. Principlism protects persons against harm and disrespect; African communitarian thought explains why well-being is a shared responsibility; the capabilities approach insists that justice be measured by real opportunities to live well. Combined, they yield an ethic of flourishing in community.

Applied to stigma, unequal access, coercive practices, vulnerable groups structural deprivation, workforce conditions and digital media, this ethic yields demanding but realistic duties. The 2023 National Mental Health Act offers an opening, but law alone will not suffice. What is needed is a moral culture in which attending to the mind is understood as an expression of care for one another, and in which the question "How are you, truly?" is taken seriously by families, institutions and the state. A society that can ask that question honestly, and organise itself to answer it, will have advanced not only its public health but also its humanity.

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