

# Ghanaian traditional and faith healers' explanatory models of intellectual disability

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## Abstract

**Background:** The use of traditional/alternative medicine for health care in Africa has been examined for various conditions. However, there is limited research about traditional/alternative health care for intellectual disability. The present authors explored the explanatory models (EMs) of intellectual disability held by traditional/faith healers in Ghana.

**Methods:** Using a case vignette, the present authors conducted semi-structured interviews with 36 traditional/faith healers in Accra, Ghana. Using the EMs of illness framework as a guide, participants were asked questions to examine their beliefs about the nature, causes, course and recommended treatment of intellectual disability.

**Results:** The healers' causal explanations included maternal negligence during pregnancy and spiritual factors. They also believed that intellectual disability was a congenital, lifelong condition which could not be cured.

**Conclusions:** Unlike other conditions which traditional healers claimed to cure, participants admitted that intellectual disability was not curable. The present authors suggest that the findings highlight opportunities that exist for collaboration between biomedicine and traditional medicine.

## KEYWORDS

explanatory models, Ghana, intellectual disability, traditional medicine

## 1 | INTRODUCTION

The rates of intellectual disability vary from country to country, but are probably higher in low- and middle-income countries (LMICs) than in wealthier countries, due to social and economic factors such as poverty, nutrition and poor or limited formal healthcare services (Kromberg et al., 2008). There is limited access to biomedical healthcare services in these countries, and the use of traditional and alternative medicine (TAM) is common (Abera, Robbins, & Tesfaye, 2015; Christianson et al., 2002; Gureje et al., 2015). TAM is often the first point of call for many people in LMICs, and TAM practitioners form a large part of the healthcare labour force in these countries (WHO, 2013).

Traditional medicine is built on the beliefs, values and norms which are traditional or peculiar to specific communities (WHO, 2013). Faith-based healing, through, for example, Christian or Muslim religions, also plays an important part in the alternative

healing sector (Chowdhury, 2016; Crawford & Lipsedge, 2004). TAM methods are therefore influenced by their understanding of illness or disability and their effects.

Various categories of TAM practitioners are recognized in different contexts (Tabi et al., 2006; Twumasi, 1975). Some practitioners are strictly herbalists, utilizing their knowledge of plant, herb and animal properties to treat people. Other practitioners use "spiritual" or faith methods for healing, such as the Islamic clerics/diviners, who use Qur'anic verses and prayers in their healing. Another example of the spiritualists is the traditional medicine men or religious shrine priests (sometimes called shrine devotees), who serve as conduits for specific deities or ancestors through various ritualistic processes such as possession and divination. Other faith healers are the Christian faith healers, who treat illness through prophecies, exorcism, sprinkling of holy water, prayers and fasts, as well as other prayer aids such as anointed oils and salts (Gessler et al., 1995; Stekelenburg et al.,

2005; Tabi et al., 2006). These faith healers may or may not use herbs as part of their craft.

Given the reported use of TAM for conditions such as intellectual disability (Brolan et al., 2014; Kromberg et al., 2008; Njenga, 2009), the practitioners' beliefs about intellectual disability are worth examining. A useful way of examining illness and disorder beliefs is through the use of explanatory models (EMs) (Kleinman, 1980). EMs reflect the beliefs of individuals about an episode of illness or life condition (i.e., its aetiology, course and effects). EMs may also determine the choice of treatment, as well as patients' adherence to and satisfaction with the treatment programme (Callan & Littlewood, 1998). Given that traditional healers are typically positioned within the communities of their patients, their EMs may be congruent with those of their patients and may reflect cultural concepts and ideas around the condition.

Despite the popularity of TAM usage, there is surprisingly little research on EMs for intellectual disability in non-western countries, particularly from Africa. Previous studies on developmental disorders have generally focused on parents or caregivers with a developmentally delayed child (e.g., Altieri & von Kluge, 2009; Brown, Ouellette-Kuntz, Hunter, Kelley, & Cobigo, 2012; DePape & Lindsay, 2015; Divan, Vajaratkar, Desai, Strik-Lievers, & Patel, 2012), examining their views on intellectual disability and the challenges that they may have experienced (John & Montgomery, 2016). Given that many people living with intellectual disability experience difficulties with communication, some studies have also examined issues of communication and the implications of these for social and family life (e.g., Wylie et al., 2017).

Other studies have explored the felt and/or enacted stigma of living with developmental disorders or caring for a child with developmental disorders (e.g., Gray, 2002, 2006; Tilahun et al., 2016), while some other studies have looked at the perceptions of biomedical health workers about developmental disorders and their treatment (e.g., Gona et al., 2015; Kromberg et al., 2008). However, very little research has examined the beliefs of traditional and alternative healers about intellectual disability.

A few studies have reported on the use of TAM services by parents of children with intellectual disability (e.g., Aldersey, 2012; Kromberg et al., 2008). These have typically been reported among parents in non-western countries, or among immigrants from non-western countries (e.g., Brolan et al., 2014; Mirza et al., 2009; Scior, Addai-Davis, Kenyon, & Sheridan, 2014). In these studies, most of the parents reportedly sought "cures" for intellectual disability from TAM practitioners. Although there are some reported claims by traditional healers about their ability to cure such disorders, Kromberg et al. (2008) argue that the evidence is mostly anecdotal. Due to these (and other) limitations, there is little research on the perspectives of the TAM healers themselves about their abilities and methods with regard to intellectual disability, particularly in African countries such as Ghana.

In Ghana, research on intellectual disability has focussed on special education and the experiences of parents (Avoke, 2002; Kassah, Kassah, & Phillips, 2018; Oti-Boadi, 2017). Services are also limited,

with no specific mention of intellectual disability in most disability policy documents (Anthony, 2011; Sackey, 2015). Although people with intellectual disability can enrol onto the National Health Insurance Scheme for free, the shortcomings of the scheme mean that the services which are accessible are likewise limited. There is also no formalized or established government disability welfare system; thus, most families rely on non-governmental organizations, churches and other social networks for support. These social support structures include TAM as a healthcare option.

This study therefore examines the beliefs and explanations held by traditional and faith healers in Ghana about intellectual disability. Previous research suggests that one of the reasons for the popularity of TAM in Ghana is the larger number of TAM practitioners over biomedical practitioners (it has been estimated that there is one traditional healer for every 200 people in Ghana); thus making them more easily accessible (Ae-Ngibise et al., 2010). The present authors thus sought to investigate the healers' notions about the causes of intellectual disability, what effects they perceived it could have for the individual and/or their family, as well as their recommended treatment options for intellectual disability or their ability to cure it. The present authors were concerned to establish whether healers believed that they could "cure" intellectual disability, as has been reported in the literature on Ghanaian healers in relation to mental health conditions (Ae-Ngibise et al., 2010). With this in mind, the present authors analyse their beliefs as factors to consider in collaboration between TAM and biomedical health systems in Ghana.

## 2 | METHODS

### 2.1 | Research setting and participants

This study was an exploratory qualitative study. It was conducted in the Greater Accra Region of Ghana and is part of a larger study of traditional and alternative healing in Ghana. Through liaising with the Ghana Federation of Traditional Medicine Practitioners' Associations (GHAFTRAM), which oversees the practice of various categories of traditional/faith healers in the country, the present authors identified potential research participants. Additional participants were identified through the Ghana Pentecostal/Charismatic Council (GPCC). GHAFTRAM is organized into groups which are classified based on orientation, creed or methods. Thus, the present authors utilized the pre-established categories within the Federation, viz. the herbalists' association, the Muslim healers' association and the psychic healers' association to access the herbalists, Muslim clerics and shrine priests, respectively. The Christian healers were drawn from the GPCC given that faith healers who operate healing prayer camps, self-identified as charismatic churches. The present authors thus sought healers from charismatic churches which operated prayer camps where individuals sought healing. Subsequent snowballing was used to recruit further participants.

To be eligible for participation, the healers needed to live/work in the Greater Accra Region, must have practised for at least five years and be able to speak English, Twi and/or Ga (the dominant languages

in the region). There were therefore four different categories of traditional/faith healers who took part in the study: traditional herbalists, traditional medicine men (also called shrine/fetish priests or devotees), Muslim clerics/healers and Pentecostal/charismatic Christian pastors/healers. A total of 36 healers were interviewed for this study, comprising ten Muslim healers (called *mallams*), ten pastors, eight traditional medicine men and eight traditional herbalists. Table 1 provides a summary of the demographic characteristics of the participants.

## 2.2 | Procedure

Before data collection, ethics approval was obtained from the Stellenbosch University Humanities Research Ethics Committee, as well as from the Ghana Health Service Ethics Review Committee and the Ghana Traditional Medicine Practitioners' Council. Additional permission was also obtained from GHAFTRAM and the GPCC. Once approval was granted, potential participants were approached and the objectives of the study were explained to them, as well as their rights as research participants. Individual informed consent was obtained from each participant before any data were collected.

Individual semi-structured interviews were conducted in English, Ga or Twi (or a combination of English and one of the local languages), depending on which the participant was most comfortable with. All interviews were conducted by the first author, who is Ghanaian, a clinical psychologist and a native speaker of both Ga and Twi. She was thus familiar with linguistic code-switching practices within that context. However, some interviews were conducted with the assistance of a male research assistant. This was necessary in instances where cultural or religious expectations frowned on direct interaction with a female. For instance, one shrine priest indicated that his position as a representative of the deity did not allow him to speak directly to a woman. The research assistant was a psychology graduate, was trained before any data were collected, and closely supervised by the first author during the interview. All the interviews were audio-recorded with the consent of the participants. The interviews took place in the participants' homes or work places (often these were the same).

**TABLE 1** Summary of demographic characteristics of participants

Characteristic	Number (%)
Gender	
Female	5 (13.9)
Male	31 (86.1)
Type of healer	
Herbalist	8 (22.2)
Shrine priest	8 (22.2)
Mallam	10 (27.8)
Pastor	10 (27.8)
Mean age	54.6 years
Mean years of practice	28.1 years

The present authors elected to use a case vignette to facilitate the interview process, given the stigma that is culturally associated with intellectual disability. The vignette method is useful for undertaking discussions on sensitive topics due to its use of the third-person approach (Gourlay et al., 2014). The present authors believed this would enable the participants to speak more comfortably on the subject. The following vignette was read to the participants:

*Effie was slower in reaching her developmental milestones such as sitting, crawling and walking, and learned to speak later than her peers. Her mother reports that at eight years old, Effie is unable to bathe and dress herself, and often requires assistance in eating and using the toilet. Effie also struggles in school with reading and writing, and has been held back twice due to her difficulties at school.*

After reading the vignette aloud, the interviewer asked participants questions to determine how they conceptualised the case. The questions that were asked were based on the eight core EM questions (see Kleinman, 1980), and sought their explanations of the nature of intellectual disability, the causes of the condition, what possible effects it could have for the individual or their family, as well as how they would treat such a condition, and whether they had experience in treating it.

The interviews were transcribed by the first author in the languages that they were conducted in and, where necessary, translated into English, then back translated into the local language by an independent linguist, to check for consistency and accuracy.

## 2.3 | Data analysis

All interviews were transcribed verbatim and analysed using ATLAS.ti qualitative data analysis software (v.8). The data were initially analysed by the first author, and subsequently checked and corroborated by the second author. Areas of disagreement were discussed and resolved by both authors. The data were analysed thematically using Braun and Clarke's (2006) recommended six-step process. First, the present authors generated initial codes to highlight the participants' beliefs about the nature, causes, effects and treatment of intellectual disability as broad thematic areas. Subsequently, the present authors tentatively classified similar trends and patterns which had emerged from the data. These initial classifications were revised as the patterns were properly defined. The present authors based our interpretations on the participants' individual accounts, but also in comparison with those expressed by other participants.

## 3 | RESULTS

### 3.1 | Identifying and naming intellectual disability

All the participants indicated that the vignette did not describe a case of mental disorder, despite popular representations of intellectual disability as a mental illness (Avoke, 2002). They suggested that

the child in the story was most likely born with some structural brain deficit. They used words such as *gyimi-gyimi* (in Twi) or *buulu-buulu* (in Ga). These words translate to “stupid, stupid,” and all the participants were quite uncomfortable using the terms. When the present authors asked for a name for the described condition, they all prefaced their answers with phrases like, “excuse me to say.” Many of them stated that they did not think it was an appropriate way to describe a child whose condition had occurred through no fault of their own. For instance, one female pastor stated the following:

*Sometimes some people call them gyimi-gyimi, because of the way they behave ... they can't do anything normally. Yes, some of them ... will be [drooling]. But that is how they were born, it is not something that they can control.*  
(P5, female pastor)

Such descriptions of deviating from “normal” were common, with participants relating the behaviours of people with intellectual disability as falling outside of expected behaviours. These names and sentiments were held by all the participants and did not vary based on the healing orientation of the healers. The participants' discomfort with the derogatory terms suggests that they had an appreciation for the stigma and discrimination attached to the use of certain names and labels.

### 3.2 | Participants' notions of severity of intellectual disability

The participants also indicated that there were different developmental disabilities with varying levels of severity. Many of them suggested that the severity determined the extent to which the child could function optimally and achieve some level of personal independence, which served as a measure of “normality”:

*Yes, some of them can be okay, they only need [a little] guidance and so if you train them in a way that they can understand the training ... oh, he can do everything that you and I can do! But just that he doesn't learn the same way that we will learn, so you have to find out how to talk to them and teach them so that they can also learn how to live ... it is not all of them that are so serious, some of them ... unless you talk to them for a long time, you won't know that there is something wrong with them.*  
(F3, shrine priest)

Thus, the healers believed that intellectual disability was a serious, lifelong condition. Here again, they emphasized the fact that intellectual disability was not an illness which needed a cure. Instead, their accounts suggested a belief in the severity of intellectual disability being constructed based on the extent of the individual's ability to behave in a manner considered socially appropriate. These notions of normality were held by all the participants and did not show much variation across the different categories of healers.

### 3.3 | Participants' explanations of aetiology

With regard to causes, each of the participants held multiple views. These views were mostly regarding circumstances or physiological problems which could have occurred in the womb. Many of the herbalists believed that intellectual disability could result from something the mother ate while pregnant. Other healers suggested that the mother had likely not attended antenatal clinics regularly, and hence had not followed the directions of doctors or midwives. Still others suggested that it could result from some strenuous activity the pregnant mother had undertaken such as lifting heavy things, as well as perhaps a road traffic accident that the pregnant mother could have been involved in:

*Mostly, these things happen during pregnancy...yes, maybe the mother did not go to antenatal clinic ... so that the doctor can check how the baby is lying, or even they can see if there is something wrong with the baby before it is born. Then they can give her medicine ... to make sure that the baby will be healthy. Some of them also don't watch their diet when they are pregnant ... there are some things that a pregnant woman should not be eating, like oily foods and too much salt.*  
(H3, male herbalist)

Apart from pregnancy-related causes, some suggested that another possible cause could be spiritual machinations. Some of the medicine men and pastors suggested that curses which ran through families could affect the child and he/she would develop an intellectual disability from birth. Further, jealousy or envy could cause a malevolent person to seek to kill the child; when these attempts to kill the child did not succeed, the resultant condition could be intellectual disability. A few participants also indicated that some unscrupulous parents may choose to trade their child's intellectual capacity for wealth and/or status. Such spiritual machinations were intensely frowned upon by the participants.

Some of the shrine priests in particular, also indicated that some people with intellectual disability were sent to earth as a message from the gods. They were thus seen as “para-human,” and care had to be taken in dealings with them. They indicated that it was the parents' and/or communities' responsibility to identify the message that the gods wished to give to them through the birth of such a child. This could be performed through various means such as divination or spirit possession.

Thus, the healers' beliefs about the aetiology of intellectual disability were both spiritual and teratogenic in nature.

### 3.4 | Participants' views on the implications of intellectual disability

As has been described above, all the participants agreed that intellectual disability was a serious condition and they believed it was mostly permanent. At most, they recommended that the child be

taken to a “special school” in order to be able to learn some personal care and social skills. Some of them believed that if the training was targeted and consistent, the child could live a fairly normal life (in the sense of a life similar to that lived by others), even though they did not expect the child to be able to achieve much success in life:

*Children like that, they are born like that, so you – the mother – you just have to manage it little by little ... If you observe the mothers of such children, they know what makes their child comfortable and even how to speak to [the child] so that he will understand. And so if they get the additional support of the Special School, it helps.*  
(P9, pastor/prophet)

All believed that intellectual disability was a congenital condition and not an illness. None of them claimed to be able to “cure” intellectual disability. All the participants indicated that they had been referred cases of intellectual disability for treatment from time to time. Some herbalists indicated that their treatment would generally consist of prescribing herbal tonics which could make the child calm, in order to allow him/her to participate in school and other social activities. The pastors and *mallams*, although also regarding intellectual disability to be a permanent condition, indicated that God could intervene and cure the child, if He so wished. These participants believed that they themselves did not have a role in curing intellectual disability.

None of the participants spoke at any length about treatment methods for intellectual disability; however, they emphasized the need to give parents the knowledge and means to care for their children with intellectual disability. Some participants believed that they had a role in management of intellectual disability. For instance, the pastors and shrine priests were strong advocates of their being involved in psychosocial support for people with intellectual disability and their families. They suggested that they could be instrumental in facilitating supportive care structures such as community spaces where children with intellectual disability could be taught skills which would enable them to earn a living. Some of them also believed in providing social support for parents of children with intellectual disability through counselling and financial assistance (from the churches), among others. In general, the participants had an appreciation of the fact that people with intellectual disability and their families required specific support. They were aware of the potential implications of intellectual disability on family life and believed that their positions within the community could be harnessed to provide support.

## 4 | DISCUSSION

In summary, from the data, the healers held multiple explanatory views about intellectual disability. Despite differences in healing orientation and methods which existed between the different categories of healers, there was much similarity in their beliefs and perceptions about intellectual disability. The nature of the condition

was largely considered to be congenital and thus not curable. There was, however, an appreciation for varying levels of severity of intellectual disability, and its attendant impact on adaptive ability. The causes were believed to be biological (i.e., prenatal) but also possibly spiritual. The pregnancy-related causes were mostly considered to be the result of negligence on the mother’s part. The healers further acknowledged the usefulness of special education for training, but did not expect children with intellectual disability to be able to live a functional life. They did not discuss the importance and value of social inclusion.

The healers hesitated to use the names that are commonly used to refer to children with intellectual disability, suggesting an appreciation for the perceived stigma and discrimination that is attached to the condition. The pastors in our sample were comparably better educated, and their empathy may be a reflection of this. Similarly, the herbalists’ sensitivity to the stigma may be a reflection of their experience in helping parents.

The names used to refer to children with intellectual disability have been reported in previous studies in Ghana. Avoke (2002) reported similar names among the Ewe of south-eastern Ghana, as well as the Lobi in the North-western parts of Ghana. All these different groups used labels which indicate the belief in persons with intellectual disability being stupid or fools. Similarly, Opare-Henaku and Utsey’s (2017) analysis of Akan concepts of mental illness also reported the use of this label. This is perhaps a reflection of the emphasis on education which has dominated disability policies and discourse in many African countries, including Ghana (Kassah et al., 2018). For many people, it appears that the ability to do well (or otherwise) in school is a reflection of an individual’s intellect. Unlike the reported attitudes of participants in the other studies, our participants were very uncomfortable using derogatory terms to refer to people with intellectual disability. Despite this, the participants’ emphasis on education was directed towards separate special education, and not inclusive educational opportunities. Although the present authors did not ask this of the participants specifically, it is worth noting as a potential direction for future research.

With regard to causes, the emphasis that is placed on the mother’s behaviour during pregnancy further reiterates the view of disorders as a consequence of negligence or a punishment for wrongdoing (including, interestingly enough, according to our participants, not attending biomedical antenatal care) (Segrave, Spivakovsky, & Eriksson, 2017). This also speaks to the expected behaviours of pregnant women in the Ghanaian context. Some previous studies have discussed the taboos and behaviours associated with pregnancy in Ghana, which seek to prevent congenital conditions such as intellectual disability. These behaviours include the avoidance of certain foods (e.g., fish, snails and eggs), and the use of herbal teas and enemas (Arzoaquoi et al., 2015; Otoo, Habib, & Ankomah, 2015). Based on the narrations of our participants, there is also the expectation of regular visits to healthcare providers, whether biomedical or traditional.

However, the participants also indicated the possibility of supernatural circumstances leading to intellectual disability. This finding

is also similar to what has been reported in other African cultures (e.g., Bunning, Gona, Newton, & Hartley, 2017 in Kenya; Etieyibo & Omiegbe, 2016 in Nigeria; Kromberg et al., 2008 in South Africa, and Stone-MacDonald & Butera, 2014 in Tanzania). These African studies also reported beliefs in mercenary spirits, jealousy and envy, as well as ancestral displeasure or curses as supernatural factors which could result in intellectual disability.

Thus, the need to apportion blame was very dominant. The blaming of mothers for congenital problems in their babies is not unknown in the literature. Studies in both western and non-western countries have reported similar beliefs and attitudes towards parents of children with developmental disorders, including self-blame by parents (McConkey, Truesdale-Kennedy, Chang, Jarrah, & Shukric, 2008; Read, 2000; Ryan & Runswick-Cole, 2008). Some studies reported participants believed that intellectual disability occurred as a consequence of perceived wrongdoing (Ha, Whittaker, Whittaker, & Rodger, 2014), or negligence on the mothers' part (Blum, 2007; Gammeltoft, 2008). Blaming has also been reported to originate from health professionals and other professionals involved in the child's care (Aston, Breau, & McLeod, 2014; Pelleboer-Gunnink, van Oorsouw, van Weeghel, & Embregts, 2017). Similarly, the traditional healers in our study believed that a child's developmental disorder may be the result of the mother's actions or inactions.

All the healers stated that they had been asked to treat children with intellectual disability in the past. However, the general consensus was that intellectual disability was congenital, and hence, a life-long condition and could not be cured but rather should be carefully managed to afford the individual the chance of a relatively stable life. This is quite different from the notions that have been reported in other African studies (Haihambo & Lightfoot, 2010; Omonzejele, 2008). Consequently, this may suggest the belief that intellectual disability is not an illness which requires a "cure," but rather a lifelong condition, or disorder which reflects the consequences of certain circumstances. The participants' view of intellectual disability as a disability rather than an illness is in keeping with contemporary biomedical views and may augur well for collaboration.

In general, the healers in our study held largely positive views about people with intellectual disability. They were keen to emphasize the importance of avoiding derogatory labels. They also appeared to have an appreciation for the importance of prenatal medical care. Further, they were also realistic about their inability to cure such conditions. Most of them (but particularly the pastors and *mallams*) believed that parents could learn important life lessons from caring for a child with intellectual disability, and advocated for an acceptance of their needs. These views are quite different from the frequently reported negative attitudes towards intellectual disability which have dominated literature from African countries, including Ghana; where children born with intellectual disability have been reportedly killed or ostracized by communities in the belief that they were a sign of bad luck (Avoke, 2002; Haihambo & Lightfoot, 2010). Several previous studies have indicated that people with intellectual disability in various African countries face derogatory labels, discrimination, stigma and negative stereotypes (e.g., Adnams,

2010; Aldersey, 2012; Baffoe, 2013; Haihambo & Lightfoot, 2010). Although our participants were aware of these negative views, they did not agree with them, and advocated for transformation in Ghanaian intellectual disability discourse. These may be a reflection of their educational backgrounds and/or experience with intellectual disability, but may also be a sign of changing times and a potential window of opportunity to drive change.

The views of the participants have potential implications. In particular, based on their admission that they saw patients with intellectual disability, they are well placed to facilitate appropriate early interventions. Given more education about intellectual disability and additional targeted training, they could be valuable for collaborative efforts in medical care and social interventions, particularly given their stated appreciation for the benefits of biomedical antenatal care. Unlike what has been suggested in the literature, our participants did not claim any personal power to cure intellectual disability. This notion presents further opportunity for collaboration with biomedicine in the care and management of a condition which they admit is life-long. It also bodes well for collaboration with other sectors such as the education, health, learning support and social care sectors.

Further, the healers' roles as community or spiritual leaders also affords them the opportunity to spearhead transformative dialogues which address stigma and social exclusion for persons living with intellectual disability (Badu, 2016). This is a role which the healers in our study indicated they were willing to play. Their discomfort with the derogatory labels may be a reflection of changing attitudes towards intellectual disability, and these can be harnessed to drive awareness and education about the condition within their spheres of influence. Such awareness and education collaboration can also potentially transform the erroneous practice of mother-blaming.

Thus, traditional and faith healers in Ghana have multiple beliefs about intellectual disability. These beliefs influence their attitudes towards patients and parents, as well as the treatment recommendations of the healers. These views have implications for collaboration, public education as well as the development of social interventions and policies.

## 5 | CONCLUSIONS

Our study had a few limitations which are noteworthy. The first limitation was the relatively small sample. Although this number is adequate for a qualitative study, the present authors wish to caution that the views expressed should not be interpreted as necessarily representative of the larger population of traditional and faith healers. Further, due to the cultural underpinnings of TAM systems of care, there is the need for larger-scale studies to be undertaken in order to obtain a clearer understanding of the beliefs of TAM practitioners in Ghana. Secondly, the views expressed by our participants were based on the case vignette which was presented to them. This method may limit what is discussed and may not be a reflection of their behaviour when confronted with actual cases. Thirdly, given the widespread understanding of intellectual disability as a gestational

occurrence, the views of traditional birth attendants (TBAs) would likely have provided additional nuanced conceptualisations. The present authors did not interview TBAs at this time, but recognize that their views and methods may differ, considering the fact that they have more contact with pregnant women in the community.

The current study focused on examining intellectual disability in the area of traditional and alternative health care, but the present authors do recognize that important interactions also exist between children with intellectual disability, and other people in their social circles (such as teachers and social workers). These interactions are also necessary to gain a more complete understanding of local concepts and available support for intellectual disability. Further, an exploration of traditional and alternative healers' perceptions of activity limitations associated with intellectual disability and their perceived roles in this area is also important to obtain a fuller understanding of TAM care for intellectual disability. The present authors did not examine this aspect of their care at this time, but these interactions may be of interest for future research. Our findings are, however, important in the intellectual disability conversation. They can serve as foundational data on which a more in-depth understanding of intellectual disability in Ghana can be built, particularly given the dearth of documented research.

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## CONFLICT OF INTEREST

The authors declare that they have no conflicting interests.

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