



## 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana

Kenneth Ae-Ngibise, Sara Cooper, Edward Adiibokah, Bright Akpalu, Crick Lund, Victor Doku & The MHaPP Research Programme Consortium

To cite this article: Kenneth Ae-Ngibise, Sara Cooper, Edward Adiibokah, Bright Akpalu, Crick Lund, Victor Doku & The MHaPP Research Programme Consortium (2010) 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana, *International Review of Psychiatry*, 22:6, 558-567, DOI: [10.3109/09540261.2010.536149](https://doi.org/10.3109/09540261.2010.536149)

To link to this article: <https://doi.org/10.3109/09540261.2010.536149>



Published online: 13 Jan 2011.



Submit your article to this journal [↗](#)



Article views: 587



Citing articles: 71 View citing articles [↗](#)

## **‘Whether you like it or not people with mental problems are going to go to them’: A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana**

KENNETH AE-NGIBISE<sup>1</sup>, SARA COOPER<sup>2</sup>, EDWARD ADIIBOKAH<sup>1</sup>,  
BRIGHT AKPALU<sup>1</sup>, CRICK LUND<sup>2</sup>, VICTOR DOKU<sup>1</sup>, & THE MHAPP RESEARCH  
PROGRAMME CONSORTIUM

<sup>1</sup>*Kintampo Health Research Centre, Ghana, and* <sup>2</sup>*Department of Psychiatry and Mental Health, University of Cape Town, South Africa*

### **Abstract**

Limited research has been conducted to explore the factors that support or obstruct collaboration between traditional healers and public sector mental health services. The first aim of this study was to explore the reasons underpinning the widespread appeal of traditional/faith healers in Ghana. This formed a backdrop for the second objective, to identify what barriers or enabling factors may exist for forming bi-sectoral partnerships. Eighty-one semi-structured interviews and seven focus group discussions were conducted with 120 key stakeholders drawn from five of the ten regions in Ghana. The results were analysed through a framework approach. Respondents indicated many reasons for the appeal of traditional and faith healers, including cultural perceptions of mental disorders, the psychosocial support afforded by such healers, as well as their availability, accessibility and affordability. A number of barriers hindering collaboration, including human rights and safety concerns, scepticism around the effectiveness of ‘conventional’ treatments, and traditional healer solidarity were identified. Mutual respect and bi-directional conversations surfaced as the key ingredients for successful partnerships. Collaboration is not as easy as commonly assumed, given paradigmatic disjunctures and widespread scepticism between different treatment modalities. Promoting greater understanding, rather than maintaining indifferent distances may lead to more successful co-operation in future.

### **Introduction**

In recent years there has been increased attention placed on addressing mental health needs in resource-poor settings (Lancet Global Mental Health Group, 2007; Prince et al., 2007). Amongst a plethora of policy and service-related recommendations, a call has been issued by prominent mental health researchers and practitioners to better harness valuable local resources for the provision of mental health care (Gureje & Lasebikan, 2006; Horton, 2007; Saraceno et al., 2007). Greater recognition of, and collaboration between traditional healers and more ‘conventional’ mental health services is increasingly being seen as a step in this direction (Jahoda, 1979; Ndeti, 2007; Ofori-Atta, Akpalu, Osei, & Doku, 2007; WHO, 2002).

In Ghana, as in most African countries, healing systems for mental health problems are pluralistic, with both traditional and ‘conventional’ biomedical theories and practices existing side by side

(Anyinam, 1987; Ensink & Robertson, 1999; Puckree, Mkhize, Mgbhozi, & Lin, 2002). Traditional healing systems still play a significant role in help-seeking behaviour for the mentally ill on the continent, despite advances in western-style psychiatric services (Quinn, 2007). In addition, with the influx of modern Pentecostal Churches, many more people seek healing and deliverance in Christian ‘prayer camps’ and healing centres. Findings from studies of a similar nature in North Africa (Alem, Araya, Kebede, & Kullgren, 1999), East Africa (Kilonzo & Simmons, 1998), West Africa (Gureje & Lasebikan, 2006) and parallel findings in Sub-Saharan Africa (Crawford & Lipsege, 2004) have all revealed the popularity and widespread use of traditional and faith healers for psycho-social problems.

Ghana is no exception. There are currently 45,000 traditional healers in the country and 70% of people, especially in rural areas, consult traditional healers

for mental health problems (Ewusi-Mensah, 2001; Osei, 2001), many as the first port of call for an individual or their family (Roberts, 2001; Tabi, Powell, & Hodnicki, 2006). The number of traditional healers in Ghana significantly outweighs the availability of allopathic mental health practitioners. There is currently one registered traditional healer for every 200 people, and the equivalent ratio for medical doctors is 1: 20,000 (Patterson, 2001; Tabi & Frimpong, 2003) and for psychiatrists is 1: 1,470,588 (Doku et al., 2008).

Traditional healing has been defined as the practice of using local herbs for the treatment of diseases. Traditional healers (in Twi, *òkòmfoò*) are trained to administer locally prepared herbal medicine for the treatment of diseases (Crawford & Lipsege, 2004; WHO, 2002). Faith healers or pastors/imams are religious leaders who base their treatment on the powers of God to heal sickness (Kale, 1995). The major difference between traditional and faith healers in treatment practices is that the former pour libation (sacrifice to the gods) to the 'small gods' (*obosom*) at the shrines and also use herbs for treatment of mental disorders, whilst the latter employ prayers, fasting and the sprinkling of holy water as the major means of treating diseases (Puckree et al., 2002). The two healing groups however believe in the common practice of confession of sins as an integral part of the healing process (Puckree et al., 2002).

Given the widespread presence and use of traditional healers in Africa, various agencies and governments have taken steps to improve the status of traditional healing systems and promote wider collaboration between them and biomedical services. Beginning with the Alma Ata International Conference on Primary Health Care in 1978, and again in 2002, the World Health Organization (WHO) made an international commitment to promoting the inclusion and integration of traditional practitioners in national and donor-specific health programmes (Summerton, 2006). This commitment has also been taken up by many other organizations and government agencies. For example, the African Union (AU) declared the period 2001–2010 as the Decade of African Traditional Medicine, and the New Partnership for Africa's Development (NEPAD) has noted traditional medicine as an important strategy in its plan (Hewson, 1998).

In Ghana, although the Alternative Medicine division of the Ministry of Health has been established, and the new Mental Health Bill drafted in 2006 attempts to recognize and regulate traditional healers and their practices, very few attempts have been made to develop the services of traditional and faith healers in the country (Montia, 2008; Ventevogel, 1996). In addition, some steps have

been taken to try and form collaborations between more 'conventional' psychiatric services, and traditional and faith healer practices in Ghana, but these have been largely unsuccessful. One exception involves the mental health non-governmental organization (NGO) BasicNeeds in northern Ghana which has established various collaborations with traditional healers in mental health care, suggesting the potential for successful partnership (Montia, 2008). These collaborations have tended to be based on establishing greater bi-directional understanding, information exchange and cross-referrals (Montia, 2008).

Very little research has been conducted to explore why most attempts at collaboration have failed in Ghana, and many other African countries (Tsey, 1997; WHO, 2002). In addition, and possibly a contributing factor to many failed collaborative initiatives, there is very little understanding of existing local beliefs and practices, and the social, economic and cultural environments in which healers actually operate in African societies (Green, 1999; Wreford, 2005). Many initiatives have thus been executed in the absence of sufficient contextual knowledge and understandings, being informed by either 'uninformed scepticism' or 'uncritical enthusiasm' (WHO, 2002).

This paper attempts to speak to this vacuum of intellectual debate by looking critically at the role of traditional and faith healers in Ghana, and the possible barriers to, and enabling factors for, inter-sectoral cooperation. This study thus has two objectives. Firstly, it explores the reasons underpinning the widespread use and popularity of traditional healers in Ghana, contextualizing these factors within the social, economic and cultural environment. The second objective of this study was to identify what barriers and enabling factors may exist for forming alliances between traditional or faith healers and more 'conventional' practitioners. These issues were explored from the perspective of traditional and faith healers, 'conventional' mental health professionals, service users, and other germane stakeholders. Based on the insights from this study, recommendations are provided on how to better facilitate collaboration between traditional or faith healers and more 'conventional' psychiatric services. To our knowledge no previous studies have documented the beliefs and attitudes of faith and traditional healers, and the manner in which these pose barriers to collaboration in Ghana.

## Methods

The data collection for this study formed part of a situation analysis of the current status of mental

health policy, legislation and services in Ghana, conducted as part of the first phase of the Mental Health and Poverty Project (MHaPP). The MHaPP, which is being conducted in four African countries: Ghana, South Africa, Uganda and Zambia, aims to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries (Flisher et al., 2007).

This particular study focuses on the qualitative data obtained from the MHaPP situation analysis. Eighty-one semi-structured interviews and seven focus group discussions were held with policy makers, health professionals, users of psychiatric services, teachers, police officers, academics, and religious (Christian and Islamic) and traditional healers drawn from five of the ten regions in Ghana. The interviews and focus group discussions were conducted with 122 respondents, who were purposively sampled from among the major stakeholders in mental health at the national, regional and district levels. Thirty-five interviews were held at the national level, 23 at the regional level and the remainder at the district level.

Interviews conducted in the local language (Twi) were transcribed verbatim, translated into English and back translated into the local language to ensure that the words used during the discussions maintain their original meaning. All transcripts were entered into NVivo 7 qualitative data analysis software, which was used for coding and analysis. A framework approach (Ritchie & Spencer, 1994) informed the analysis. As part of this process, an a priori analytical framework was developed, using themes based on the objectives of the research, and local emergent themes were added to this framework as analysis proceeded.

Ethical approval was sought from the Scientific Review Committee (SRC) of Kintampo Health Research Centre, and the Research Ethics Committee of the Faculty of Health Sciences, University of Cape Town for the scientific relevance of the study. Ethical approval was also granted by the Ghana Health Service Ethics Committee at the national level as well as the Institutional Ethics Board at the Kintampo Health Research Centre.

Detailed information was provided to participants concerning participation and the consequence of the study. Participants were then required to sign/thumbprint (depending on the level of literacy of each participant) a consent form to indicate their willingness to participate in the study. All respondents consented. The names and other identifying features of the respondents have been omitted in order to ensure their confidentiality.

## Results

### *Widespread use and popularity of traditional and faith healers*

Many respondents referred to the pluralistic system of health care in Ghana, in which traditional and faith healers are major providers, alongside more 'conventional' practices. The interviews were saturated with comments that traditional and faith healers are 'widely used' and 'see the most amount of mental patients'. As a Government official in the Department of health explained:

Traditional healers have been part of our societies for a very long time and whether we like it or not people with mental problems are going to go to them... I don't know what the numbers are... but I know that a significant number of people still patronize their services.

Similarly, an official from a mental health NGO remarked:

I would say that the greater percentage of all cases of mental illness are addressed by healers and fetish priest organizations, and so by virtue of their presence and number of cases they see, you cannot easily brush them aside.

### *Cultural constructions of mental disease aetiology*

Respondents indicated a coalescence of reasons for the widespread use and popularity of traditional and faith healers. One key reason revealed by the data was that traditional and faith healers' understandings of mental illness are consistent with hegemonic cultural explanatory models of mental disease aetiology. This surfaced in two ways. Firstly, the majority of the respondents, both biomedical as well as traditional and faith service practitioners directly emphasized this as a reason for the widespread popularity of traditional healers. Secondly, by exploring dominant understandings of mental disease aetiology, and the beliefs and practices of traditional and faith healers, it became clear that aetiology and beliefs or practices are intimately connected.

Most health care practitioners were of the view that the community understandings of mental illness underpin the widespread appeal of traditional and faith healers. For example, a senior psychiatric nurse contended:

You know in our society, most people believe in this spiritualist and the fetish and these things... So some of our clients no matter what you do, no matter how well they become, they still go to them [traditional and faith healers].

Similarly, when talking about why traditional and faith healers are so widely used, a programme manager argued:

It is also based on the theology of mental health. People think that mental health is not physical, but it is spiritual and they believe these are the custodians of spiritual issues so they go to them.

Indeed, when exploring dominant understandings of the causes of mental disorders, there was a great deal of consensus among respondents that mental illness in the general community tends to be understood as a 'spiritual illness' and attributed to 'juju', 'supernatural powers' and 'evil spirits'. The harmony between such perceptions, and the beliefs and practices of faith and traditional healers was clearly revealed in the interviews and focus group discussions with traditional practitioners. Such healers appear to diagnose mental illness through spiritual means, and provide their clients with spiritual explanations and treatments for their predicaments. For example, when talking about how he understands mental illness, one traditional healer explained:

At times, it could happen that somebody might have gone in for another person's wife and then he will be struck by a juju, or somebody might steal another person's belonging, or it could happen that, as a result of some litigation, somebody may go mad.

In line with such beliefs, the treatment strategies of traditional and faith healers are also buttressed in spiritual cosmologies. For example, many traditional healers indicated that they need to consult the gods in respect of every patient that comes for treatment in order to receive spiritual guidance for the correct treatment:

We find out from the god and he in turn reveals to us which medicine to use in curing a particular problem. The diseases are different so it is the god who reveals to us which medicine to use at every instance.

Similarly, faith healers tend to use prayers, fasting and anointing oils or holy water to support the healing processes. Confessions of wrongdoing are also a key ingredient in the healing process for both traditional and faith healers. Some healers insist on confessions as the first step, before they start the treatment:

It happens that, someone may be a witch or has done something wrong and as a result, has this problem. In that case, it is necessary for the person to tell the truth, before the right medicine to be given will be known.

It is thus clear that the mental health care systems of traditional and faith healers are firmly embedded within wider belief systems, and are synchronous with dominant constructions of health and illness. This emerged both explicitly and implicitly as one of the key reasons for their widespread use.

#### *Psychosocial support*

The interviews revealed that the psychosocial support which traditional and faith healers provide may be an additional reason for their popularity. Once again, this was evident explicitly, and was further supported by exploring how people perceive and talk about different treatment modalities in Ghana. Numerous stakeholders, including those at the policy-making level, directly indicated that traditional and faith healers may be appealing to many people as they provided psychosocial and spiritual support. As the director of a mental health NGO articulated:

I think people go to them [traditional healers] as they don't just give the physical causes, they also give the supernatural causes of your illness... they also address those psychological problems and so are able to allay the fears of people... so they try understand where the person is coming from in terms of his own psyche. I think people want this.

Similarly, a senior health researcher explained:

If you go to some of the spiritual healers and those kinds of things, like the churches and those kinds of things, the psychology of preaching to you, of telling positive things, may rekindle you and bring you to normalcy, even without medication.

Indeed, accounts provided from many respondents about the characteristics of both traditional and faith healers and more 'conventional' health practitioners provide further weight to the view that the psychosocial support afforded by the former may contribute to their widespread use. Many respondents highlighted that traditional and faith healers are like 'clinical psychologists', providing 'talk therapy', 'counselling' and 'asking questions and providing solutions'. In contrast, many respondents alluded to the predominantly 'curative' and 'biomedical' approach of more 'conventional' mental health care, which 'just give drugs and then send you away'.

#### *Accessibility and affordability*

Many respondents also attributed the accessible, available and affordable nature of traditional and

faith healers as additional factors contributing to their widespread use. A common theme amongst the respondents when talking about the appeal of traditional and faith healers was the 'easy access' to such practitioners, 'practising in every community' and 'in both rural and urban areas'. For example, in describing why traditional healers may be so popular, one nurse suggested:

You see you must understand that there are so many traditional healers, based in all of our communities, so they don't have to travel very far which cuts a lot of costs for people.

Other respondents attributed the widespread appeal of such practitioners to their affordability, with common remarks that such practitioners 'are cheap' and on many occasions 'the only affordable means of health care for many people'. Indeed, one traditional healer confirmed the affordable nature of such practice when he explained that:

When we treat someone of his or her illness, whatever is brought for appreciation is received in good faith.

In direct contrast, more 'conventional' services were frequently described as 'prescribing very expensive drugs', 'understaffed', and 'unevenly distributed, with most being in the south', and therefore 'difficult for rural populations to access'. Drawing the links between these different characteristics of treatment modalities and the widespread use of less 'conventional' practitioners, the director of a mental health NGO remarked:

The most important thing is that clinic professionals are woefully inadequate. So these people [traditional and faith healers] fill the gap. A very, very big yawning gap. Even if it is not adequate, if it is not to the best of standards, how many psychiatrists are in the three northern regions? How many clinical psychologists are available to people?

One senior academic health researcher succinctly summed up the myriad array of factors contributing to the widespread use of traditional and faith healers when he said:

There are people who live in Accra who would get up and go to a traditional healer in the village somewhere. So, it is not just because of access. I think it is a mixture of several factors. For some people it might be because of access and costs, for some people it might be because of religious beliefs, for some people it might be because of their perceptions of disease causation. It is multi-factorial.

### *Barriers preventing collaboration between healing systems*

Given the widespread use and popularity of traditional and faith healers, many of the participants, including those at the policy-making level, emphasized that collaboration with such practitioners and more 'conventional' services should take place. For example, sharing the views of many, a respondent from the World Health Organization emphasized:

We should involve them [traditional and faith healers] and also collaborate with them, so that even when they [patients] come to their place, like faith healers, even though they are praying for that person, at least the pastor can advise that: 'See your doctor, take your medication, come back to the church, and let's pray.' So I think we need to involve them and collaborate with them a lot.

Although support for collaboration was widely appreciated, the interviews revealed that there may be a number of barriers hindering possible collaboration between the different treatment modalities. This surfaced in two ways. Firstly, many respondents directly highlighted where some of the barriers are preventing intersectoral collaboration. Secondly, this was shown by the fact that underneath the dominant rhetoric of support for alliances, widespread pessimism and disapproval around partnership was also conveyed by a number of respondents.

### *Human rights concerns of traditional/faith healing practices*

One of the main obstacles hindering possible collaboration between 'conventional' psychiatric service and traditional/faith healing practices both identified and implied by the participants was concerns regarding the human rights abuses that can occur in the prayer camps and traditional shrines. Many respondents spoke about the various 'abuses', 'maltreatment', 'neglect' and 'exploitation' of some traditional healers and their practices, including forced fasting, exorcisms which include physical beatings (sometimes resulting in death), chaining to contain agitated patients and forced confinement. Sharing the views of many others, when talking about the practices of faith healers, a senior academic psychologist lamented:

The faith healers you know sometimes end up abusing the people in various forms. They extort a lot of money from them for example. Sometimes there is physical abuse, right, people are still being chained and beaten because they think that demons are in them, and all of these are all forms of abuse.

In light of these abuses, many respondents expressed scepticism about possible collaboration as it was seen that the 'system has not been well developed . . . they just go about and do their own things and nobody checks them' (senior academic researcher). Many biomedical practitioners stated that if they formed alliances with traditional and faith healers they could be seen to be 'condoning such practices' and 'encouraging such abuses'. Other respondents emphasized that collaboration would only be possible if such practitioners were 'educated', 'trained' and 'regulated from a clinical perspective'. It was emphasized, however, that this would not be an easy task. For example, a programme director explained:

We cannot totally exclude traditional healing because that is where some people have got their faith and it works for them. So we need to collaborate with them, and help them to be able to actually clean their system . . . but we mustn't be naïve about how difficult this really is.

*Safety and efficiency concerns of traditional/faith healing practices*

In addition to human rights worries, many participants raised questions regarding the safety and efficiency of traditional and faith healing treatments, particularly for more serious mental disorders. Some participants emphasized that very little clinical evidence exists concerning the quality of such methods. For example, when talking about possible collaboration with traditional and faith healers, an official from the Ministry of Health lamented:

What worries me though is . . . when they take charge of the treatment and they start dispensing treatments that are not authorized and are not scientifically based.

Similar concerns were expressed by a programme director when talking about possible collaboration:

The absence of clear guidelines and regulatory framework is a major challenge, I mean what is not clearly defined is the scientific basis of some of their claims and other things, and people's unwillingness to subject their claims to that same scientific rigour which is demanded of orthodox medicine. We believe that they have a role, but I personally believe that the same standards we are applying to orthodox medicine should be applied to traditional medicine.

This respondent implies that the unwillingness of traditional healers to be subject to regulation, and problems around establishing the scientific validity of traditional and faith healers' practices makes

cooperation very difficult, a view that was shared by other respondents, particularly at the policy-making level.

*Scepticism around the effectiveness of 'conventional' psychiatric treatments*

Uncertainties about possible collaboration were also conveyed by some traditional healers, who revealed cynicism regarding the value of 'conventional' psychiatric treatments. Given their perceptions of the underlying spiritual cause of mental disorders, some traditional healers felt that 'conventional' treatment was not always appropriate. For example, one traditional healer remarked that 'conventional' medical practitioners just 'treat the symptoms and not the causes', while another traditional healer commented that such practitioners 'have very different views about health and disease to us . . . and this is shown in the type of medications they prescribe'. Similarly, another traditional healer argued:

I do not think that doctors really know the difference between demons and real madness. Because if somebody goes in trance, they start speaking in tongues, that is not madness but spirituality, that is demon possession. If someone is being haunted by a ghost, it is not madness. And so in these cases doctors' medicine won't make an improvement.

*Traditional healer solidarity and internal referral systems*

Some traditional and faith healers also appeared to be reluctant to engage with 'conventional' medical practitioners due to the solidarity and camaraderie they felt with other traditional healers. They expressed a preference for referring a client to another healer rather than to a doctor:

We the fetish priests, we are one, like the doctors, and so when someone comes to me and I am unable to treat him/her, I can direct the patient to another fetish.

Many of the traditional healers shared these sentiments, indicating that they would normally refer a patient to another healer when they found the condition very difficult to manage. A few said they would refer the person to a more powerful healer to take over the treatment process. Many said they would combine spiritual forces with another healer for the management of some patients, especially in more complex cases. Some also stated that a deity may inform the healer to refer the patient specifically to another deity because that deity has the cure for that particular disorder. This may occur when the

healer is in a trance, as indicated by this traditional healer:

In the same way a doctor gives a referral note to a patient to take it to Techiman or Jema hospital, deities also direct somebody to go to some places. For instance, it may say... if you take your illness to 'Akwatia Firi', it will tell you that, for that particular disease it does not have a cure and so take it to 'Kyiri Akyingye' [another special deity].

Through the narratives of traditional and faith healers, it became clear that they have a complex referral system amongst themselves, which would become compromised if partnerships were forged with 'conventional' practitioners.

#### *Potential for collaboration*

Despite the various barriers, and widespread scepticism that were revealed around possible collaboration, the interviews did suggest some potential for collaboration. This was revealed for the most part through a handful of respondents' accounts of some of the positive interactions they have experienced between different healing systems. For example, one nurse reported working successfully with traditional and faith healers:

Some patients will like to visit them [traditional healers] and we don't deny them that. All that we are interested is taking your medication from our side whilst you are attending for treatment from the other side too. So when our clients are maybe admitted at such places we pay them visits. We talk to the either the spiritualist, the fetish priests, we chat with them, tell them they are friends, and then we find some of them encourage the relatives and the clients to come for treatment whilst they are there.

This same nurse went on to state that the nurses may confer with the faith or traditional healers, giving them advice, but also respecting the support that such healers may be able to provide:

We tell them [traditional and faith healers] that there are conditions, especially the acute phase, where the person may be very restless or aggressive, and they should know that is not their area. That side they cannot do much about it, so they should convince them to come to the hospital. After the person has settled, we tell them that the person can go to them where they can take care of the spiritual side.

The potential for collaboration was also revealed through some of the accounts given by faith and traditional healers. Although many of these

practitioners expressed uneasiness around referring patients to more 'conventional' practitioners, there were exceptions. A few faith and traditional healers said that they do see some of the benefits of more 'conventional' medicine, and consequently advise patients to use such treatments alongside spiritual care. One of the pastors from a healing church stated that he normally refers patients to the hospital first, and then carries out his own healing methods:

When somebody comes to me I first of all let him go to the hospital for treatment and when he comes back from the hospital I put him on fasting and prayers. We fast and pray for him till he gets well.

Another Muslim healer said:

Those illnesses where I try all possible means yet is not going, I advise them to go to the hospital so that the doctor can diagnose what is wrong with them. Because the medicines are the same so if someone comes here and is above my control I refer him to the hospital.

This healer implies that there are points of commonality between different treatment modalities, rather than just differences and contradictions as was commonly expressed. Ultimately, a health programme director admitted that treatment of people with mental disorders is most successful when partnership between different healing systems occurs:

Where I have seen successful management of mental cases is being the link between the two – where the church encourages the patients to take their drugs and keeps monitoring them... And so we need to be able to strike that kind of relationship between the clinical setting and the faith-based setting.

These admissions and positive accounts by practitioners on both sides of the healing spectrum highlight that despite the obstacles, barriers and uncertainty, the potential for collaboration most certainly exists.

## **Discussion**

This study provides qualitative insights into the role that faith and traditional healers appear to play in Ghanaian society, shedding light on some of the reasons for their widespread use. In addition, this paper documents some of the key obstacles to establishing alliances between traditional and faith healers and more 'conventional' practitioners. In contrast with much of the medical and social research which has made traditional and faith healers the objects of analysis (Wreford, 2005), this study sought to explore the subjectivity of these individuals,

giving voice to their frequently muted voices. An attempt was made to highlight some of their beliefs and practices from their own perspectives, and how this relates to the views and opinions of others.

The results revealed that a multitude of overlapping social, economic and cultural factors shape the widespread use of traditional and faith healers. The cultural authority of traditional constructions of health and illness appears to play a significant part in the appeal of traditional mental healthcare systems. This corroborates findings from other studies which revealed that cultural perceptions of mental disorders as 'spiritual' illnesses may be a significant influencing factor in the popularity of traditional and faith healers (Hewson, 1998; Jahoda, 1979; Ofori-Atta & Linden, 1995; Tanner, 1999).

The psychological and social support afforded by traditional and faith healing practices was seen as an additional contributing factor. This finding supports the results of other studies which highlighted the immense psychosocial support many traditional and faith healers provide, factors which are highly valued by their service users (Hewson, 1998; Meissner, 2004; Tanner, 1999; Van der Geest, 1997).

Finally, the availability and affordability of such practitioners were seen to also shape their widespread use. In Ghana, as in many other low-income African countries (Jacob et al., 2007; Kohn, Saxena, Levav, & Saraceno, 2004; Saxena, Thornicroft, Knapp, & Whiteford, 2007), 'conventional' mental health services are plagued by inadequate resources, frequently lacking sufficient medications and a paucity of mental health staff, particularly amongst the allied mental health professions (Ofori-Atta, Read, & Lund, 2010). In addition, the availability of psychiatric care in Ghana is geographically inequitable and significantly skewed in favour of the southern urban areas (Doku et al., 2008). It is thus somewhat understandable why the participants in this study perceived traditional and faith healers to be filling a significant gap in mental health care provision. The results from this study substantiate findings from other studies that have suggested that the scarcity, high cost and uneven distribution of more western psychiatric mental health care may be in part responsible for the popularity of traditional healers in Africa (Roberts, 2001; Tsey, 1997). Indeed, for many poor people, traditional healers may in fact be the only affordable and accessible form of health care (Cocks & Moller, 2002; Sodi, 1996; Tabi, 1994).

Given the significant role that faith and traditional healers appear to be playing in Ghana, many respondents voiced support for collaboration between such practitioners and 'conventional' psychiatric services. Despite such calls for partnerships, participants' narratives explicitly and implicitly suggested that a number of factors may impede greater

alliance between the different mental health care sectors.

Suspicion and scepticism were revealed to be pervasive from all sides of the mental health care spectrum, key issues hindering possible partnerships. Many 'conventional' mental health practitioners and policy makers questioned the safety and efficiency of traditional treatments, and raised concerns about the human rights impact of such practices. These issues have been dominant themes in the literature on traditional and faith healers (Ensink & Robertson, 1999; Vinorkor, 2004; WHO, 2002).

On the other side of the mental health care spectrum, due to their explanatory models of mental disease aetiology, many traditional healers questioned the value of more conventional treatments. Other studies have documented additional fears traditional and faith healers may have about working together with 'conventional' psychiatric services. For example, Ramsay (2002) reported that practitioners in traditional medicine may fear giving information about their treatments, in case they are reproduced in scientific laboratories. This study found that cooperation with 'conventional' psychiatric practitioners may also threaten the solidarity and complex referral matrix that appears to occur between traditional healers, a finding which has been shown in other studies (Kilonzo & Simmons, 1998; Wreford, 2005).

Most certainly, concerns of safety, efficiency and maltreatment amongst traditional and faith healing practices are very real and need to be taken extremely seriously if collaboration is to occur. Indeed, very little clinical evidence exists concerning the quality of such methods (WHO, 2002), and the harrowing abuses that do occur amongst some practitioners have been widely documented (Roberts, 2001; Selby, 2008). With this said, it is important to take heed of the assertion that has been made that 'conventional' mental health professionals and policy makers are frequently guided by 'uninformed scepticism' (WHO, 2002). It has been argued that discourses on traditional healing practices in Africa are still too frequently situated within colonial rhetoric that consistently undermined indigenous knowledge and practices relegating them to the 'harmful', 'primitive' and 'fallacious' (Summerton, 2006; Kilonzo & Simmons, 1998; Wreford, 2005). Scepticism around possible partnership thus appears to represent a blurring of some of the harsh realities of traditional and faith healing practices, with potentially denigrating and derogatory constructions.

The obvious question that therefore remains is how, in light of the obstacles hindering collaboration highlighted in this study, can better partnerships be established? A promising sign is that, as revealed in this study, the majority of practitioners, on both sides

of the healing spectrum expressed at least some willingness for collaboration. This is an important starting point (WHO, 2002). Based on the results from this study, it appears clear that traditional and faith healers do require training and education in human rights issues, and the quality and effectiveness of their treatment modalities need to be established. Most certainly, assessing the scientific validity of such treatments is a very difficult and challenging prospect (WHO, 2002).

In analysing the few accounts given in this study on successful engagement between different treatment modalities, it appears that this occurred when they were based on mutual respect and bi-directional conversations. The findings from this study revealed that when nurses engaged with traditional healers as equals, and genuinely valued the psychosocial support they provided, many traditional healers encouraged their patients to visit the hospital and take their biomedical treatment. Indeed, various scholars have suggested that certain collaborative initiatives have failed because they have been uni-directional, with more 'conventional' practitioners failing to respect the positive aspects of more traditional practices (Summerton, 2006; Wreford, 2005). Indeed, many more 'conventional' practitioners could learn from the psychosocial approaches of traditional and faith healers. Furthermore, it may be worth biomedical practitioners also reflecting on their own practices, as human rights abuses occur not only amongst traditional practices, but also in the psychiatric hospitals, for example in the use of unnecessary seclusion and restraint, and unsanitary and deplorable conditions (Gostin, 2004; Kelly, 2006; WHO, 2005).

This study indicates that mutual respect can only be achieved if practitioners seek to understand local beliefs and practices, and engage with their complexities (Green, 1999). Ultimately, all treatment ontologies, whether traditional or conventional can be 'promotive of health, damaging to health or of no direct health consequence' (Green, 1999, p. 75). The ultimate goal is to be able to harness and draw on those practices that are promotive to mental health.

## Conclusion

The current burden of mental health in Ghana and the related underdevelopment of accessible public sector mental health services underscore the need for mobilizing local resources for the better detection, referral and management of mental disorders. Given the widespread availability, use and appeal of traditional and faith healing, harnessing and cooperating with the positive and productive aspects of such practices could be a step in this direction. However, collaboration is not as easy as commonly assumed, given paradigmatic disjunctions and mutual

scepticism between different treatment modalities. Working together within these contexts, reflectively considering one's own and other practices, rather than maintaining an indifferent and suspicious distance, may lead to more successful co-operation in future. More studies are thus needed to understand the complexities of traditional and faith beliefs and practices, and to document attempts to collaborate.

**Declaration of interest:** The Mental Health and Poverty Project (MHAPP) is a Research Programme Consortium (RPC) funded by the UK Department for International Development (DfID)(RPC HD6 2005- 2010) for the benefit of developing countries. The views expressed are not necessarily those of DfID. RPC members include Alan J. Flisher (Director) and Crick Lund (Co-ordinator) (University of Cape Town, Republic of South Africa (RSA)), Therese Agossou, Natalie Drew, Edwige Faydi and Michelle Funk (World Health Organization), Arvin Bhana (Human Sciences Research Council, RSA), Victor Doku (Kintampo Health Research Centre, Ghana), Andrew Green and Mayeh Omar (University of Leeds, UK), Fred Kigozi (Butabika Hospital, Uganda), Martin Knapp (University of London, UK), John Mayeya (Ministry of Health, Zambia), Eva N Mulutsi (Department of Health, RSA), Sheila Zaramba Ndyanabangi (Ministry of Health, Uganda), Angela Ofori-Atta (University of Ghana), Akwasi Osei (Ghana Health Service), and Inge Petersen (University of KwaZulu-Natal, RSA). The authors alone are responsible for the content and writing of the paper.

## References

- Alem, A., Araya, J.M., Kebede, D., & Kullgren, G. (1999). How are mental disorders seen and where is help sought in a rural Ethiopian community? A key informant study in Butajira, Ethiopia. *Acta Psychiatrica Scandinavica*, 100, 40-47.
- Anyinam, C. (1987). Traditional medical practice in contemporary Ghana: A dying or growing profession? *Canadian Journal of African Studies*, 21, 315-336.
- Cocks, M., & Moller, V. (2002). Use of indigenous and indigenized medicines to enhance personal well-being: A South African case study. *Social Science & Medicine*, 54, 387-398.
- Crawford, T.A., & Lipsege, M. (2004). Seeking help for psychological distress: The interface of Zulu traditional healing and western biomedicine. *Mental Health, Religion & Culture*, 7, 131-148.
- Doku, V., Ofori-Atta, A., Akpalu, B., Read, U., Osei, A., Ae-Ngibise, K., . . . , Omar, M. (2008). *A situation analysis of mental health policy development and implementation in Ghana. Phase 1 country report*. Accra: Mental Health and Poverty Project.

- Ensink, K., & Robertson, B. (1999). Patient and family experiences of psychiatric services and African indigenous healers. *Transcultural Psychiatry*, 36, 23–43.
- Ewusi-Mensah, I. (2001). Post colonial psychiatric care in Ghana. *Psychiatric Bulletin*, 25, 228–229.
- Flisher, A.J., Lund, C., Funk, M., Banda, M., Bhana, A., . . . , Doku, V. (2007). Mental health policy development and implementation in four African countries. *Journal of Health Psychology*, 12, 505–516.
- Gostin, L.O. (2004). International human rights law and mental disability. *Hastings Center Report*, (march/April), 11–12.
- Green, E. (1999). Engaging indigenous African healers in the prevention of AIDS and STDs. In R. Hahn (Ed.), *Anthropology in public health* (pp. 63–83). London: Oxford University Press.
- Gureje, O., & Lasebikan, V. (2006). Use of mental health services in a developing country. *Social Psychiatry and Psychiatric Epidemiology*, 41(1), 44–49.
- Hewson, M.G. (1998). Traditional healers in southern Africa. *Annals of Internal Medicine*, 128, 1029–1034.
- Horton, R. (2007). Launching a new movement for mental health. *Lancet*, 370, 306.
- Jacob, K.S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J.J., . . . , Shekhar, S. (2007). Mental health systems in countries: Where are we now? *Lancet*, 370, 1061–1077.
- Jahoda, G. (1979). Traditional healers and other institutions concerned with mental illness in Ghana. In Z. Ademuwagun, J.A. Ayoade, I.E. Harrison & D.M. Warren (Eds.), *African therapeutic systems* (pp. 98–109). Waltham: African Studies Association.
- Kale, R. (1995). South Africa's health: Traditional healers in South Africa: A parallel health care system. *British Medical Journal*, 310, 1182–1185.
- Kelly, B.D. (2006). The power gap: Freedom, power and mental illness. *Social Science & Medicine*, 63, 2118–2128.
- Kilonzo, G.P., & Simmons, N. (1998). Development of mental health services in Tanzania: A reappraisal for the future. *Social Science & Medicine*, 47, 419–428.
- Kohn, R., Saxena, S., Levav, I., & Saraceno, B. (2004). The treatment gap in mental health care. *Bulletin of the World Health Organization*, 82, 858–866.
- Lancet Global Mental Health Group (2007). Scale up services for mental disorders: A call for action. *Lancet*, 370, 1241–1252.
- Meissner, O. (2004). The traditional healer as part of the primary health care team? *South African Medical Journal*, 94, 901–902.
- Montia, S. (2008). *Fostering productive partnerships with traditional healers*. Retrieved 10/09, 2007, from <http://www.mentalhealthanddevelopment.org/files/Traditional%20Healers%20Article.pdf> (accessed 18 June 2010).
- Ndetei, D.M. (2007). Traditional healers in East Africa. *International Psychiatry*, 4, 85–86.
- Ofori-Atta, A., Akpalu, B., Osei, A.O. & Doku, V.C.K. (2007, September). What happens when your mental health fails and society wants you out? A critical study of available options in mental health services around Ghana. Paper Presented at the Scientific Conference of the College of Health Sciences, University of Ghana, Accra, Ghana.
- Ofori-Atta, A., Read, U.M., & Lund, C. (2010). A situation analysis of mental health services and legislation in Ghana: Challenges for transformation. *African Journal of Psychiatry*, 13, 99–108.
- Ofori-Atta, A.M.L., & Linden, W. (1995). The effect of social change on causal beliefs of mental disorders and treatment preferences in Ghana. *Social Science & Medicine*, 40, 1231–1242.
- Osei, A.O. (2001). Types of psychiatric illness at traditional healing centres in Ghana. *Ghana Medical Journal*, 35, 106–110.
- Patterson, L. (2001, July). Traditional medicine in Ghana. Paper presented at the Second Annual International Conference on Traditional Medicine, Ghana, Accra. Available at [http://www.ccnh.edu/community/newsletter/holtimesv8n4/ht\\_v8n4.pdf](http://www.ccnh.edu/community/newsletter/holtimesv8n4/ht_v8n4.pdf) (accessed 11 December 2010).
- Prince, M., Patel, V., Saxena, S., Maj, M., Maserko, J., Phillips, M.R., & Rahaman, A. (2007). No health without mental health. *Lancet*, 370, 859–877.
- Puckree, T., Mkhize, M., Mgbobhozi, Z., & Lin, J. (2002). African traditional healers: What health care professionals need to know. *International Journal of Rehabilitation Research*, 25, 247–251.
- Quinn, N. (2007). Beliefs and community responses to mental illness in Ghana: The experiences of family carers. *International Journal of Social Psychiatry*, 53, 175–188.
- Ramsay, S. (2002). Traditional medicine gets healthy recognition. *Lancet*, 359, 1760.
- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R.G. Burgess (Eds.), *Analysing qualitative data* (pp. 173–194). London: Routledge.
- Roberts, H. (2001). A way forward for mental health care in Ghana? *Lancet*, 357, 1859.
- Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., . . . , Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet*, 370, 1164–1174.
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H.A. (2007). Resources for mental health: Scarcity, inequity and inefficiency. *Lancet*, 370, 878–889.
- Selby, H. (2008). Mental illness, prayer camps and society: A factor of human rights abuse. *Ghanaian Chronicle*.
- Sodi, T. (1996). Towards recognition of indigenous healing: Prospects and constraints. *Journal of Comprehensive Health*, 7, 5–9.
- Summerton, J.V. (2006). The organisation and infrastructure of the African traditional healing system: Reflections from a sub-district of South Africa. *African Studies*, 65, 297–319.
- Tabi, M. (1994). Nursing in Ghana. *Journal of Nursing Administration*, 24, 17–18.
- Tabi, M., & Frimpong, S. (2003). HIV infection of women in developing countries. *International Nursing Review*, 50, 40–50.
- Tabi, M., Powell, M., & Hodnicki, D. (2006). Use of traditional healers and modern medicine in Ghana. *International Nursing Review*, 53, 52–58.
- Tanner, R.E.S. (1999). Concern, cooperation, and coexistence in healing. *British Medical Journal*, 319, 133.
- Tsey, K. (1997). Traditional medicine in contemporary Ghana: A public policy analysis. *Social Science & Medicine*, 45, 1065–1074.
- Van der Geest, S. (1997). Is there a role for traditional medicine in basic health services in Africa? A plea for community perspective. *Tropical Medicine & International Health*, 2, 903–911.
- Ventevogel, P. (1996). *Whiteman's things: Training and de-training healers in Ghana* (pp. 38–40). Amsterdam: Het Spinhuis.
- Vinorkor, M.A. (2004). Move to protect mental patients. *Daily Graphic*.
- WHO (2002). *WHO traditional medicine strategy 2002–2005*. Geneva: World Health Organization.
- WHO (2005). *WHO resource book on mental health, human rights and legislation*. Geneva: World Health Organization.
- Wreford, J. (2005). Missing each other: Problems and potential for collaborative efforts between biomedicine and traditional healers in South Africa in the time of AIDS. *Social Dynamics*, 31, 55–89.